"Asking Why" From a Distance: Its Cognitive and Emotional Consequences for People With Major Depressive Disorder

Ethan Kross
University of Michigan, Ann Arbor

David Gard
San Francisco State University

Patricia Deldin
University of Michigan, Ann Arbor

Jessica Clifton
San Francisco State University

Ozlem Ayduk
University of California, Berkeley

Although analyzing negative experiences leads to physical and mental health benefits among healthy populations, when people with depression engage in this process on their own they often ruminate and feel worse. Here we examine whether it is possible for adults with depression to analyze their feelings adaptively if they adopt a *self-distanced perspective*. We examined this issue by randomly assigning depressed and nondepressed adults to analyze their feelings surrounding a depressing life experience from either a self-distanced or a self-immersed perspective and then examined the implications of these manipulations for depressotypic thought accessibility, negative affect, implicit and explicit avoidance, and thought content. Four key results emerged. First, all participants were capable of self-distancing while analyzing their feelings. Second, participants who analyzed their feelings from a self-distanced perspective showed lower levels of depressotypic thought accessibility and negative affect compared to their self-immersed counterparts. Third, analyzing negative feelings from a self-distanced perspective led to an adaptive shift in the way people construed their experience—they recounted the emotionally arousing details of their experience less and reconstrued them in ways that promoted insight and closure. It did not promote avoidance. Finally, self-distancing did not influence negative affect or depressotypic thought accessibility among nondepressed participants. These findings suggest that whether depressed adults' attempts to analyze negative feelings lead to adaptive or maladaptive consequences may depend critically on whether they do so from a self-immersed or a self-distanced perspective.

Keywords: rumination, distance, depression, coping, perspective, emotion regulation

Although analyzing negative experiences leads to a variety of physical and mental health benefits among healthy populations (e.g., Greenberg, 2002; Pennebaker & Chung, 2007; Wilson & Gilbert, 2008), when people with depression engage in this process on their own they often ruminate and feel worse (Gotlib & Joormann, 2010; Mor & Winquist, 2002; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Smith & Alloy, 2009). Here we examine whether it is possible for adults with depression to analyze their feelings adaptively if they adopt a *self-distanced* perspective.

Self-Distancing: Definition, Theoretical Antecedents, and Prior Research

Self-distancing refers to a process that allows people to transcend their egocentric viewpoint. To illustrate, consider Sara—a dejected young adult who is mired in despair after being fired. Motivated to understand her feelings, Sara might recall her experience of being fired and replay the event happening all over again through her own eyes. From this perspective, Sara might think, "Why did *I* feel that way during that situation?" Here Sara is focusing on her feelings from a *self-immersed* perspective—the self that is reasoning about the negative experience and the self that is experiencing the breakup are one.

However, it is also possible for Sara to take a step back when thinking about her experience and reason about it from the perspective of a distanced observer, akin to a fly on the wall who can see herself in the experience. From this perspective, Sara might think: "Why did *Sara* feel the way *she* did during that situation?" Here, Sara is focusing on her feelings from a *self-distanced* perspective—the self that is reasoning about the experience is psychologically removed from the self that is experiencing the event.

Although research has only recently begun to examine how self-distancing influences the way people analyze their feelings, psychologists have long acknowledged the self-regulatory benefits of this mechanism. For example, in reviewing 30 years of research on delay of gratification in children Mischel and Rodriguez (1993) described psychological distance as one of the "basic ingredients" that enable self-control, an inference that is supported by research indicating that distancing strategies facilitate impulse control, cognitive change, and emotion regulation (e.g., Fujita, Trope, Liberman, & Levin-Sagi, 2006; McIsaac & Eich, 2004; Mischel, Shoda, & Rodriguez, 1989; Ray, Wilhelm, & Gross, 2008).

In the clinical domain, Beck (1970) described "distancing" as a process that allows adult clients to "gain objectivity toward [their] cognitions" and noted that, "once the patient is able to 'objectify' his thoughts, he is ready for the later stages of reality testing: applying rules of evidence and logic and considering alternative explanations (Beck, 1970, pp. 189–190)." Ingram and Hollon (1986) echoed a similar view noting, "C[ognitive] T[herapy] relies heavily on helping individuals switch to a controlled mode of processing that is metacognitive in nature. . .typically referred to as *distancing*." They suggested further, "the long-term effectiveness of cognitive therapy may reside in teaching individuals how to initiate this process on their own (p. 272)."

The concept of distancing, although sometimes referred to as "decentering" or "self-as-context," is also popular among many third waveforms of cognitive therapy (e.g., Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Teasdale et al., 2002). Central to these approaches is the idea that distancing is helpful for allowing people to recognize that their feelings are mental events, not facts, so they can observe and accept them.

"Asking Why" From a Self-Distanced Perspective

Whereas third-waveforms of cognitive therapy encourage clients to distance in order to observe and accept their emotions, Kross, Ayduk, and Mischel (2005) predicted that distancing might be useful in another context—it might allow people to analyze painful emotional experiences without succumbing to rumination. They proposed that people's attempts to analyze negative experiences often lead to rumination because they reflect on them from a self-immersed perspective, which predisposes them to recount the emotionally arousing features of their experience (e.g., what happened? what did I feel?). Therefore, they suggested that a mechanism is needed to distance people from the self, to allow them to reconstrue their feelings adaptively.

A number of experiments have tested this prediction in young adults and children and provided evidence to support it. In these studies unselected participants are randomly assigned to visualize an intense negative experience happening to them all over again either through their own eyes (self-immersed) or from the vantage point of a fly on the wall peering down on the scene (self-distanced). Next, they are asked to analyze why they felt the way they did during the situation while maintaining the perspective they adopted (for verbatim instructions, see Appendix).[1]

The results of these experiments indicate that participants who analyze their feelings from a self-distanced perspective *recount* the emotionally arousing details of their experience less (i.e., what happened? what did I feel?) and *reconstrue* their feelings in ways that promote closure and insight. This shift in thought content—

less recounting and more reconstruing—leads participants who self-distance to experience less distress. Over time, analyzing negative experiences from a self-distanced perspective buffers people against recurring negative thoughts, future negative affect, and delayed cardiovascular reactivity. It also reduces the accessibility of negative thoughts (for review, see Kross & Ayduk, 2011). Importantly, analyzing negative experiences from a self-distanced perspective does not promote avoidance (Ayduk & Kross, 2010).

Generalizability to Major Depressive Disorder (MDD)

Although the aforementioned findings suggest that self-distancing allows people to "ask why" adaptively, all of these results were observed in unselected samples. Therefore, whether they translate to adults with depression is unclear. This question is particularly vexing because extant research provides mixed forecasts about whether depressed adults will be capable of self-distancing, and if so, what the consequences of doing so will be.

One possibility is that depressed adults will experience more difficulty self-distancing when they analyze their feelings than nondepressed adults, and thus less capable of utilizing this process to reflect adaptively. This prediction is motivated by two sets of findings. First, prior research suggests that adopting a self-distanced perspective is effortful because people habitually adopt a self-immersed perspective when analyzing past experiences (Ayduk & Kross, 2008, 2010; Kross & Ayduk, 2008). Second, depressed people experience more difficulty engaging in effortful tasks than healthy people (Hartlage, Alloy, Vazquez, & Dykman, 1993)—they are characterized by inhibitory control deficits and experience difficulties disengaging attention from negative material (Gotlib & Joormann, 2010).

Another possibility is that adults with depression will be capable of analyzing their feelings from a self-distanced perspective, but that engaging in this process will not lead to beneficial patterns of thinking and feeling. This prediction is motivated by research indicating that adopting an abstract-analytic-evaluative orientation (i.e., focusing on "why") is harmful for adults with depression (e.g., Segal, Williams, & Teasdale, 2002; Watkins, 2008). If analyzing negative emotions is one of the active ingredients underlying rumination, than it may not matter how one engages in this process—any way of "asking why," regardless of the perspective from which it is done, may be counterproductive.

A third possibility is that depressed adults will benefit from analyzing their feelings from a self-distanced perspective and is motivated largely by the research reviewed earlier. Specifically, several researchers have speculated that "distancing" plays a role in the success of cognitive therapy for depression (Beck, 1970;

---

[1] Research in cognitive psychology indicates that people can recall negative experiences from either a field perspective (i.e., visualizing recalled experiences through one's own eyes) or an observer perspective (i.e., seeing oneself in a recalled experience). Memories that are recalled from a field perspective tend to be more vivid, recent, and emotionally rich than memories recalled from an observer perspective (e.g., McIsaac & Eich, 2002; Nigro & Neisser, 1983; Robinson & Swanson, 1993). As the discussion section notes, a critical difference between these studies and the current work is that the former focus on the perspective people adopt when recalling experiences whereas we focus on the perspective people adopt when analyzing experiences.

Ingram & Hollon, 1986). Moreover, the shifts in thought content that self-distancing promotes—less recounting and more reconstruing—overlap closely with the concept of cognitive change in clinical research, which has been linked with adaptive outcomes for adults with depression (e.g., Greenberg, 2002; Hayes et al., 2007; Tang & DeRubeis, 1999; Whisman, 1993). Thus, if depressed adults can adopt a self-distanced perspective as they analyze their feelings, this perspective suggests that they should benefit from this process.

Circumstantial evidence supporting this view comes from two studies on dysphoria. In one study, Kross and Ayduk (2009) found that depressive symptoms moderated the effectiveness of self-distancing for reducing negative affect. Specifically, the higher participants Beck Depression Inventory (BDI) scores, the more effective self-distancing was at reducing negative affect. Interestingly, participants who scored especially low on the BDI (<3) experienced no emotion regulatory benefit from self-distancing, suggesting that a certain level of depressive symptoms is necessary for self-distancing to be effective. These findings were partially replicated by Wisco and Nolen-Hoeksema (2011). They found that self-distancing reduced emotional reactivity for *both* dysphoric and nondysphoric participants, raising questions about the role that depressive symptoms play in moderating the benefits of this process. An important caveat associated with both of these studies, however, is that they used the BDI to index depression, which does not provide a surrogate for clinical diagnoses (Coyne, 1994). Therefore, although these findings are consistent with the position that self-distancing may facilitate adaptive emotional analysis among people with depression, they do not address the issue directly.

In sum, theoretical perspectives diverge regarding whether adults with depression will be capable of adopting a self-distanced perspective when they analyze their feelings and whether doing so will lead to helpful or harmful patterns of thinking and feeling. Furthermore, even if self-distancing leads to beneficial outcomes, whether the benefits will be more pronounced for depressed adults than nondepressed adults is unknown.

Research Overview

We addressed these issues by randomly assigning adults diagnosed with MDD and a healthy comparison group to analyze a depressing life experience from either a self-immersed or a self-distanced perspective. We predicted that adults with depression would be capable of analyzing their feelings from a self-distanced perspective and that doing so would lead to a more adaptive profile of thinking (i.e., less recounting, more reconstruing) and feeling (lower levels of self-report and implicit negative affect) than analyzing negative feelings from a self-immersed perspective. Following prior research (Ayduk & Kross, 2010), we also predicted that there would be no relationship between self-distancing and avoidance. Finally, given mixed evidence about how depressive symptoms influence the effectiveness of self-distancing in undiagnosed samples (Kross & Ayduk, 2009; Wisco & Nolen-Hoeksema, 2011), we were agnostic about whether depressed participants would display equal or larger reductions in negative affect compared to the healthy comparison group.

Method

Participants

Participants were 51 adults diagnosed with MDD and 45 healthy adults without any history of MDD. All participants were native English language speaking adults (M_{age} = 29.10, SD_{age} = 12.17) who were recruited from the Ann Arbor, MI and San Francisco Bay, CA areas through fliers and Craigslist advertisements (for demographics, see Table 1).[2] Participants recruited from Ann Arbor and the Bay Area were not statistically different from each other on any of the demographic variables except age, $t(94)$ = 4.80, $p < .001$—Bay Area participants (M = 35.86, SD = 14.63) were older than Ann Arbor participants (M = 24.83, SD = 7.87). As noted below, controlling for age or recruitment site did not influence any of the results.

At both recruitment sites the diagnostic status of each participant was assessed using the Structured Clinical Interview for *DSM–IV* (SCID; First, Spitzer, Gibbon, & Williams, 2002), administered by a clinical psychologist or a trained clinical graduate student. All interviewers were trained to administer the SCID and had experience doing so. They were directly supervised by one of the study clinical PIs at each site. Each interview was audio-recorded, and an independent rater assured diagnostic reliability for a random selection of 40% of the tapes. For the Bay Area sample, the second raters consisted of clinical psychology graduate students and advanced research assistants who were trained to administer the SCID. For the Ann Arbor sample, the second raters consisted of the same people who performed the SCIDs originally (with the caveat that the second rater never rated their own interview). At both sites, the second rater was blind to the original diagnosis and made his or her own assessment of participants' mental health status. There was 100% interrater reliability for reviewed diagnoses at both sites. To further ensure the validity of MDD diagnoses and to assess the severity of depressive symptoms, each participant also completed the BDI (Beck, Steer, & Brown, 1996).

Exclusion criteria for all groups comprised a history of head injury with loss of consciousness for more than two minutes, and major medical illnesses or neurologic disorders. For the depressed group, only individuals in a current major depressive episode were enrolled—80% of depressed participants experienced at least one major depressive episode in the past. The exclusion criteria for potential control participants differed by recruitment site. For the Bay Area sample, potential control participants were excluded if they met diagnostic criteria for any current or past mood disorder whereas potential control participants from the Michigan sample were excluded if they met diagnostic criteria for any current or past Axis I disorder (including any current or past mood disorder). Ann Arbor versus Bay Area control participants did not differ significantly from each other on any of the dependent variables we assessed ($Fs < 2.81$, $ps > .10$) and controlling for recruitment site did not substantively alter any of the results.

---

[2] Twelve non-native English language speakers accidentally participated. These data were not analyzed because they violated our inclusion requirement that participants be native English language speakers to ensure comprehension of the experimental manipulations.

Table 1
Descriptive Statistics

	Depressed		Nondepressed	
	Self-immersed ($n = 25$)	Self-distanced ($n = 26$)	Self-immersed ($n = 21$)	Self-distanced ($n = 24$)
Demographics				
% Female	68%[a]	69%[a]	76%[a]	58%[a]
Age (years)	31.64 (11.49)[a]	30.65 (13.40)[a]	27.10 (11.91)[a]	26.46 (11.60)[a]
Education Level (years)	14.87 (2.99)[a]	15.65 (1.75)[a]	15.67 (1.56)[a]	15.40 (1.10)[a]
Baseline affect	5.20 (1.66)[a]	4.81 (1.27)[a]	6.76 (1.22)[b]	6.08 (1.67)[b]
BDI	26.36 (9.86)[a]	23.81 (10.58)[a]	3.57 (5.89)[b]	4.38 (5.70)[b]
Racial Distribution				
% White	52%[a]	50%[a]	62%[a]	58%[a]
% Asian	4%[a]	12%[a]	10%[a]	13%[a]
% Latino	12%[a]	19%[a]	5%[a]	17%[a]
% Black	16%[a,b]	8%[a,b]	24%[a]	4%[b]
% Other	16%[a]	8%[a]	0%[a]	8%[a]
Treatment Status				
% Undergoing therapy	24%[a]	27%[a]	0%[b]	4%[b]
% On psychotropic medications	48%[a]	27%[a]	5%[b]	4%[b]

Note. Values given are either means with standard deviations in parentheses or percentages. Means in the same row that do not share subscripts differ at $p < .05$.

Procedure

Eligible participants returned for a lab session within 2 weeks of the SCID interview. Three participants did not return for the second session. After baseline affect was assessed, participants completed the BDI. They were then cued to recall a past experience in which they felt overwhelming sadness. Recall time ($M = 6.99$ sec, $SD = 13.58$ sec) did not differ by diagnostic status ($t < 1$, *ns*). They were then randomly assigned to adopt a self-immersed ($N_{MDD} = 25$; $N_{HC} = 21$) or a self-distanced ($N_{MDD} = 26$; $N_{HC} = 24$) perspective and given as much time as they needed to do so. Next, participants in both conditions were cued to analyze the emotions that they (or their "distant self") experienced during the event they recalled for 60 seconds (for verbatim instructions, see Appendix) using instructions from prior research (Kross & Ayduk, 2008; Kross, Ayduk, & Mischel, 2005). Following the reflection task, participants performed a lexical-decision task. They then completed a package of measures that assessed the rest of the dependent variables and were debriefed.

Measures

Baseline affect. Participants completed the valence subscale of the Self Assessment Mannequin (SAM; Bradley & Lang, 1994), which presents participants with a series of nine faces that range in their expression from an *extreme frown* (1) to a *broad smile* (9).

BDI-II. Participants completed the 21-item version of the BDI (Beck et al., 1996).

Lexical-decision task. Following the self-reflection task, participants completed a lexical-decision task to assess the accessibility of depressotypic thoughts. Each trial began with a star presented in the middle of the screen for 500 ms. The target stimulus then appeared in the same location as the star and remained there until the participant indicated whether the stimulus was a word or nonword. A blank screen followed for 500 ms and then the next trial began. Reaction time on this measure reflects the accessibility of target constructs. The faster the reaction time (RT), the more accessible the target construct.

Participants made lexical decisions about 30 neutral words, 30 depressotypic words, and 30 nonwords with the presentation of words randomized for each participant. The task was administered over two runs, each consisting of 45 trials. Thus, each participant completed 90 trials. Twenty-two of the depressotypic words (e.g., dismal, hopeless) and 22 of the neutral words (e.g., thread, suitcase) were used previously (Johnson, Joormann, & Gotlib, 2007). We added eight more of each type of word to bring the total number of stimuli per category to 30. Depressotypic and neutral words were matched on word length and frequency ($ts < .67$, $ps > .51$). Six independent judges categorized all 30 depressotypic words as more related to depression than neutral content, and vice versa for the neutral words ($K_{Average} = .94$). The 30 nonwords were obtained from Ayduk, Mischel, and Downey (2002). They consisted of a pool of phonetically possible nonwords (e.g., cawteg, wongract).

We followed established procedures for cleaning the RT data (Bargh & Chartrand, 2000; Blair & Banaji, 1996). First, we removed trials on which participants incorrectly classified the target stimulus (328 trials; 4.34% error rate), trials on which participants responded faster than 300 ms (12 trials; 0.16% of nonerror trials), and trials in which participants responded extremely slow (i.e., 3 *SD*s above the mean; 150 trials; 1.98% of nonerror trials). Excluded trials were equally distributed across samples and conditions ($F < 1.17$, *ns*). Second, we excluded data from two participants (one nondepressed participant each in the immersed-why and distanced-why groups) with error rates that were 3 *SD*s above the sample mean (i.e., error rates higher than 13.7%). Finally, to reduce the skewness of the response latencies for depressotypic words (skew = 2.37) and neutral words (skew = 2.07), we winsorized these variables so that scores above the 95th percentile value for each type of stimulus ($n_{neutral} = 4$; $n_{depressotypic} = 4$) were rescored into 95th percentile values. As with excluded trials,

winsorized data was not systematically related to condition or diagnostic status (χ^2s < 2.05, ps > .56).

Self-distancing. Next, participants rated the extent to which they self-distanced while analyzing their feelings using two items (Mischowski, Kross, & Bushman, 2012). First, they rated the extent to which they adopted an immersed perspective and saw the event replay through their own eyes versus a distanced perspective and watched the event unfold as an observer (1 = *predominantly immersed*, 7 = *predominantly distanced*). Next, they rated "how far away from the scene they were" as they visualized their experience (1 = *very close, saw it through my own eyes*, 7 = *very far, saw it as if an observer*). These items were averaged to create a self-distancing index (α = .76).

Negative affect. Next, participants completed two types of affect measures. First, they answered a number of questions that assessed how they felt "right now." These questions included the valence subscale of the SAM, and the Negative Affect subscale of the Positive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988), with the addition of *sad* and *depressed*, which asks participants to rate the extent to which they're experiencing a series of negative emotions right now (1 = *not at all*, 5 = *extremely*). Participants' responses to these questions were highly correlated with the exception of scores on the "afraid" item, which was negatively correlated with all other items. Therefore, we collapsed across all items except afraid to form a single affect composite after reverse scoring the valence question and rescaling it to a 5-point scale (α = .90).

Second, to directly examine participants' current feelings about their experience, their agreement ratings (1 = *strongly disagree*, 5 = *strongly agree*) with the following four items were averaged to create an event-related reactivity composite: "Thinking about the event right now made me feel upset (e.g., rejected, angry, hurt, sad)," "As I think about the event now, my emotions and physical reactions to this experience are still intense," "I reexperienced the emotions I originally felt during the experience when I thought about it now," and "This experience remains unresolved and an active source of distress for me" (α = .86).

Preliminary analyses indicated that scores on the general and experience-specific affect composites were highly correlated (α = .75). Therefore, to enhance the reliability of our affect measurements and parsimony, data across the two composites were averaged to create a single negative affect index.

Thought content. We next assessed participants' tendency to recount (i.e., focus on the specific chain of events that took place) and reconstrue (i.e., expressing subjective perceptions of insight, closure, and cognitive change) their experience as they analyzed their feelings during the study. Participants rated their agreement (1 = *strongly disagree*, 5 = *strongly agree*) with the statement "My thoughts focused on the specific chain of events—sequence of events, what happened, what was said and done—as I thought about the experience in this study" to operationalize recounting. Participants' agreement ratings with the following four items were averaged to operationalize reconstruing: "As I thought about my experience during the study I had a realization that caused me to think differently about the experience," "As I thought about my experience during the study I had a realization that made me experience a sense of closure," "I feel a sense of closure about this experience," and "Thinking about my experience during the experiment led me to have a clearer and more coherent under-

standing of this experience." Scores on these questions were collapsed to form a single reconstruing index (α = .72). Prior research indicates that self-distancing influences recounting and reconstruing similarly regardless of whether it is assessed using these Likert-style questions (Ayduk & Kross, 2010; Grossmann & Kross, 2010) or blindly coded stream-of-thought essays (Kross & Ayduk, 2008; Kross et al., 2005; Kross, Duckworth, Ayduk, Tsukayama, & Mischel, 2011).

Explicit avoidance. Participants' agreement ratings (1 = *strongly disagree*, 5 = *strongly agree*) with the following two statements (Ayduk & Kross, 2010) were averaged to index explicit avoidance: "When prompted to recall this experience, I tried to avoid thinking about it" and "When prompted to recall this experience, I tried to suppress (push away) my feelings about it" (α = .78).

Implicit avoidance. Prior research indicates that it is possible to measure passive forms of avoidance such as repression by looking at the dissociation between scores on self-report and implicit emotional reactivity measures (Ayduk & Kross, 2010; Bonanno, Keltner, Holen, & Horowitz, 1995; Newton & Contrada, 1992). The logic motivating this approach is that people who repress their emotions display high scores on implicit measures of emotionality (which are less susceptible to conscious influence) but low scores on self-report measures (which are susceptible to conscious influence). Using data from the lexical-decision task and self-reported affect, we computed an explicit-implicit emotion dissociation score by (a) subtracting depressotypic word RT scores from neutral words RT scores to create an implicit affect score (i.e., higher scores = higher depressotypic thought accessibility), (b) standardizing the implicit affect and explicit affect scores, and (c) subtracting implicit scores from explicit scores. Negative scores on this variable indicate implicit avoidance.

Imagery vividness. Participants rated the extent to which their "memory of [the] experience was vivid and clear using a 1 (*strongly disagree*) to 5 (*strongly agree*) scale to examine whether the distanced-why strategy influence this dimension and, if so, whether it accounted for its effects on emotional reactivity or thought content.

Missing values. Less than 1% of all responses across all measures were missing due to response omission. Missing values were replaced with the sample mean.[3]

Results

Overview

The experimental design consisted of a 2 (Diagnostic Status: nondepressed vs. depressed) × 2 (Condition: immersed-why vs. distanced-why). We first compared the groups on all background variables. Next, we examined the main and interactive effects of diagnostic status and condition on each dependent variable using 2 × 2 ANOVAs unless otherwise noted.

---

[3] Due to procedural errors, 17 participants were missing data on the second distancing question, 11 participants were missing lexical decisions task data, and 12 participants were missing recall time data.

Preliminary Analyses

There were no significant differences between the conditions on any of the demographic variables except for race—there were slightly more Black participants in the nondepressed, immersed-why group than in the nondepressed, distanced-why group. As expected, depressed participants displayed more negative affect at baseline, and were significantly more likely to be undergoing psychotherapy treatment and taking antidepressant medication (see Table 1). None of the variables listed in Table 1 interacted with condition or diagnostic status to predict any the dependent variables and controlling for them did not substantively alter the results.

Dependent Variable Analyses

Self-distancing. The effect of condition was significant ($F(1, 92) = 9.02$, $p = .003$, $\eta^2 = .089$) indicating that distanced-why participants ($M = 4.15$, $SD = 1.33$) self-distanced more while analyzing their feelings than immersed-why participants ($M = 3.19$, $SD = 1.74$). There were no other significant effects ($Fs < 1$, $ps < .75$).

Depressotypic thought accessibility. The response latency for depressotypic words were subjected to an ANCOVA analysis with condition, diagnostic status, and their interaction as predictor variables and the response latency for neutral words as the covariate (neither the effect of diagnostic status, condition, or their interaction predicted neutral word response latency [$Fs < 1$]). This analysis revealed a significant condition by diagnostic status interaction, ($F(1, 77) = 4.87$, $p = .03$, $\eta^2 = .059$). As Figure 1, Panel A illustrates, depressed participants in the distanced-why group were slower to respond to depression words than their self-immersed counterparts ($F(1, 42) = 4.11$, $p = .049$, $\eta^2 = .089$). In contrast, the difference between nondepressed participants in the distanced-why and immersed-why groups was not significant ($F(1, 34) = 1.50$, $p = .23$, $\eta^2 = .042$).

Avoidance. The effect of diagnostic status was significant for explicit avoidance ($F(1, 92) = 7.75$, $p = .010$, $\eta^2 = .069$) and implicit avoidance ($F(1, 78) = 16.32$, $p < .001$, $\eta^2 = .173$) indicating that depressed participants displayed higher levels of explicit avoidance ($M = 3.07$; $SD = 1.21$) but lower levels of implicit avoidance ($M = .42$; $SD = 1.38$) than nondepressed participants (explicit avoidance: $M = 2.42$; $SD = 1.09$; implicit

avoidance: $M = -.66$; $SD = .89$). There were no significant main effects of condition or Condition X diagnostic status interactions on these variables ($Fs < 1.01$, $ps > .30$).

Imagery vividness. The effect of condition was significant ($F(1, 92) = 5.26$, $p = .024$, $\eta^2 = .054$) indicating that immersed-why participants ($M = 4.33$, $SD = .845$) imagined their experience more vividly than distanced-why participants ($M = 3.86$, $SD = 1.11$). There were no other significant main effects or interactions ($Fs < 2.38$, $ps > .12$).

Negative affect. The effect of diagnostic status was significant ($F(1, 92) = 34.78$, $p < .001$, $\eta^2 = .274$) indicating that depressed participants experienced more negative affect than nondepressed participants. This main effect was qualified by a significant condition by diagnostic status interaction ($F(1, 92) = 4.50$, $p = .037$, $\eta^2 = .047$). As Figure 1 illustrates, depressed participants in the distanced-why group displayed less negative affect than depressed participants in the immersed-why group, $t(49) = 2.19$, $p = .034$. The effect of condition on negative affect for nondepressed participants was not significant ($t(43) = -.79$, $p = .43$).

Although the aforementioned analysis indicates that depressed participants in the distanced-why group experienced less negative affect than their self-immersed counterparts, it does not address whether this effect was driven by self-distancing leading depressed participants to feel better after analyzing their feeling or self-immersion leading depressed participants to feel worse. Because participants rated how they felt at baseline, we were able to address this question. Specifically, we ran a repeated measures ANOVA that included affect as a within participants factor (reverse scored, standardized premanipulation affect vs. standardized postmanipulation affect) and condition as the between participants factor. This analysis revealed a significant condition by time of affect interaction ($F(1, 49) = 8.25$, $p < .01$, $\eta^2 = .144$). As Figure 2 illustrates, depressed participants in the immersed-why group displayed a significant increase in negative affect relative to baseline, $t = -2.40$, $p < .05$, whereas depressed participants in the distanced-why group displayed a trend toward a decrease in negative affect relative to baseline, $t = 1.65$, $p = .11$.

Thought content: Recounting versus reconstruing. A repeated measures ANOVA that included thought content (recounting and reconstruing) as the within participant factor and condition and diagnostic status as between participant factors (for similar
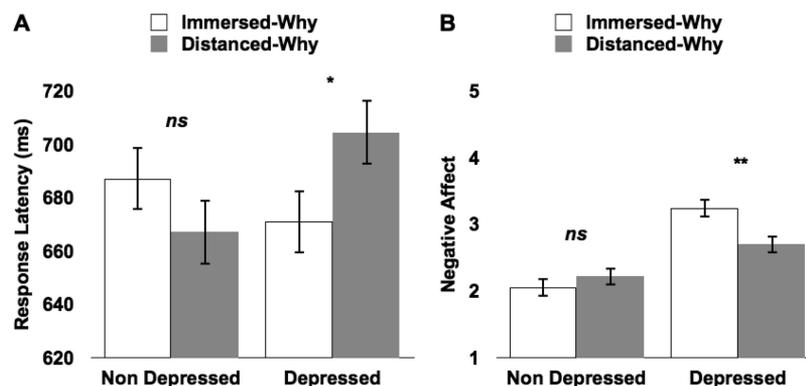

Figure 1. A: Mean response latency for correctly classifying depressotypic words, controlling for neutral word response latency. Error bars indicate standard errors. B: Mean negative affect. Error bars indicate standard errors.
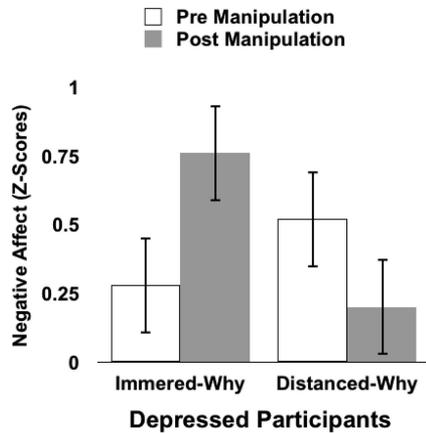
Figure 2. Change in negative affect from baseline (i.e., premanipulation) to postmanipulation among depressed participants.

analytic approach, see Ayduk & Kross, 2010; Kross & Ayduk, 2008; Kross et al., 2011) revealed a significant effect of thought content ($F(1, 92) = 156.46$, $p < .001$, $\eta^2 = .630$) indicating that participants in both groups recounted their experience more than they reconstrued it (see Figure 3). As predicted, however, this main effect was qualified by a significant thought content by condition interaction ($F(1, 92) = 12.30$, $p < .001$, $\eta^2 = .118$) indicating that participants in the distanced-why group recounted their experience less and reconstrued it more than participants in the immersed-why group (recounting minus reconstruing difference score: distanced-why: $M = 1.16$, $SD = 1.42$; immersed-why: $M = 2.07$, $SD = 1.03$; univariate F test: $F(1, 94) = 12.71$, $p < .001$, $\eta^2 = .119$; Figure 3). There were no other significant interactions ($Fs < 1.34$, $ps > .25$).

Discussion

This research examined whether *self-distancing* allows adults with depression to analyze their feelings adaptively in the short-term. Four key findings emerged. First, both depressed and non-depressed participants were equally capable of self-distancing when analyzing their feelings. Second, depressed participants who analyzed their feelings from a self-distanced perspective displayed lower levels of depressive thought accessibility and negative affect than their self-immersed counterparts. Moreover, change score analyses indicated that depressed participants in the distanced-why group were buffered against the increase in negative affect (relative to baseline) that depressed participants in the immersed-why group experienced after analyzing their feelings.

Third, analyzing negative experiences from a self-distanced perspective led all participants to recount their experience less and reconstrue it more. It did not promote avoidance. This finding is noteworthy given prior research linking "cognitive change" processes to effective emotion regulation (e.g., Gross, 1998; Lazarus & Alfert, 1964; Wilson & Gilbert, 2008) and therapeutic gains (Greenberg, 2002; Hayes et al., 2007; Resick et al., 2008; Seligman et al., 1988; Tang & DeRubeis, 1999; Whisman, 1993).

Finally, condition did not influence negative affect or depressive thought accessibility among healthy participants. These findings suggest that analyzing negative experiences from a self-distanced perspective has beneficial implications for people displaying relatively high levels of depressive symptoms. However, they highlight the need for future work to examine the role that depressive symptomatology plays in moderating the effects of this manipulation on negative affect among nondepressed and nondysphoric samples.

Theoretical and Practical Implications

Prior research on rumination in MDD has focused exclusively on when depressed people "ask why" from a de facto self-immersed perspective. For example, the most commonly used rumination induction asks depressed participants to ponder ideas like, "why *your* body feels this way," and "why *you* get this way sometimes." The brooding subscale of Ruminative Responses Scale (Treynor, Gonzalez, & Nolen-Hoeksema, 2003), a popular trait measure of rumination, asks participants to rate the extent to which they think, "Why can't *I* handle things better?" and "Why do *I* have problems other people don't have," among other items, when they feel depressed. Both the current findings and the theoretical model driving this work (Kross & Ayduk, 2011) are consistent with the results of these studies, which suggest that analyzing negative experiences from a self-immersed perspective is maladaptive. What the current findings contribute to this literature is the idea that "asking why" in an attempt to understand one's feelings is not in and of itself harmful. Instead, they suggest that adopting a self-distanced perspective mitigates some of the harmful effects that are typically associated with analyzing negative experiences.

It is important to acknowledge that some research suggests that thinking "abstractly" is a key mechanism underlying depressive rumination. For example, the Processing Mode Theory suggests that "the pathological form of rumination, which contributes to the onset and maintenance of depression, is characterized by more abstract identifications focused on the meanings and implications of negative events, and asking 'Why?' negative events happen (Watkins, Moberly, & Moulds, 2011)." The current findings do not dispute the notion that depressive rumination is characterized by certain forms abstract thinking. However, they suggest that thinking abstractly per
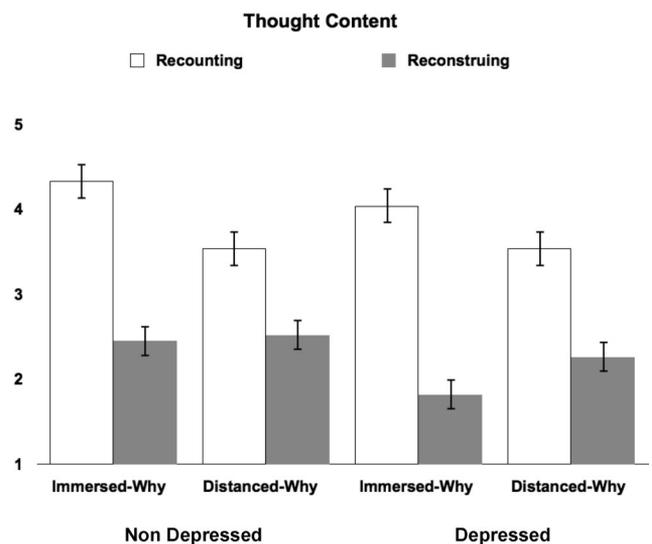

Figure 3. Level of thought content: recounting versus reconstruing. Error bars indicate standard errors.

se is not the active ingredient underlying depressive rumination by demonstrating that people can "ask why" in different ways that directly influence how this process influences the way people think and feel (also see, Rude, Mazzetti, Pal, & Stauble, 2010).[4]

It is also important to recognize that participants in the current study were asked to both adopt a self-distanced perspective *and* analyze their feelings. Thus, we did not examine the effect of self-distancing alone, but rather the effect of self-distancing in the service of analyzing negative emotions. This distinction is noteworthy because people can attend to their emotions in a variety of ways once they adopt a self-distanced perspective, which may influence whether self-distancing is adaptive (Kross et al., 2005, Study 1). For example, some people may adopt a self-distanced perspective to observe their feelings without evaluating them, an approach that mindfulness and acceptance-based approaches to treating depression advocate (Bishop et al., 2006; Fresco, Segal, Buis, & Kennedy, 2007; Segal et al., 2002). Other people may self-distance and then focus on the nonemotional features of their experience (i.e., the surroundings in which the event took place) to avoid their emotions—a strategy that many depression and anxiety researchers would characterize as harmful (e.g., Kenny & Bryant, 2007; Kenny et al., 2009; Kuyken & Moulds, 2009; McIsaac & Eich, 2004). These examples suggest that whether self-distancing is adaptive or not may depend critically on how people focus on their emotions once they adopt this perspective.

Future Directions

An interesting question raised by these findings concerns the role that *spontaneous* self-distancing plays in the etiology of MDD. One line of relevant research has examined whether depression influences people's tendency to self-distance when *recalling* negative experiences and has generated inconsistent findings. Specifically, whereas some studies indicate that dysphoric and depressed patients are *more* likely to recall negative memories from a self-distanced perspective than healthy individuals (e.g., Kuyken & Howell, 2006; Williams & Moulds, 2007), others have not replicated this effect (Newby & Moulds, 2011). To our knowledge, however, no research has examined the relationship between MDD and the tendency to adopt a self-distanced perspective when people *analyze* their feelings. This distinction is noteworthy because memory recall (i.e., retrieving memories) and analysis (i.e., elaborating on memories once they are retrieved) tap into distinct aspects of information processing (Cabeza, Dolcos, Graham, & Nyberg, 2002; Israel, Seibert, Black, & Brewer, 2010). Thus, whether people spontaneously self-distance when recalling versus analyzing their emotions may have different implications (for discussion, see Ayduk & Kross, 2010).

Initial evidence supporting the idea that spontaneous self-distancing during emotional *analysis* may be negatively linked with depression comes from Ayduk and Kross (2010), who found that the tendency to spontaneously self-distance while analyzing negative experiences was negatively correlated with trait rumination in an unselected sample. Future research should examine whether these findings generalize to adults with MDD under a variety of conditions—when they are asked to recall negative experiences, when they recall experiences involuntarily in response to environmental cues, and when they reflect on negative experiences they are experiencing "in the moment."

Future research is also needed to examine the developmental implications of these findings. Two issues stand out to us as particularly interesting in this regard. First, recent work indicates that 10-year old children are capable of self-distancing when they analyze anger experiences, and demonstrates that engaging in this process leads to short-term benefits similar to those observed in adults (Kross et al., 2011). However, whether these findings generalize to depressed children of various ages is unclear. Second, how does the capacity to spontaneously self-distance when reflecting over negative experiences develop? Although a number of studies have documented individual differences in this capacity (Ayduk & Kross, 2010; Grossmann & Kross, 2010; Verduyn, Van Mechelen, Kross, Chezzi, & Van Bever, in press) its developmental antecedents are unclear.

Another question raised by these findings concerns the physiological and long-term effects of analyzing one's feelings from a self-distanced perspective. Research with unselected samples indicate that self-distancing enhances the pace of autonomic nervous system recovery (Ayduk & Kross, 2008, 2010), reduces intrusive thoughts over time, and buffers people against future negative affect (Ayduk & Kross, 2010; Kross & Ayduk, 2008). Identifying whether these benefits extend to depressed participants is important for fully explicating the role that self-distancing plays in depression.

When considering how this process may impact people over time, it is important to acknowledge that some work conceptualizes self-distancing as an avoidance mechanism (e.g., Kuyken & Moulds, 2009; Williams & Moulds, 2007), which should interfere with beneficial long-term outcomes (cf., Bonanno et al., 1995). However, we found no link between self-distancing and implicit or explicit avoidance. Instead, we found that self-distancing promoted less recounting and more reconstruing—a form of "cognitive change" linked with positive outcomes. These findings suggest that examining the long-term implications of this process for people with depression is important.

Finally, what role does self-distancing play in psychotherapy? Several researchers have suggested that "distancing" may be an important mechanism underlying the benefits of various forms of cognitive therapy (Beck, 1970; Ingram & Hollon, 1986). Consistent with this view, clinical theory and research suggests that cognitive shifts similar to those that self-distancing promoted in the current study predict positive therapeutic outcomes in depression (Hayes et al., 2007; Tang & DeRubeis, 1999; Whisman, 1993) and other disorders (e.g., Greenberg, 2002; Resick et al., 2008; also, see Wilson & Gilbert, 2008). These observations suggest that examining whether cognitive therapy directly influences people's tendency to analyze their feelings from a self-distanced perspective, and identifying whether this shift, in turn allows for cognitive gains that are thought to be so critical to its success, may be a fruitful endeavor.

---

[4] Although Kross et al., (2005) used the term, "abstract construals" to refer to the type of thinking that asking why from a self-distanced perspective promotes, we moved away from using this term in subsequent papers because we recognized that people can think "abstractly" in ways that are harmful (i.e., a depressed person who broods about the implications of being rejected for his self-worth) or helpful (i.e., a depressed person who reconstrues his negative experiences in ways that provide closure).

Concluding Comment

In their classic article on attribution style and depression, Abramson, Seligman and Teasdale (1978) noted that when people experience uncontrollable negative events, they try to understand them. They "ask why." This drive to make meaning out of negative experiences is fueled by a fundamental epistemic need—human beings are built to search for causes and assign meaning to their experiences (e.g., Heider, 1958; Wilson & Gilbert, 2008; Wong & Weiner, 1981). Although this meaning-making process often breaks down in the context of depression, the current findings suggest that self-distancing may be one mechanism that helps people with depression analyze their feelings adaptively, highlighting multiple avenues for future research.

References

Abramson, L. Y., Seligman, M. E., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87,* 49–74. doi:10.1037/0021-843X.87.1.49

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

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

Ayduk, Ö., Mischel, W., & Downey, G. (2002). Attentional mechanisms linking rejection to hostile reactivity: The role of "hot" versus "cool" focus. *Psychological Science, 13,* 443–448. doi:10.1111/1467-9280.00478

Bargh, J. A., & Chartrand, T. L. (2000). The mind in the middle: A practical guide to priming and automaticity research. In H. Reis & C. Judd (Eds.), *Handbook of research methods in social and personality psychology* (pp. 253–285). New York, NY: Cambridge University Press.

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

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

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., . . . Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical psychology: Science and practice, 11,* 230–241. doi:10.1093/clipsy.bph077

Blair, I. V., & Banaji, M. R. (1996). Automatic and controlled processes in stereotype priming. *Journal of Personality and Social Psychology, 70,* 1142–1163. doi:10.1037/0022-3514.70.6.1142

Bonanno, G. A., Keltner, D., Holen, A., & Horowitz, M. J. (1995). When avoiding unpleasant emotions might not be such a bad thing: Verbal-autonomic response dissociation and midlife conjugal bereavement. *Journal of Personality and Social Psychology, 69,* 975–989. doi:10.1037/0022-3514.69.5.975

Bradley, M. M., & Lang, P. J. (1994). Measuring emotion: The Self-Assessment Manikin and the Semantic Differential. *Journal of Behavior Therapy and Experimental Psychiatry, 25,* 49–59. doi:10.1016/0005-7916(94)90063-9

Cabeza, R., Dolcos, F., Graham, R., & Nyberg, L. (2002). Similarities and differences in the neural correlates of episodic memory retrieval and working memory. *Neuroimage, 16,* 317–330. doi:10.1006/nimg.2002.1063

Coyne, J. C. (1994). Self-reported distress: Analog or Ersatz depression? *Psychological Bulletin, 116,* 29–45. doi:10.1037/0033-2909.116.1.29

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002).

Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P) New York: Biometrics Research, New York State Psychiatric Institute.

Fresco, D. M., Segal, Z. V., Buis, T., & Kennedy, S. (2007). Relationship of posttreatment decentering and cognitive reactivity to relapse in major depression. *Journal of Consulting and Clinical Psychology, 75,* 447–455. doi:10.1037/0022-006X.75.3.447

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

Gotlib, I. H., & Joormann, J. (2010). Cognition and depression: Current status and future directions. *Annual Review of Clinical Psychology, 6,* 285–312. doi:10.1146/annurev.clinpsy.121208.131305

Greenberg, L. S. (2002). Integrating an emotion-focused approach to treatment intopsychotherapy integration. *Journal of Psychotherapy Integration, 12,* 154–189. doi:10.1037/1053-0479.12.2.154

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

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

Hartlage, S., Alloy, L. B., Vazquez, C., & Dykman, B. (1993). Automatic and effortful processing in depression. *Psychological Bulletin, 113,* 247–278. doi:10.1037/0033-2909.113.2.247

Hayes, A. M., Feldman, G. C., Beevers, C. G., Laurenceau, J. P., Cardaciotto, L., & Lewis-Smith, J. (2007). Discontinuities and cognitive changes in an exposure-based cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 75,* 409–421. doi:10.1037/0022-006X.75.3.409

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25. doi:10.1016/j.brat.2005.06.006

Heider, F. (1958). *The psychology of interpersonal relations.* New York, NY: Wiley. doi:10.1037/10628-000

Ingram, R. E., & Hollon, S. D. (1986). Cognitive therapy for depression from an information processing perspective. In R. E. Ingram (Ed.), *Information processing approaches to clinical psychology* (pp. 259–281). San Diego, CA: Academic Press.

Israel, S. L., Seibert, T. M., Black, M. L., & Brewer, J. B. (2010). Going their separate ways: Dissociation of hippocampal and dorsolateral prefrontal activation during episodic retrieval and post-retrieval processing. *Journal of Cognitive Neuroscience, 22,* 513–525. doi:10.1162/jocn.2009.21198

Johnson, S. L., Joormann, J., & Gotlib, I. H. (2007). Does processing of emotional stimuli predict symptomatic improvement and diagnostic recovery from major depression? *Emotion, 7,* 201–206. doi:10.1037/1528-3542.7.1.201

Kenny, L. M., & Bryant, R. A. (2007). Keeping memories at an arm's length: Vantage point of trauma memories. *Behaviour Research and Therapy, 45,* 1915–1920. doi:10.1016/j.brat.2006.09.004

Kenny, L. M., Bryant, R. A., Silove, D., Creamer, M., O'Donnell, M., & McFarlane, A. C. (2009). Distant memories: A prospective study of vantage point of trauma memories. *Psychological Science, 20,* 1049–1052. doi:10.1111/j.1467-9280.2009.02393.x

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

Kross, E., & Ayduk, Ö. (2009). Boundary conditions and buffering effects: Does depressive symptomology moderate the effectiveness of distanced-

analysis for facilitating adaptive self-reflection? *Journal of Research in Personality, 43,* 923–927. doi:10.1016/j.jrp.2009.04.004

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

Kross, E., Ayduk, Ö., & Mischel, W. (2005). When asking "why" does not hurt. Distinguishing rumination from reflective processing of negative emotions. *Psychological Science, 16,* 709–715. doi:10.1111/j.1467-9280.2005.01600.x

Kross, E., Duckworth, A., Ayduk, Ö., Tsukayama, E., & Mischel, W. (2011). The effect of self-distancing on adaptive versus maladaptive self-reflection in children. *Emotion, 11,* 1032–1039. doi:10.1037/a0021787

Kuyken, W., & Howell, R. (2006). Facets of autobiographical memory in adolescents with major depressive disorder and never-depressed controls. *Cognition and Emotion, 20,* 466–487. doi:10.1080/02699930500342639

Kuyken, W., & Moulds, M. L. (2009). Remembering as an observer: How is autobiographical memory retrieval vantage perspective linked to depression? *Memory, 17,* 624–634. doi:10.1080/09658210902984526

Lazarus, R. S., & Alfert, E. (1964). Short-circuiting of threat by experimentally altering cognitive appraisal. *Journal of Abnormal and Social Psychology, 69,* 195–205. doi:10.1037/h0044635

McIsaac, H. K., & Eich, E. (2002). Vantage point in episodic memory. *Psychonomic bulletin & Review, 9,* 146–150. doi:10.3758/BF03196271

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

Mischel, W., & Rodriguez, M. (1993). Psychological distance in self-imposed delay of gratification. In R. R. Cocking & K. A. Renninger (Eds.), *The development and meaning of psychological distance* (pp. 109–121). Hillsdale, NJ: Erlbaum.

Mischel, W., Shoda, Y., & Rodriguez, M. (1989). Delay of gratification in children. *Science, 244,* 933–938. doi:10.1126/science.2658056

Mischowski, D., Kross, E., & Bushman, B. (2012). Flies on the wall are less aggressive: The effect of self-distancing on aggressive affect, cognition, and behavior. *Journal of Experimental Social Psychology.* doi:10.1016/j.jesp.2012.03.012

Mor, N., & Winquist, J. (2002). Self-focused attention and negative affect: A meta-analysis. *Psychological Bulletin, 128,* 638–662. doi:10.1037/0033-2909.128.4.638

Newby, J. M., & Moulds, M. L. (2011). Characteristics of intrusive memories in a community sample of depressed, recovered depressed and never-depressed individuals. *Behaviour Research and Therapy, 49,* 234–243. doi:10.1016/j.brat.2011.01.003

Newton, T. L., & Contrada, R. J. (1992). Repressive coping and verbal-autonomic response dissociation—The influence of social-context. *Journal of Personality and Social Psychology, 62,* 159–167. doi:10.1037/0022-3514.62.1.159

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

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

Pennebaker, J. W., & Chung, C. K. (2007). Expressive writing, emotional upheavals, and health. In H. Friedman & R. Silver (Eds.), *Handbook of health psychology* (pp. 263–284). New York, NY: Oxford University Press.

Ray, R., Wilhelm, F., & Gross, J. (2008). All in the mind's eye? Anger rumination and reappraisal. *Journal of Personality and Social Psychology, 94,* 133–145. doi:10.1037/0022-3514.94.1.133

Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A Randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76,* 243–258. doi:10.1037/0022-006X.76.2.243

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

Rude, S. S., Mazzetti, F. A., Pal, H., & Stauble, M. R. (2011). Social rejection: How best to think about it? *Cognitive Therapy and Research, 35,* 209–216. doi:10.1007/s10608-010-9296-0

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

Seligman, M. E. P., Castellon, C., Cacciola, J., Schulman, P., Luborsky, L., Ollove, M., & Downing, R. (1988). Explanatory style change during cognitive therapy for unipolar depression. *Journal of Abnormal Psychology, 97,* 13–18. doi:10.1037/0021-843X.97.1.13

Smith, J. M., & Alloy, L. B. (2009). A roadmap to rumination: A review of the definition, assessment, and conceptualization of this multifaceted construct. *Clinical Psychology Review, 29,* 116–128. doi:10.1016/j.cpr.2008.10.003

Tang, T. Z., & DeRubeis, R. J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology, 67,* 894–904. doi:10.1037/0022-006X.67.6.894

Teasdale, J. D., Moore, R. G., Hayhurst, H., Pope, M., Williams, S., & Segal, Z. V. (2002). Metacognitive awareness and prevention of relapse in depression: Empirical evidence. *Journal of Consulting and Clinical Psychology, 70,* 275–287. doi:10.1037/0022-006X.70.2.275

Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003). Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research, 27,* 247–259. doi:10.1023/A:1023910315561

Verduyn, P., Van Mechelen, I., Kross, E., Chezzi, C., & Van Bever, F. (in press). The relationship between self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion.*

Watkins, E. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin, 134,* 163–206. doi:10.1037/0033-2909.134.2.163

Watkins, E., Moberly, N. J., & Moulds, M. L. (2011). When the ends outweigh the means: Mood and level of identification in depression. [Research Support, Non-U.S. Gov't]. *Cognition and Emotion, 25,* 1214–1227. doi:10.1080/02699931.2010.532389

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54,* 1063–1070. doi:10.1037/0022-3514.54.6.1063

Whisman, M. A. (1993). Mediators and moderators of change in cognitive therapy of depression. *Psychological Bulletin, 114,* 248–265. doi:10.1037/0033-2909.114.2.248

Williams, A. D., & Moulds, M. L. (2007). Cognitive avoidance of intrusive memories: Recall vantage perspective and associations with depression. *Behaviour Research and Therapy, 45,* 1141–1153. doi:10.1016/j.brat.2006.09.005

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

Wisco, B. E., & Nolen-Hoeksema, S. (2011). Effect of visual perspective on memory and interpretation in dysphoria. *Behaviour Research and Therapy, 49,* 406–412. doi:10.1016/j.brat.2011.03.012

Wong, P. T. P., & Weiner, B. (1981). When people ask why questions, and the heuristics of attributional search. *Journal of Personality and Social Psychology, 40,* 650–663. doi:10.1037/0022-3514.40.4.650

Appendix

Experimental Manipulations

Self-Immersed Reflection

Now close your eyes. Go back to the time and place of the experience you just recalled and see the scene in your mind's eye. Now *see* the experience unfold through your own eyes as if it were happening to you all over again. Replay the event as it unfolds in your imagination through your own eyes. Take a few moments to do this. When you're ready to continue press the space bar.

As you continue to see the situation unfold through your own eyes, try to understand your feelings. Why did you have those feelings? What were the underlying causes and reasons? We will continue in 60 seconds.

Self-Distanced Reflection

Now close your eyes. Go back to the time and place of the experience you just recalled and see the scene in your mind's eye.

Now take a few steps back. Move away from the situation to a point where you can now watch the event unfold from a distance and see yourself in the event. As you do this, focus on what has now become the distant you. Now *watch* the experience unfold as if it were happening to the distant you all over again. Replay the event as it unfolds in your imagination as you observe your distant self. Take a few moments to do this. When you're ready to continue press the space bar.

As you continue to watch the situation unfold to your distant self, try to understand his or her feelings. Why did he (she) have those feelings? What were the underlying causes and reasons? Take a few moments to do this. We will continue in 60 seconds.