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An Evaluation of Socioemotional Styles Therapy (SET) for Psychological Distress: a Multiple Baseline Study

Una Evaluación de la Terapia de Estilos Socioemocionales (SET) para el Malestar Psicológico: un Estudio de Línea Base Múltiple

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ABSTRACT

OBJECTIVE: Socioemotional Styles Therapy (SET) is a process-based transdiagnostic model linking emotion-regulation mechanisms to the interpersonal motives they serve and the attachment history that shaped them. This study examined the feasibility, acceptability, and treatment-contingent change of a brief online SET protocol in adults with clinically significant distress. METHOD: Nine adults entered a non-concurrent randomized multiple-baseline single-case experimental design, with baselines randomly assigned to three, four, or five weeks, eight weekly online sessions, and one-month follow-up; seven completers were analyzed. Distress (CORE-OM) was assessed weekly and a five-item well-being composite daily. Phase contrasts were evaluated with visual inspection and Tau-U; individual change with reliable and clinically significant change indices (CORE-OM, PHQ-9, GAD-7, DERS-E). RESULTS: Completers attended all sessions, and patient satisfaction and therapist-rated acceptability, appropriateness, and feasibility were high, although adherence to daily assessment varied (33.7–96.1%). Four of seven showed significant distress reductions, and the aggregated effect was significant (Tau = 0.44, $p < .001$), though effects concentrated in the four- and five-week conditions. Six improved reliably on at least one instrument; one deteriorated reliably at follow-up. CONCLUSIONS: A brief online SET protocol was feasible and acceptable and yielded preliminary evidence of treatment-contingent change.

Keywords: emotional regulation, single-case study, psychological distress, feasibility studies.

RESUMEN

OBJETIVO: La Terapia de Estilos Socioemocionales (SET) es un modelo transdiagnóstico basado en procesos que vincula la regulación emocional con los motivos interpersonales y la historia de apego que la configuran. Se examinaron la factibilidad, la aceptabilidad y el cambio contingente del tratamiento mediante un breve protocolo de SET en línea en adultos con malestar clínicamente significativo. MÉTODO: Nueve adultos ingresaron a un diseño de línea base múltiple no concurrente (líneas base aleatorizadas de tres a cinco semanas, ocho sesiones semanales y seguimiento al mes); siete lo completaron. El malestar (CORE-OM) se evaluó semanalmente y el bienestar, diariamente. Las fases se contrastaron con inspección visual y Tau-U; el cambio individual, con índices de cambio confiable y clínicamente significativo (CORE-OM, PHQ-9, GAD-7, DERS-E). RESULTADOS: La asistencia fue completa; la satisfacción usuaria y la aceptabilidad, adecuación y factibilidad, según los terapeutas, fueron altas, con adherencia diaria variable (33.7–96.1%). Cuatro de siete redujeron significativamente el malestar (Tau = 0,44; $p < .001$), con efectos concentrados en las líneas base más largas. Seis mejoraron de manera consistente en al menos un instrumento; uno se deterioró en el seguimiento. CONCLUSIONES: El protocolo resultó factible y aceptable, con evidencia preliminar de cambio contingente al tratamiento.

Palabras clave: regulación emocional, estudio de casos únicos, angustia psicológica, estudios de factibilidad.

Introduction

Emotion regulation (ER) has become one of the most influential constructs in contemporary clinical psychology (Saccaro et al., 2024). Since Gross's formulations (2015), ER has been defined as the set of processes through which individuals influence the intensity, duration, and quality of their emotional experiences in the service of explicit or implicit goals. Its clinical relevance lies in difficulties in its deployment operating as a transdiagnostic factor across the emotional disorders, underlying both anxiety and mood conditions (Aldao et al., 2010; Sloan et al., 2017). Convergence around this common factor has shifted clinical attention from the specific symptoms of each diagnosis toward the processes that generate and maintain them, opening the way to transdiagnostic interventions of greater parsimony and reach (Barlow et al., 2017; Iwakabe et al., 2023).

The Extended Process Model of ER (Gross, 2015) is the field's dominant framework. It conceptualizes ER as a sequence of decisions: identifying the emotional relevance of a stimulus, selecting a strategy family (situation selection, attentional deployment, cognitive change, and response modulation), and implementing specific tactics within it. Clinically, maladaptation resides not in the use of any particular strategy but in the rigidity with which it is applied regardless of context (Aldao et al., 2010; Bonanno & Burton, 2013). Regulatory flexibility—sensitivity to contextual demands, a diverse repertoire, and the capacity to adjust regulation in response to feedback (Bonanno & Burton, 2013)—thus emerges as a central target of therapeutic change.

ER-focused interventions have accumulated evidence of efficacy on psychological distress, depressive and anxiety symptoms, and ER difficulties in adults (Iwakabe et al., 2023; Saccaro et al., 2024; Sloan et al., 2017) and youth (Espenes et al., 2025). Among the most systematized skill-based models are Emotion Regulation Therapy (ERT; Mennin & Fresco, 2014) and Affect Regulation Training (Berking & Whitley, 2014). The motivational and interpersonal dimensions of regulation are addressed across emotion-focused (Greenberg, 2017), dialectical-behavioral (Linehan, 2015), unified-protocol (Barlow et al., 2017), mentalization-based (Fonagy et al., 2002), and interpersonal-regulation traditions (Zaki & Williams, 2013). Likewise, open and transdiagnostic case formulation models are also present (Quiñones Bergeret, 2024). To the best of our knowledge, what remains underdeveloped is a single case-formulation construct that binds, for the individual patient, the regulatory mechanism, the interpersonal motive it serves, and the attachment history in which it was shaped.

This gap is sharpened by a conceptual shift from the mechanisms of regulation to the motives for it (from “how” to “why” one regulates). Tamir (2016) distinguishes hedonic motives, aimed at immediate pleasure or the avoidance of displeasure, from instrumental motives oriented toward higher-order goals such as performance, cognition, or relationships.

The distinction is clinically consequential because many patients regulate hedonically and in the short term, sacrificing longer-term goals that include relational well-being (Tamir, 2016). Within this motivational hierarchy, the interpersonal domain is prominent: Zaki and Williams (2013) delineated the field of interpersonal ER, and experience-sampling evidence indicates that a substantial proportion of everyday ER episodes occur in relational contexts and are guided by specific interpersonal needs, such as maintaining emotional proximity or preserving autonomy (Tran et al., 2025). These episodes are modulated by adult attachment (Springstein et al., 2023) and by the prosocial or pro-self direction of regulation (Niven, 2016).

These two underdeveloped links—between regulatory mechanisms and the interpersonal motives they serve, and between a person's regulatory style and the attachment bonds that shaped it—concern the same operational level: how treatment is tailored to the individual case. Both point toward process-based therapy, which organizes formulation around individualized biopsychosocial processes and evaluates treatment not only by aggregate efficacy but by the processes through which change operates (Hayes et al., 2019).

Socioemotional Styles Therapy (SET; Silva, 2024) is a process-based model developed to address this integration. It conceptualizes psychological distress not as a deficit in regulatory skills but as the rigidification of regulatory patterns that once had adaptive value in earlier interpersonal contexts and now perpetuate cycles of unmet needs; its aims are the expansion of regulatory flexibility and the realignment of emotional action with underlying socioemotional needs, alongside symptom reduction. The model articulates three frameworks: the Extended Process Model (Gross, 2015) for the architecture of regulatory mechanisms, the theory of motivated ER (Tamir, 2016) for the contents of regulation, and attachment theory (Bowlby, 1969; Mikulincer & Shaver, 2019) for the developmental link between early bonds and adult affective functioning. Its central articulating construct is the socioemotional style, an idiosyncratic configuration of affective-relational functioning defined across temperament, attachment, motivational processing, and regulatory flexibility, with two prototypical configurations—cautious and curious—described by Silva & Medina (2023).

The evaluation of a novel psychotherapy model proceeds through an ordered set of questions: (1) whether it can be delivered feasibly and is acceptable to patients and therapists (Onken et al., 2014); (2) whether change during treatment is contingent on its introduction rather than attributable to elapsed time, regression toward the mean, or the reactivity of repeated measurement (Shadish et al., 2002); and (3) whether it operates through the processes the model posits (Kazdin, 2007). The third presupposes affirmative answers to the first two and requires measures of the model's specific constructs, which do not yet exist for SET. The present study addresses the first two. Because none of the outcomes employed here is specific to SET, evidence of treatment-contingent change would indicate that improvement

coincides with the introduction of SET, not that it arises through the socioemotional mechanisms the model proposes.

The present study evaluates the feasibility, acceptability, and preliminary treatment-contingent change of a brief, eight-session, weekly, online SET protocol in adults with clinically significant distress. To address these aims, we used a non-concurrent randomized multiple-baseline single-case experimental design (SCED) combined with diary assessments, which permits within-person comparison of baseline and treatment phases and real-time tracking of change under everyday conditions (Levin & Ferron, 2021). We hypothesized (H1) a reduction in psychological distress contingent on the randomized introduction of treatment and replicated across the three baseline durations; and (H2) reliable and clinically significant improvement from pre- to posttreatment on secondary measures—depressive symptoms, anxiety, and ER difficulties—maintained at one-month follow-up. Daily process indicators (H3) were exploratory, without directional hypotheses. Finally (H4), we expected high patient satisfaction and high therapist-rated acceptability, appropriateness, and feasibility.

Methods

Study design

We used a non-concurrent multiple-baseline single-case experimental design (SCED) with randomized assignment to baseline duration (block-randomized with therapist; see Procedure) to evaluate the feasibility, acceptability, and preliminary treatment-contingent change of Socioemotional Styles Therapy (SET; Silva, 2024) in adults seeking psychotherapy for clinically significant psychological distress. Three baseline durations (three, four, and five weeks) were followed by eight weekly intervention sessions and a one-month follow-up.

A non-concurrent design was adopted for pragmatic reasons: in routine practice, it lets participants begin baseline as they are recruited rather than awaiting a common start date. Randomizing baseline duration provides probabilistic control over history and maturation threats, rendering the design inferentially comparable to a concurrent multiple-baseline design (Levin & Ferron, 2021). The study followed recommendations for randomized multiple-baseline designs (Levin & Ferron, 2021; Wampold & Worsham, 1986) and the SCRIBE reporting guidelines (Tate et al., 2016).

Participants

Recruitment and selection

Recruitment was conducted through social media dissemination.

Inclusion criteria were: (a) age ≥ 18; (b) actively seeking psychotherapy for clinically significant distress, operationalized as a CORE-OM mean-scale score ≥ 1.23 (Chilean cutoff; Errázuriz et al., 2025); (c) capacity to provide informed consent; (d) sufficient Spanish proficiency; (e) stable internet access and a compatible device; (f) willingness to wait up to five weeks for treatment onset; (g) commitment to attend eight weekly sessions and complete daily and scheduled assessments; (h) abstention from concurrent psychotherapy during the study; (i) and for those on psychotropic medication, a stable regimen or discontinuation for at least two weeks before intake.

Exclusion criteria were assessed through a clinical interview based on DSM-5 criteria, conducted by a trained clinician and comprised: (a) current psychotic disorder or manic/hypomanic episode; (b) active substance dependence likely to interfere with adherence or safety; (c) acute suicide risk (ideation with plan or intent, or recent suicidal behavior); and (d) an eating disorder requiring specialized treatment. In addition, (e) impaired personality functioning, defined as an LPFS-BF 2.0 score ≥ 27 (Cottin, 2022), was exclusionary. Participants meeting clinical exclusion criteria were referred to specialized care.

Participant flow

Participant flow is shown in Figure 1. Of 49 individuals who completed screening, the first 14 were contacted in order of registration; 5 were not enrolled (suicide risk, problematic cannabis use, CORE-OM below cutoff, no response), and 9 were enrolled. The 9 were block-randomized to the three baseline conditions and three therapists, one participant per condition per therapist. Two participants discontinued at their own request (one during the four-week baseline, one after the first session of the three-week condition); neither reached the preregistered minimum of three measurements per phase, and both were excluded from analysis. The final analytic sample comprised 7 participants who completed all eight sessions, of whom 5 completed follow-up.

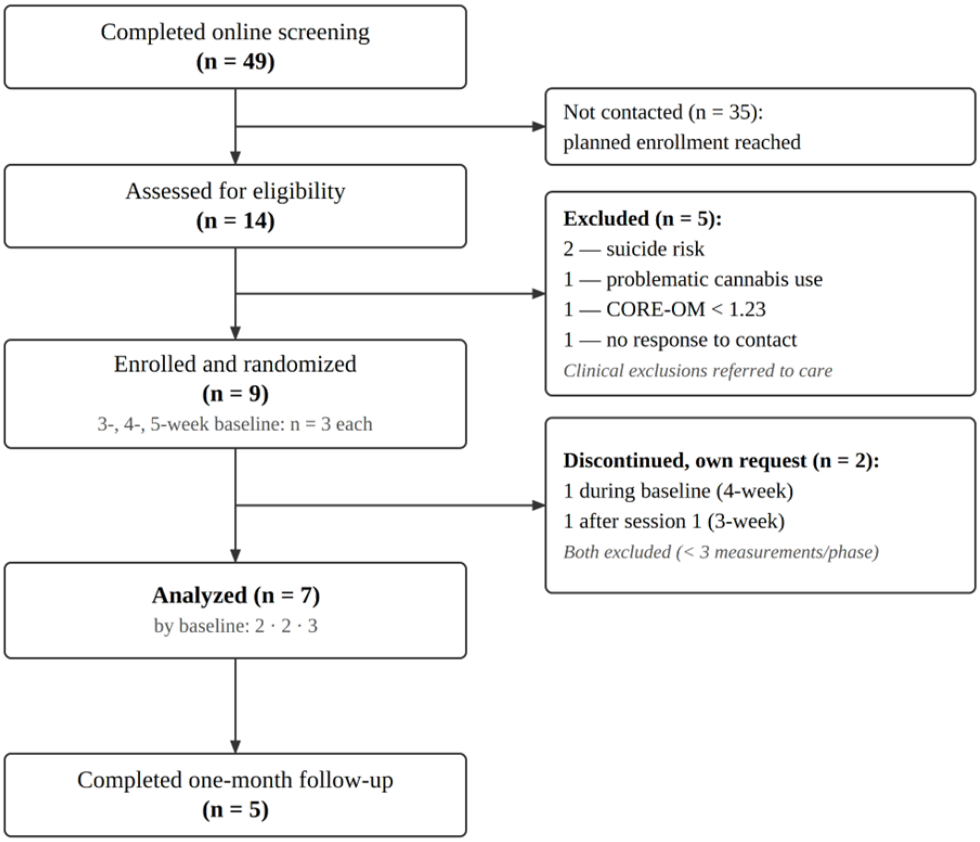

Figure 1. Participant Flow Through the Study (Note. Allocation balanced baseline duration and therapist assignment (each therapist treated one participant per condition). The analyzed sample (n = 7) reflects the preregistered exclusion of both discontinued participants, neither of whom reached three measurements per phase).

Sample description

Seven adults (M age = 26.1 years, *SD* = 8.3, range: 19-40) completed the study: five women, one man, and one non-binary person. Six were Chilean, and all were enrolled in or had completed tertiary education, except one who had completed secondary education. Demographic and clinical characteristics are presented in Table 1.

Table 1. Age and clinical characteristics of the participants

	P1	P2	P3	P4	P5	P6	P7
Age range (in years)	18-25	18-25	18-25	26–40	18–25	26–40	18–25
Pharmacological treatment (lifetime)	Yes	Yes	No	Yes	No	Yes	Yes
Baseline duration	BL3	BL3	BL4	BL4	BL5	BL5	BL5

Note. BL = baseline length (BL3 = 3 weeks, BL4 = 4 weeks, BL5 = 5 weeks). Pharmacological treatment indicates any lifetime psychopharmacological treatment, whether past or ongoing.

Clinical characterization

P1 sought help for irritability and mood changes. P2 sought support to better understand and manage disproportionate emotional reactions. P3 presented with severe emotional dysregulation and fears of emotional invalidation. P4 sought help for emotion-regulation difficulties and anticipatory worry. P5 presented with elevated stress, irritability, and anxiety. P6 reported significant relational distress and difficulty managing anger. P7 presented with somatic symptoms and persistent affective neutrality.

Measures

Primary outcome

The Spanish-language CORE-OM assessed psychological distress at intake and weekly across baseline and treatment. It is a 34-item self-report measure (mean score 0–4, higher = greater distress), selected for its transdiagnostic scope, consistent with the process-based rationale of SET. The Chilean validation shows excellent internal consistency (α = .94), adequate test–retest reliability, and convergent validity with the OQ-45.2, with a clinical cutoff of 1.23 (Errázuriz et al., 2025).

Daily Assessments.

A brief daily assessment served as an exploratory process indicator across both phases. Five investigator-developed items assessed four theoretically derived well-being domains (Dahl et al., 2020): interpersonal connection, presence, clarity of purpose, and emotional self-knowledge (two items). Items were rated 1–10 and summed into a daily well-being composite (range 5–50; Table 2). A daily psychological-flexibility measure was also preregistered but is not reported, owing to an administration error that compromised its validity.

Table 2. Subjective Well-Being Items Assessed via Daily Assessment

Construct	**Item**
Interpersonal connection	*"Today I felt emotionally connected to other people"*
Presence	*"Today I enjoyed the present moment"*
Clarity of purpose	*"Today what I did was meaningful to me"*
Clarity (self knowledge)	*"Today I could clearly identify what I was feeling"*
Understanding (self knowledge)	*"Today I understood why I felt the way I felt"*

Note. All items were preceded by the stem "Thinking about today…" and rated on a visual analog scale from 1 (*not at all*) to 10 (*completely*). Higher values indicate greater well-being. The composite indicator is the sum of the five items (range 5–50). Items were administered in Spanish.

Pre-, post-, and follow-up measures

Emotion-regulation difficulties (DERS-E; Chilean adaptation (Guzmán-González et al., 2020), depressive symptoms (PHQ-9; Saldivia et al., 2019), and anxiety symptoms (GAD-7; García-Campayo et al., 2010) were assessed at pretreatment, posttreatment, and one-month follow-up. The DERS-E comprises 25 items (range 25–125); the PHQ-9, 9 items (0–27); and the GAD-7, 7 items (0–21); higher scores indicate greater severity on all three.

Satisfaction and implementation outcomes

Treatment satisfaction was assessed at posttreatment with the CSQ-8 (8 items, range 8–32; Roberts & Attkisson, 1983). The day after treatment completion, therapists rated the acceptability, appropriateness, and feasibility of SET with the AIM, IAM, and FIM, respectively (4 items each, 1–5; Weiner et al., 2017), translated into Spanish by the research team with "SET" replacing the intervention placeholder.

Eligibility instruments

LPFS-BF 2.0 (Cottin, 2022) was administered to assess the clinical exclusion criteria described above.

Intervention

The intervention comprised eight weekly individual sessions of SET, delivered according to a manualized protocol (Silva, 2024).

The protocol comprised three recursive phases. The *self-awareness* phase identified the dominant socioemotional style, rigid ER mechanisms, triggering interpersonal contexts, and underlying needs through the exploration of critical scenes and the construction of an emotion-regulation map. The *flexibility* phase introduced controlled experiences of regulatory change linked to interpersonal needs, incorporating the *Knowing the Other* technique, in which patients work to understand the emotional needs, motivations, and regulatory patterns of significant others in order to broaden their interpersonal perspective. The *coping* phase consolidated adaptive emotional actions in real interpersonal contexts through *Anticipating Scenes*, which involves mentally simulating upcoming challenging interactions and planning adaptive responses before they occur. In the eight-session format, the three phases were integrated within a more compact frame than the full 12-session protocol. Each session reviewed the previous week's emotional events, included phase-appropriate experiential or reflective exercises, and planned between-session continuity tasks.

Sessions were delivered by three licensed clinical psychologists who completed an approximately 90-hour SET certification. Fidelity was monitored through a session-by-session adherence checklist covering the components prescribed for each phase, reviewed in weekly supervision meetings that addressed model adherence and procedural consistency across therapists. Checklists were completed by the treating therapists immediately after each

session and reviewed during weekly clinical supervision meetings, in which deviations from the prescribed components were identified and addressed before the following session. This process was used to monitor adherence to the model and procedural consistency across the three therapists.

Procedure

Interested individuals completed an online screening survey; those meeting preliminary criteria were contacted by telephone for an initial eligibility review and study information. After informed consent, each participant was interviewed via videoconference by a research-team assessor, independent of the treating therapists, who conducted the clinical interview and administered the LPFS-BF 2.0 to confirm eligibility.

Eligible participants were instructed to download the study application (Avicenna Research), within which baseline instruments were administered (sociodemographic and clinical questionnaires, CORE-OM, PHQ-9, GAD-7, and DERS-E). Each was then assigned to one of the three baseline durations following order of entry, using a computer-generated block-randomization sequence prepared before recruitment that balanced baseline duration and therapist (one participant per therapist per condition). Daily well-being and weekly CORE-OM assessments began the same day and continued through both phases.

At the end of baseline, each participant began eight weekly online SET sessions of approximately 60 minutes. Posttreatment assessments (CORE-OM, PHQ-9, GAD-7, DERS-E, CSQ-8) were administered at the end of treatment, and follow-up assessments (CORE-OM, PHQ-9, GAD-7, DERS-E) one month later; therapists completed the AIM, IAM, and FIM at the end of treatment.

Daily prompts were delivered at 17:00 with an automated reminder and expired at 23:59; weekly CORE-OM assessments were delivered on Wednesdays at 9:00. Non-response over several consecutive days prompted a contact to encourage responding, and an unanswered weekly CORE-OM was redelivered the next day. Participants could withdraw at any time. Safety was monitored clinically during sessions; because outcome data were not analyzed until study completion, they did not inform real-time monitoring.

Data analysis

Feasibility and acceptability indicators (recruitment, retention, session adherence, and questionnaire compliance), plus satisfaction and therapists´ feasibility and acceptability, were summarized descriptively.

Individual time-series graphs of weekly CORE-OM and the daily well-being composite were inspected across phases A (baseline) and B (treatment) on six parameters: level, trend, variability, immediacy, consistency, and overlap (Gallo et al., 2013). Contrasts were

interpreted at the individual level and examined for replication across participants and baseline conditions. Effect sizes were estimated with Tau-U (Brossart et al., 2018) under two models: a conservative, preregistered model (Tau-bc: A vs. B − trend A) adjusting for baseline trend, and a full model (A vs. B + trend B − trend A) additionally incorporating treatment-phase trend. Baseline-trend correction was applied when visual inspection indicated a systematic monotonic baseline trend. Effects were aggregated across cases using the z-based meta-analytic method for both the weekly CORE-OM (primary, H1) and the daily well-being composite (exploratory, H3). Analyses used the *scan* package (Wilbert & Lüke, 2023) in RStudio.

Reliable and clinically significant change was evaluated at the individual level (Jacobson & Truax, 1992) on the CORE-OM, PHQ-9, GAD-7, and DERS-E, using pretreatment, posttreatment, and follow-up scores. The Reliable Change Index (RCI) was the post- (or follow-up) minus baseline difference divided by the standard error of the difference ($SEdiff = \sqrt{2} \times SD \times \sqrt{(1 - \alpha)}$). Because higher scores indicate greater severity, reliable improvement corresponds to $RCI < -1.96$ and deterioration to $RCI > +1.96$. Change was classified as Recovered when reliable improvement crossed from the clinical to the nonclinical range and as Improved when reliable but not crossing the (inclusive) cutoff. Reference parameters were: CORE-OM (SD = 0.59, α = .94, cutoff = 1.23; Errázuriz et al., 2025); PHQ-9 (SD = 5.57, α = .89, cutoff = 10; Saldivia et al., 2019; Kroenke et al., 2001); GAD-7 (SD = 6.44, α = .94, cutoff = 10; García-Campayo et al., 2010); and DERS-E (SD = 15.15, α = .91, cutoff = 73; Guzmán-González et al., 2020). Because parameters derive from heterogeneous reference samples, RCI sensitivity differs across instruments.

Ethical considerations

The study was approved by the Institutional Research Ethics Committee (CEII) of Universidad del Desarrollo (approval ID 21102025ADB) and conducted in accordance with the Declaration of Helsinki and applicable national regulations. Written informed consent was obtained from all participants before enrollment; therapists provided separate consent covering their responsibilities and confidentiality. Participants received no monetary compensation, and psychotherapy was provided free of charge within the protocol. Data were pseudonymized, with the identification key stored separately on encrypted, access-restricted servers; to preserve assessment independence, therapists did not access participants' questionnaire responses. Referral and emergency protocols for deterioration or risk were available throughout, though none required activation, and participants could withdraw at any time without penalty, with guidance offered on alternative care when appropriate. The study was preregistered prior to its execution on the Open Science Framework (OSF), DOI: https://doi.org/10.17605/OSF.IO/4M5PS.

Results

Feasibility and acceptability

Retention and adherence

All seven completers attended the full course of eight weekly sessions, with no missed sessions; five of the seven completed the one-month follow-up.

Measure compliance

Adherence to the weekly CORE-OM was high and consistent across participants (range 90.0–100.0%). Adherence to the daily assessment was substantially lower and far more variable (33.7–96.1%; P1 = 96.1, P2 = 34.2, P3 = 80.0, P4 = 55.1, P5 = 77.8, P6 = 33.7, P7 = 68.2).

Patient satisfaction

All seven participants completed the CSQ-8, with no missing data. Scores were uniformly high (M = 30.4, SD = 2.15, range 27–32), with every participant scoring close to the scale ceiling.

Therapist-rated acceptability, appropriateness, and feasibility

All three therapists selected the highest response option ("completely agree") for every item of the AIM and the IAM. FIM responses were likewise at the maximum, with a single exception: one therapist rated the item "this therapy seems easy to use" as "agree" (4). Therapists thus evaluated SET as highly acceptable, appropriate, and feasible to implement in this context.

Qualitative feedback

Responses to the two optional open-ended CSQ-8 prompts were summarized descriptively. What participants valued most centered on three themes: the therapeutic relationship and a sense of a safe, non-judgmental space; increased emotional awareness and understanding of their own emotional functioning; and the therapeutic approach itself. The most frequent suggested improvement was a wish for more sessions, with several participants noting that the eight-session format felt insufficient to cover what they wished to address; one participant additionally found the daily assessments tedious and demotivating, and criticized it as unclearly worded and insufficiently inclusive. Notably, satisfaction ratings near the scale ceiling coexisted with these concrete criticisms of session dosage and daily assessment burden.

Primary Analysis

Visual analysis.

Weekly CORE-OM and daily subjective well-being scores are presented in Figures 2 and 3, respectively.

For psychological distress (Figure 2), four participants (P3, P4, P5, and P7) scored consistently above the clinical cutoff of 1.23 throughout baseline, P6 declined toward it, P1 fluctuated around it, and P2 remained below it. The most pronounced reductions were shown by P4 and P7, whose scores fell from treatment onset and continued to decline, ending well below the threshold, and by P3, which declined more gradually and crossed the threshold in the final weeks. P1 showed a delayed pattern; scores initially rose above baseline levels during the first three treatment weeks before dropping abruptly to near zero. In contrast, P5 declined only slightly, approaching the threshold in the final week; P6 showed a descending baseline trend that flattened during treatment, with no appreciable change between phases; and P2, below the cutoff throughout baseline, showed a slight increase, fluctuating around the threshold.

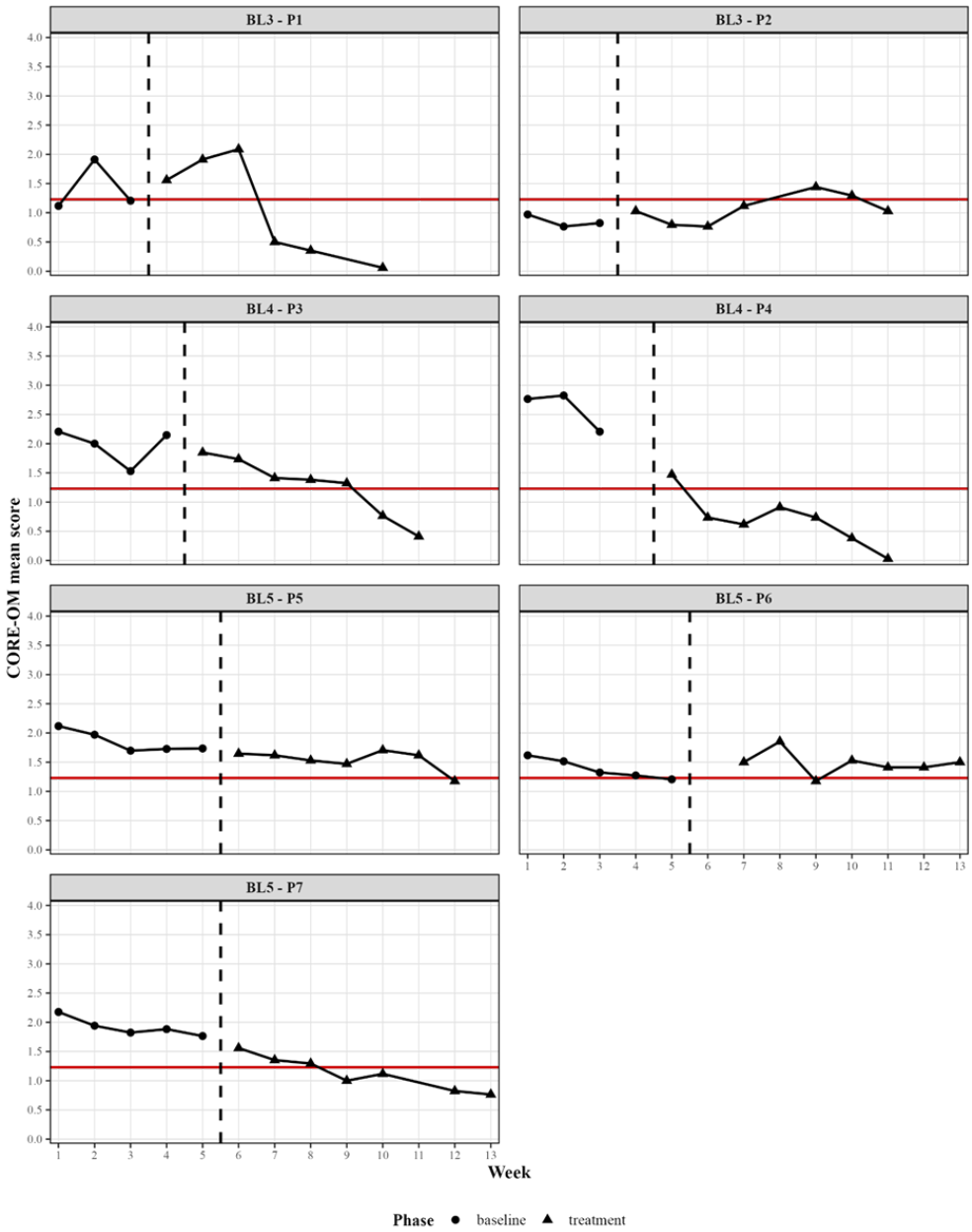

Figure 2. Weekly repeated measures of CORE-OM by participant over time. Lower scores indicate lower psychological distress. The vertical line marks the start of the intervention. The horizontal line represents the clinical cutoff score of 1.23 for the Chilean population.

For daily subjective well-being (Figure 3), P5 showed the clearest change, with an increase in level at treatment onset sustained throughout the phase. P4 shifted upward in level with reduced variability, though with a slight downward drift in the final weeks. P1, P3, and P7 improved mainly in the later part of the treatment phase: P1 stabilized at high levels after marked baseline variability, whereas P3 and P7 rose toward the scale maximum in the final weeks following an initially variable period. P2 and P6 showed no visually apparent change between phases. Scores for P1 and P3 reached the scale maximum (50) on multiple occasions, limiting the range available to detect further improvement.

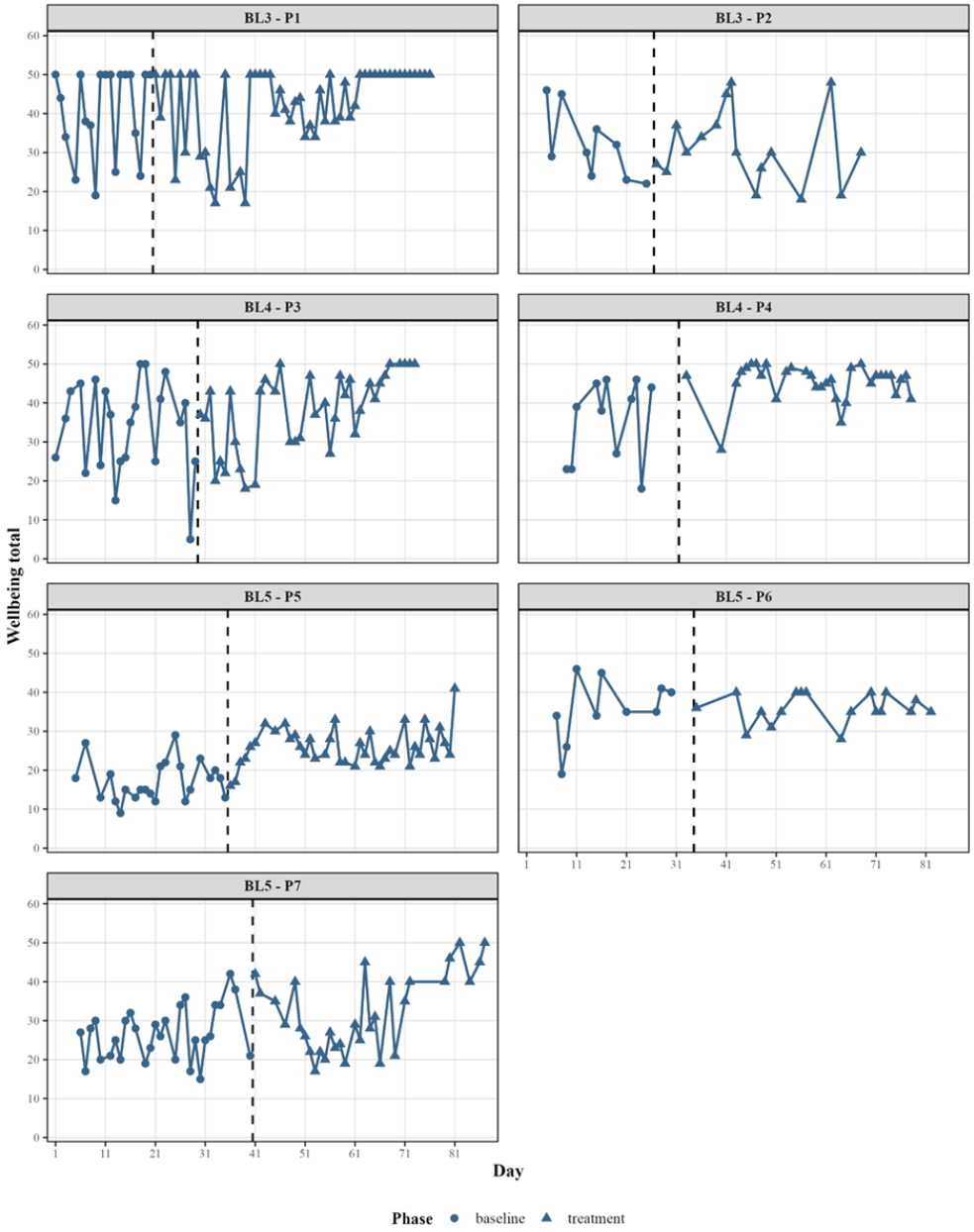

Figure 3. Daily repeated measures of well-being by participant over time. Higher scores indicate greater well-being. The vertical line marks the start of the intervention.

Tau-U: psychological distress (CORE-OM)

Effect sizes are presented in Table 3. Positive Tau values indicate improvement. Under the full model, four participants showed statistically significant positive effects (P3, Tau = 0.78; P4, Tau = 0.76; P7, Tau = 0.70, all $p < .001$; P5, Tau = 0.56, $p < .05$), and P1 a positive but nonsignificant trend (Tau = 0.37, $p = .17$). P2 (Tau = −0.43, $p = .09$) and P6 (Tau = −0.22, $p = .33$) showed negative values, indicating a nonsignificant trend toward deterioration; for P6, the near-zero value is consistent with the absence of visible change between phases. The

pattern of significance was stable across both models, with more conservative estimates under the Tau-bc model. The aggregated effect was statistically significant under both the conservative model (Tau = 0.26, $p = .047$) and the full model (Tau = 0.44, $p < .001$), although with marked variability across participants.

Table 3. Tau-U Effect Sizes for Psychological Distress (CORE-OM) by Participant and meta-analysis

	Tau-bc (- Trend A)		Tau-bc + Trend B	
Participant	**Tau**	***p***	**Tau**	***p***
BL3				
P1	0.15	.61	0.37	.17
P2	−0.40	.15	−0.43	.09
BL4				
P3	0.51	**.05**	0.78	**< .001**
P4	0.62	**< .05**	0.76	**< .001**
BL5				
P5	0.54	**< .05**	0.56	**< .05**
P6	−0.32	.19	−0.22	.33
P7	0.50	**< .05**	0.70	**< .001**
Meta-analysis	0.26	**.047**	0.44	**< .001**

Note. Tau-bc = A vs. B − Trend A (controls trend at baseline). Tau-bc + Trend B = A vs. B + Trend B − Trend A (controls trends in both phases). Participants are presented in the order shown in the visual inspection charts. The meta-analysis reports the overall effect across all cases using the z method. Statistically significant values are marked in bold.

Tau-U: subjective well-being

Effect sizes are presented in Table 4. Under the full model, four participants showed significant positive effects (P5, Tau = 0.46, and P3, Tau = 0.30, both $p < .001$; P7, Tau = 0.26, and P1, Tau = 0.19, both $p < .05$). Unlike the CORE-OM, the two models diverged for two participants. P1 was significant only under the full model (Tau-bc = 0.02, $p = .81$), indicating an effect driven mainly by the positive trend within the treatment phase rather than by a level change between phases; P4 showed the reverse pattern (Tau-bc = 0.40, $p < .001$; full model Tau = 0.19, $p = .08$), suggesting that a negative trend during treatment partially attenuated the level effect. P2 and P6 showed no significant change under either model. The aggregated effect was significant under both the conservative (Tau = 0.20) and the full model (Tau = 0.25), both $p < .001$, with heterogeneity across participants. Effects on subjective well-being were smaller in magnitude than those on psychological distress.

Table 4. Tau-U Effect Sizes for Subjective Well-being by Participant and meta-analysis

	Tau-bc (- Trend A)		Tau-bc + Trend B	
Participant	**Tau**	***p***	**Tau**	***p***
BL3				
P1	0.02	.81	0.19	**< .05**
P2	0.09	.56	−0.03	.85
BL4				
P3	0.13	.20	0.30	**< .001**
P4	0.40	**< .001**	0.19	.08
BL5				
P5	0.48	**<.001**	0.46	**<.001**
P6	-0.05	.76	0.03	.85
P7	0.13	.20	0.26	**< .05**
Meta-analysis	0.20	**< .001**	0.25	**< .001**

Note. Tau-bc = A vs. B − Trend A (controls trend at baseline). Tau-bc + Trend B = A vs. B + Trend B − Trend A (controls trends in both phases). Participants are presented in the order shown in the visual inspection charts. The meta-analysis reports the overall effect across all cases using the z method. Statistically significant values are marked in bold.

Reliable and clinically significant change.

At posttreatment, six of the seven participants showed reliable improvement on at least one instrument, and five crossed the clinical threshold (recovered) on at least one. P1, P3, P5, and P7 improved or recovered on all four instruments, with P1 showing the most favorable pattern (recovery on the CORE-OM, PHQ-9, and DERS-E). P4, whose CORE-OM and GAD-7 baseline scores were already below the cutoff, improved reliably on the PHQ-9 and DERS-E without reliable change on the other two. P2 showed a mixed pattern, recovering on the CORE-OM and GAD-7 with no reliable change on the PHQ-9 or DERS-E, and P6 showed no reliable change on any instrument.

Table 5. Reliable and Clinically Significant Change by Participant, Time Point, and Instrument

	CORE-OM			PHQ-9			GAD-7			DERS-E		
PID	*Pre*	*Post*	*Follow-up*	*Pre*	*Post*	*Follow-up*	*Pre*	*Post*	*Follow-up*	*Pre*	*Post*	*Follow-up*
P1	1.91	1.00^{R}	1.06^{R}	13	2^{R}	2^{R}	9	0^{I}	0^{I}	81	25^{R}	25^{R}
P2	1.94	1.21^{R}	1.42^{I}	12	12	10	13	8^{R}	7^{R}	46	51	37
P3	2.21	1.29^{I}	1.12^{R}	22	3^{R}	2^{R}	20	0^{R}	0^{R}	59	25^{I}	33^{I}
P4	1.21	0.97	—	8	0^{I}	0^{I}	3	0	—	64	27^{I}	—
P5	2.12	1.47^{I}	1.68^{I}	19	9^{R}	13^{I}	16	6^{R}	9^{R}	83	42^{R}	51^{R}
P6	1.71	1.44	2.00	9	8	17^{D}	8	6	13^{D}	62	59	52
P7	2.00	1.59^{I}	—	15	8^{R}	—	11	4^{R}	—	68	39^{I}	—

Note. N = 7. Each cell shows the observed score; the superscript indicates change status relative to baseline. ^{R} Recovered = reliable improvement (RCI < −1.96) with the baseline score above the clinical cutoff and the posttreatment score below it, indicating the clinical threshold was crossed. ^{I} Improved = reliable improvement that did not cross the clinical threshold. ^{D} Deteriorated = reliable deterioration (RCI > +1.96). Scores with no superscript indicate no reliable change. — = data not available. RCI = (post − pre)/SEdiff; the clinical cutoff is inclusive of the clinical range.

Among the five participants with follow-up data, gains were largely maintained, and P3 additionally met the recovery criterion on the CORE-OM. Two exceptions were observed: P2 (CORE-OM) and P5 (PHQ-9) each returned above the clinical cutoff on one instrument while remaining reliably improved relative to baseline. P6 was the only participant to show reliable deterioration on the PHQ-9 and GAD-7 at follow-up, consistent with the absence of effects in the visual and Tau-U analyses.

Discussion

This study evaluated the feasibility, acceptability, and treatment-contingent change of a brief, eight-session protocol of Socioemotional Styles Therapy (SET), delivered online within a non-concurrent randomized multiple-baseline single-case experimental design. Seven of the nine enrolled participants completed the eight sessions, and attendance was complete among those who remained in treatment (H4). Four of the seven analyzed cases showed a significant reduction in psychological distress during the intervention phase, with replication in two of the three baseline conditions and a significant aggregated effect (H1). Support for H1 was therefore partial. Reliable improvement extended across clinical domains in most participants (H2), and the daily well-being indicator moved in the same direction, though with smaller and less stable effects (H3). These findings warrant continued evaluation of SET but do not yet permit attributing change to its specific mechanisms.

The format was feasible, though participation in treatment should be distinguished from the burden of the research procedure. Both dropouts occurred before sufficient series

were available, so the change estimates describe only completers, and because only the first 14 of 49 screened were contacted, the data do not permit estimating the eligibility or recruitment rate. Adherence to the weekly CORE-OM was high and stable, whereas compliance with the daily assessment was more variable, even among participants with full attendance and regular weekly responding. The main operational difficulty therefore lay in daily self-report rather than in the intervention, consistent with Ecological Momentary Assessment reviews reporting mean compliance near 72% with substantial dispersion (de Vries et al., 2021). By contrast, sustained weekly self-report proved within reach, supporting current calls to implement routine outcome monitoring in Latin American mental health services (Paz et al., 2025). Future research should reduce the frequency or length of daily records and reserve intensive measurement for clearly defined processes.

Patient satisfaction and therapist ratings were high but require qualification: scores near the CSQ-8 ceiling (M = 30.4 of a maximum of 32) indicate a ceiling effect that limits its discriminative capacity, a distributional feature documented for the instrument in outpatient mental health care (Pedersen et al., 2022), and the therapists evaluated a model they had been trained and supervised in (Munder et al., 2013), so the high ratings may reflect a committed team rather than an independent evaluation. The qualitative feedback qualifies this further: alongside valuing the therapeutic relationship, the sense of a safe space, and greater knowledge of their own emotional functioning, several participants considered eight sessions insufficient. This convergent request for a higher dose is consistent with the psychotherapy dose–response literature (Robinson et al., 2020) and informs the design of the next phase.

The primary hypothesis received partial support. Four participants (P3, P4, P5, and P7) showed significant positive effects under both Tau-U models, as did the aggregated effect. Visual inspection converges with these estimates: P4 and P7 showed pronounced reductions with early onset following the introduction of treatment, P3 a more gradual decline, and P5 a slight and late one; P1, by contrast, showed a delayed pattern, with initial worsening before an abrupt decline, consistent with a nonsignificant Tau-U. Even so, in a multiple-baseline design the central evidence depends on change replicating across different points of treatment introduction, and here the effects were concentrated in the four- and five-week conditions, with none among the two participants assigned to three weeks. The shorter baseline may have limited the characterization of prior stability and trend, but the small number of cases precludes attributing the absence of effects to it. Evidence of treatment-contingent change should therefore be read as preliminary; with seven cases and baselines separated by only one week, the design supports a plausible temporal association rather than a demonstrated one, and replication with more cases and more widely spaced baselines is required.

On the other hand, the cases of P2 and P4 share a common root. P4 met the inclusion criterion at screening but subsequently showed subclinical scores on several measures. P2 is sharper: the participant was classified as recovered on the CORE-OM, yet Tau-U was

negative, and weekly series already fluctuated below the clinical cutoff during baseline, because the pretreatment score in the reliable change analysis precedes the start of the weekly series. Since eligibility was defined by an elevated value on the same construct subsequently tracked, regression to the mean is the most plausible explanation, though the data cannot confirm it. The risk is structural rather than particular to P2: eligibility was established with a single CORE-OM administration at screening, so participants entered selected at a momentary peak on the same construct that was then monitored weekly, and some downward drift during baseline is expected irrespective of treatment. Consistent with this, the preregistered Tau-bc model, which discounts baseline trend, provides the more conservative reading of the phase contrasts. Two consequences follow: the clinical criterion should be confirmed at a second assessment close to allocation, and the design shows its value, since a simple pre-post comparison would have attributed to treatment an improvement that the time series locates before its onset.

The reliable change analysis complemented the evidence of treatment contingency. Six of the seven participants showed reliable improvement or recovery on at least two instruments at posttreatment and, among the five cases with follow-up data, gains were largely maintained; P2 and P5 returned above a clinical cutoff on one measure while remaining reliably improved relative to baseline, showing that small fluctuations around a threshold can change the recovery classification without amounting to relapse. The two indices answer different questions, the difference between phases of a series and the magnitude of change relative to measurement error, as P1 illustrates, with substantial clinical change despite a nonsignificant Tau-U. No single indicator should therefore be treated as decisive.

Findings for the daily composite are exploratory (H3). Daily well-being improved in the same direction as general distress but more weakly and less consistently: only P5 was significant under both models, P1, P3, and P7 only under the full model, and P4 only under the conservative one, suggesting that in several cases the effect was driven by the within-phase trend rather than by a level change. It is unclear whether daily well-being changed less than distress or whether the scale, developed ad hoc, unvalidated, and answered irregularly (33.7–96.1% adherence), was less sensitive. Whether the processes SET proposes to modify accompany symptomatic change cannot be answered here, because none of the measures assesses those processes directly.

The heterogeneity was itself informative: the study included clear responders, partial responses, discrepancies between indicators, absence of response, and one case of reliable deterioration at follow-up. No participant deteriorated during treatment or required activation of the referral or emergency protocols; P6's deterioration emerged one month after termination and should be recorded as an adverse clinical signal that cannot be causally attributed to SET, underscoring the value of monitoring deterioration beyond the

intervention. This variability raises a central question for an individualized model (Hayes et al., 2019): which processes, patient characteristics, or implementation conditions distinguish response, non-response, and deterioration.

The novelty lies not in showing that emotion regulation is a useful target, which prior literature establishes (Iwakabe et al., 2023; Saccaro et al., 2024; Sloan et al., 2017), but in bringing into a brief online protocol a formulation linking regulatory mechanisms, interpersonal motives, and relational history (Silva, 2024; Silva et al., 2017). Where skills-based models such as ERT and ART organize treatment around expanding the strategy repertoire (Berking & Whitley, 2014; Mennin & Fresco, 2014), SET rests on the interpersonal motives that sustain inflexible regulation (Tamir, 2016). The formulation proved deliverable in a Latin American context underrepresented in the field (Henrich et al., 2010); the design does not, however, establish that improvement occurred through the model's distinctive components, and the value participants placed on the therapeutic relationship points to common factors.

The next inferential step is to operationalize and validate the constructs specific to SET, then to test whether treatment modifies them and whether their change precedes clinical improvement, for which single-case mediation methods offer one avenue (Valente et al., 2023). An active comparator would then clarify what SET adds beyond common factors. The next study should also increase replications, space the baselines more widely, confirm eligibility close to allocation, assess fidelity through independent observers, and include therapists less connected to the model's development.

Several limitations qualify these findings. Cases were few, baselines spanned a narrow range, and follow-up was limited to one month with data for five participants, reducing the precision with which contingency and maintenance can be established. Although randomization of baseline duration controls probabilistically for history and maturation, the non-concurrent design limits control over historical events shared across participants. The sample was predominantly young, female, and university-educated, and self-selected to accept online treatment, waiting, and intensive assessment, so generalization to routine or other cultural settings is limited. The absence of an active comparator prevents separating SET from common factors, expectancies, or the initiation of psychotherapy itself. One coauthor developed the model under evaluation and was involved in training and supervising the therapists, a condition associated with more favorable outcomes across psychotherapy research (Munder et al., 2013), and that warrants independent replication. Moreover, fidelity was monitored through therapists' self-report rather than independent coding of sessions. Process measurement was also limited: the daily indicator was unvalidated with uneven adherence, and an administration error precluded analysis of the preregistered measure of psychological flexibility. Taken together, these limitations position the findings as

preliminary evidence of feasibility and partial treatment contingency rather than as a demonstration of efficacy or specific mechanisms.

Conclusions and main contributions

1. A brief, eight-session online SET protocol proved feasible and acceptable: retention and session attendance were high, and patients and therapists rated it favorably.

2. Four of seven participants showed reductions in psychological distress temporally associated with the randomized introduction of treatment, with a significant aggregated effect. Replication across baseline conditions was not consistent, so this evidence remains preliminary.

3. The study provides a first signal of clinical plausibility for SET as a treatment package in a Latin American setting.

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Conflict of interest: Author J.R.S. is the developer of the Socioemotional Styles Therapy (SET) model evaluated in this study. The therapists who delivered the intervention were trained and supervised by the research team within the framework of the model. This developer allegiance is explicitly declared, as it constitutes a potential source of bias in the evaluation of outcomes and implementation. The authors declare no other conflicts of interest.

Declaration of AI use: During the preparation of this manuscript, the authors used generative artificial intelligence tools (Claude, Anthropic) to assist with language editing, drafting, and the structural organization of the text. All AI-assisted text was reviewed, verified, and edited by the authors, who take full responsibility for the content, accuracy, and integrity of the manuscript.

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