Chapter 10
Emotion-Focused Techniques in Schema Therapy and the Role of Exposure Techniques

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10.1 Introduction

During the last decade, Schema Therapy (ST), a recent CBT development mainly for the treatment of personality disorders (Arntz & van Genderen, 2009; Young, Klosko & Weishaar, 2003), has become increasingly popular. ST integrates traditional CBT with elements of psychodynamic therapy, experiential therapies, and humanistic therapy. Emotion-focused interventions are extensively used, and systematic emotional work is central to this approach. However, different from standard CBT, ST does not mainly use exposure techniques aiming at habituation and extinction. Instead, the main focus is on changing the implicit and explicit meaning of emotional triggers through emotional restructuring mostly by means of imagery exercises, "chair work," or historical role plays.

This chapter provides, first, a brief overview of the ST approach. Secondly, the model of emotional work in ST is explained. Finally, studies investigating both the effectiveness of ST and emotion-focused interventions (i.e., therapeutic techniques aiming at a direct change of problematic emotions) as used in ST are summarized and open questions are discussed.

10.2 The Schema Therapy Model

The two central concepts in ST are the so-called *early maladaptive schemas* (EMS) and the *schema modes.* EMS as defined by ST are "extremely stable and enduring themes, that develop during childhood and are elaborated upon throughout an individual's lifetime" (Young, 1995). Schema modes, in contrast, represent the

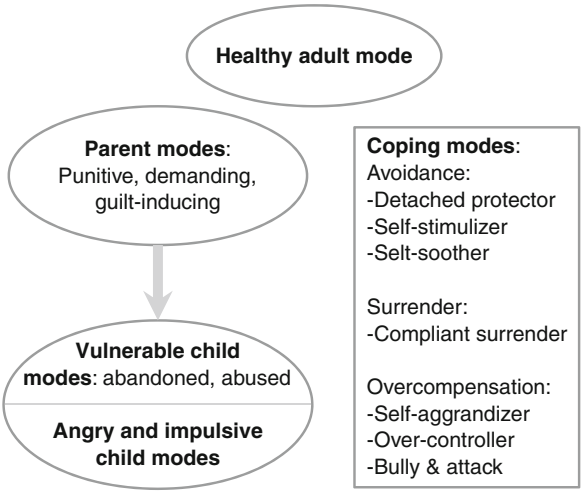

Fig. 10.1 General mode concept

moment-to-moment emotional and cognitive states and coping responses that are active at a given point in time, in which an EMS is triggered. For example, a patient may experience feelings of anxiety or abandonment. At another moment, the same patient may suppress these feelings and feel numb or empty. Both states are conceptualized as different schema modes. The mode model generally describes the rapid shifting in emotion (i.e., shifting between modes) and behavior demonstrated by patients suffering from severe personality disorders (overview in Lobbestael, van Vreeswijk & Arntz, 2007). Schema modes can be triggered by emotional events and an individual may shift from one schema mode into another depending on the situation, the mode constellation, and his individual reactivity.

The concept of schema modes comprises both a general approach and disorder-specific mode conceptualizations. Within the *general approach*, four categories of modes are defined: The first mode category is that of the maladaptive child modes which develop when certain basic emotional needs were not adequately met in childhood. Childhood modes are characterized by strong negative feelings, such as intensive fear of abandonment, helplessness, sadness, rage, or anger. The second category describes dysfunctional parent modes, which reflect internalized problem behaviors of parents, peers, or other significant others toward the patient during childhood. Dysfunctional parent modes are accompanied by self-devaluation, self-hate, or putting extremely high pressure upon oneself. The third category comprises the dysfunctional coping modes that reflect excessive use of maladaptive coping styles of overcompensation, avoidance, or surrender. They occur, for example, when patients suppress their feelings completely or when they cope with threatening situations by exerting overly aggressive behaviors. Finally, there is the healthy adult mode which includes functional cognitions, thoughts, and behaviors (Young et al., 2003). Figure 10.1 gives an overview of the schema mode conceptualization.

Regarding *specific mode concepts*, a particular personality disorder (PD) is characterized by a typical set of modes. The most commonly used specific mode model is the model of borderline personality disorder (BPD; Arntz & van Genderen, 2009),

which comprises a strong punitive parent mode, an abandoned, abused child mode, an angry and/or impulsive child mode, and the detached protector coping mode. Pervasive feelings of abandonment and anxiety are connected with the vulnerable child mode, which is assumed to be related to childhood traumatization and abandonment. Problems with rage, such as rage attacks, belong to the angry child mode. The impulsive behavior of BPD is reflected by the impulsive child mode, which fulfills own needs regardless of negative consequences. Self-hate and low self-esteem, which are also typical of BPD, belong to the punitive parent mode, reflecting an internalization of punitive responses of the parents. The detached protector coping mode comprises behaviors that help the patient to suppress the negative emotions connected to dysfunctional child and parent modes; it includes behaviors aimed at numbing unfavorable emotional states such as emptiness or dissociation, for example, by substance abuse or bingeing. Further, the symptoms of identity disturbance and emotional impulsivity are connected to rapid mode switches. Self-harming behaviors such as cutting, are possibly associated with different modes—if the patient uses self-harm as a self-punishment, it belongs to the punitive parent mode, whereas feelings of numbness after self-injury behavior are considered to be part of the detached protector mode.

Case example Maria B

Maria is a 22-year-old woman with BPD. She reports cutting and alcohol abuse during acute emotional crisis, which often occurs in the context of interpersonal conflicts. When she goes clubbing with a new man, she often starts a sexual relationship quite quickly. In the beginning, she typically feels happy to make close contact with somebody, since she mostly feels lonely and abandoned. When a sexual interaction however starts, she is unable to set limits and tolerates sexual intercourse even when she doesn't feel desire. During intercourse, she feels numb and often uses alcohol or drugs. Afterwards she hates herself, feels ashamed and guilty, and often cuts her legs in order to calm down and to punish herself. When she is in this state, her level of functioning declines, i.e., she holes up at home, spends all day with screen activities including impulsive online shopping, and is on sick leaves. Frequent sick leaves often cause conflicts at work, resulting in frequent job changes. Maria usually feels very helpless, but is hardly angry at the same time. However, when a relationship gets closer, she sometimes gets furiously enraged. Maria grew up in an unstable family, her father was an aggressive alcoholic and her mother did not dare leave him. At age 8–10, Maria was sexually abused by a friend of her father, who often served as her babysitter.

Maria's sense of abandonment and her feelings of shame and guilt are conceptualized as vulnerable, abandoned child mode. Rage attacks are related to the angry child mode. Self-hate and self-cutting for the purpose of self-punishment refer to the punitive parent mode, which developed probably due to the

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experiences of aggression by her father, and sexual abuse by one of his friends. Feeling numb and using alcohol to detach from unfavorable emotions belong to the detached protector mode. Her inability to set limits and her pattern of giving in to sexual contact she actually doesn't want may be seen as compliant surrender mode, which was probably also modeled by her mother, who stayed with the father and sustained his aggression instead of leaving him.

The general goal of ST is to help the patient understand how dysfunctional schemas or schema modes have developed, how the patient is handicapped by these schemas and modes today, which needs have not been met during childhood, and how own needs can be adequately met today.

10.3 Treatment

At first, an individual schema mode model is set up together with the patient. In the following, all problems or symptoms are conceptualized and treated in terms of the modes involved. Childhood modes are elicited, vented, soothed, and mitigated. Dysfunctional parent modes are reduced. Patients are empathically confronted with dysfunctional coping modes, their pros and cons are discussed, and they are reduced in the therapy setting and then transferred into the patients' everyday life. Figure 10.2 gives an overview of the treatment.

ST uses emotional, cognitive, behavioral, and therapy relationship techniques to reach these goals. On the *cognitive* level, characteristics and origins of modes are discussed, related cognitive distortions are restructured (for example, "I am worthless" as a cognition related to the punitive parent mode). On the *behavioral* level, usual CBT techniques are applied to reduce symptomatic behaviors, which are often (but not always) part of the dysfunctional coping modes (for example, assertiveness training to teach setting limits or skills training to replace self-injuring behaviors). When patients display persistent avoidance behavior, the therapist may use in-vivo

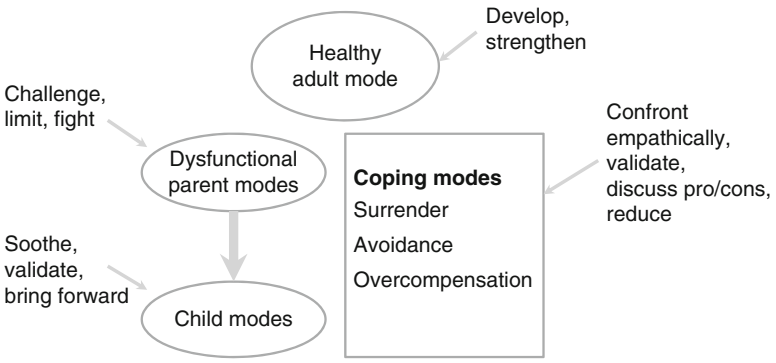

Fig. 10.2 General treatment principles

exposure exercises. Usually, this is done at a later stage in therapy, and often prepared by the use of emotional techniques. On the *emotional* level, the focus is on child and dysfunctional parent modes, since these modes are most strongly associated with intensive unfavorable emotional states such as self-hate, guilt, low self-esteem (dysfunctional parent modes), or abandonment, loneliness, shame, threat, anxiety, sadness, disgust (vulnerable child modes), rage, and anger (angry child mode). In emotional interventions, these emotions are firstly clarified and processed; and then restructured mainly via transformational chair dialogues and imagery techniques (see Sect. 8.3). Concerning the *therapy relationship*, the therapist is empathic, active, self-disclosing, and offers sincere contact as a real person. "Limited reparenting" is used to fulfill needs of the patient which have not been met during childhood, however, to a limited degree. The therapy relationship is also an important vehicle in emotional interventions, since the therapist models functional behaviors and feelings in chair dialogues, comforts the vulnerable child mode, fights the punitive parent mode in imagery exercises, directly supports the transfer to everyday life with the help of transitional objects, etc.

10.4 Emotional Techniques in Schema Therapy

Emotional interventions in ST aim (1) to overcome dysfunctional coping modes and to help the patient to feel emotions which have been avoided so far, (2) to clarify and process problematic negative emotions, (3) to change implicit and explicit meaning, and (4) to strengthen positive emotions and the experience of safe attachment.

10.4.1 Overcome Emotion Avoidance

This is a general goal of all emotional techniques both in ST and in other psychotherapy approaches. Concepts such as defense mechanisms, emotion suppression (Gross & Levenson, 1993), or experiential avoidance (EA), the dysfunctional avoidance of emotions and other private experiences (Hayes, Wilson, Strosahl, Gifford & Follette, 1996) imply that avoiding unfavorable emotions is unhealthy. EA has been investigated in a number of recent studies, and substantially overlaps with dysfunctional coping in ST, in particular with the avoidant coping of avoidant and detached protector modes. Research in EA shows that high EA increases the risk of relapse in substance use disorders, EA moderates the relationship between traumatic experiences and psychological stress, and increases the symptom severity in different psychological disorders (overview in Chawla & Ostafin, 2007; Kashdan, Breen, Afram & Terhar, 2010). High EA is a predictor for negative psychotherapy outcome (Rüsch et al., 2008; Berking, Neacsiu, Comtois & Linehan, 2009) and is associated with lower pleasant activities and less positive emotions (Kashdan, Barrios, Forsyth & Steger, 2006).

Different techniques are used in ST to overcome emotion avoidance or coping modes, respectively. In the therapy relationship, the therapist welcomes emotions,

labels them as important, and expresses a clear motivation for emotional work. On the cognitive level, the therapist firstly explains to the patient the disadvantages of emotion avoidance, pros and cons of dysfunctional coping, and avoidance of emotions. When a patient is frightened by the idea of experiencing emotions, therapist and patient discuss how to set up emotional work in small steps. Thereby the patient is pushed into emotional experiences; however, this is within a well-controlled process. This process is very similar to the beginning of exposure therapy. However, different from exposure therapy where emotions are meant to be processed until the patient habituates, during ST emotions are elicited in order to get a starting point for techniques aimed at changing these emotions.

If a dysfunctional coping mode is very strong, cognitive interventions may not be sufficient to motivate the patient to start with emotional interventions. Then two-chair dialogues (coping mode and therapist) with the respective coping mode are used to validate this mode intensively, to explore its functions in more detail, and to find out more about the emotions "behind" it.

10.4.2 Clarify and Process Problematic Negative Emotions

This is also a general goal of all emotional techniques. For example, the mindfulness-oriented "third-wave therapies" (overview in Ost, 2008) aim at decreasing EA by focusing on acceptance instead of control over emotions. As long as they avoid emotions, patients often don't know which emotions they actually feel and what they need. When they start to actually experience emotions, patients get familiar with their feelings and learn to tolerate intensive negative affect, which in turn is an important prerequisite for reducing avoidance. However, in ST "processing" does usually not mean to expose a patient to problematic emotions until habituation. It rather means to process an emotion as long as necessary—until the characteristics of the respective emotion (i.e., shame, sadness), the connected needs (i.e., need for comfort), and/or its biographical background become clear.

Typical emotional interventions with this goal are diagnostic imagery exercises and chair dialogues. Diagnostic imagery exercises are used when a current situation triggers an unexpectedly strong emotional reaction or an unexpectedly strong coping response. The patient closes eyes, relaxes, and re-experiences the current trigger situation as real as possible in imagery. Feelings related to the situation are explored and deepened by focusing on affective and bodily experiences. When the current emotion is clear, the patient is asked to wipe away the inner image and build an affective bridge to earlier biographical images (i.e., "do you remember childhood situations when you felt similar?"). The biographical image is explored, again with an emphasis on (negative) emotions (i.e., "how does the child in the image feel?") and (unmet) needs (i.e., "what does the child need?"). Feelings like loneliness, shame, or sadness are connected with the vulnerable child mode. Self-hate or pressure upon oneself are connected with the punitive parent mode. This exercise often clarifies the biographical origin of problematic emotions and related interactional or behavioral

patterns. It helps the patient to understand himself and his reactions on a deeper level. In doing so, the connection between trigger situations and negative emotional reactions becomes weaker, as the emotional reaction is put into perspective.

Case example: Diagnostic imagery with Maria

Maria reports intensive social anxiety combined with self-hate as a central emotional problem, which can be triggered by all kinds of social situations. In a diagnostic imagery exercise, she starts from a party situation in which she felt anxious and threatened. The therapist asks her for a childhood image in which "little Maria" felt similar. Maria recalls a situation in which her drunken father enters the house and starts shouting at her and her mother in a very aggressive way, calling them bad names. Little Maria feels horribly frightened. Anxiety and threat resemble her social anxiety (→ vulnerable child mode), while the negative, aggressive messages of the father can be linked to self-hate (→ punitive parent mode).

Chair dialogues are also a useful tool to clarify inner conflicts or to view a situation from different (inner) perspectives. They can be used when the nature of the emotional experience is ambivalent or unclear, or when an inner conflict seems to be important. Different chairs are used for different perspectives or feelings involved. In ST, different chairs are usually related to different schema modes. The patient alternatingly takes a seat and expresses the related perspective or feeling on each chair. When another emotion pops up during the exercise, the patients changes the seat back to the chair connected to the pop-up emotion, or another chair is added. Note that patients with strong avoidance of emotions often devaluate their own emotions ("emotions are ridiculous and stupid"). This position is connected with the punitive parent mode and biographical experiences concerning the devaluation of emotions are explored. The tasks of the therapist are to detect different emotions and perspectives, to help the patient differentiate between them, and to model those emotions or perspectives the patients finds hard to express. This exercise clarifies ambivalent emotions and inner conflicts. Often the solution for an emotional problem becomes clear by exploring the nature of the problem in this way.

10.4.3 Change of Felt Meaning

In general, emotional interventions are necessary when a distorted cognition cannot be changed by means of cognitive interventions. When a patient responds to the therapist "I know that you're right, but I don't feel it," he relates to the emotional meaning of the respective cognition. Emotional interventions trigger and change the emotional meaning. In ST, negative meaning is related to dysfunctional parent or

child modes, and the desired (healthy) meaning is connected to the healthy adult mode. Within emotional interventions, the healthy adult mode either fights the dysfunctional parent mode and/or defends the vulnerable child mode and cares for it. Thus, the healthy meaning is intensified. Both imagery exercises and chair dialogues can be used to set up this process.

With respect to imagery techniques, the technique of *im*agery *res*cripting (ImRS; Arntz & Weertman, 1999) is most useful. In an ImRS exercise, the patient is asked to enter a traumatic biographic (for example, abuse or bullying) situation in imagery. The patient may enter the traumatic situation either directly or via an affective bridge as in a diagnostic imagery exercise. The patient has to stay in the traumatic situation until he clearly feels the related emotions and needs. Note that from an ST-perspective, it is not necessary to relive the whole trauma. In the following "rescripting" part of the exercise, the needs of the patient are fulfilled in the image. Usually a helping person enters the imagery, since in his imagination, the patient is typically either a child or in a helpless position. The helping person may be the patient himself as a strong adult, or the therapist, or any other helping person. In a typical ImRS exercise, the patient recalls a traumatic childhood situation of sexual, physical, or emotional abuse. The therapist enters the image, stops the perpetrator, and protects and cares for the child. Often the therapist then takes the child to a better, i.e. safe place. During the rescripting part, negative emotions such as threat, anxiety, or shame are reduced, and safety is induced. By this, the therapist actively brings about a change in the meaning of the original trauma. As compared to trauma exposition, a patient also relives part of the trauma during an ImRS exercise. However, the trauma is not necessarily fully processed, and the general goal of the exercise is not habituation, but an active change of the meaning of the trauma, including its implications.

Case example: Imagery rescripting with Maria

Since Maria is deeply frightened in the diagnostic imagery (see above), the therapists suggest to rescript the memory. The therapist enters the image of the shouting father and the frightened little girl and offers "little Maria" to hind behind her while she is talking with her father. She then harshly asks the father to stop shouting. As the father gets even more aggressive and threatens to hit the therapist, two police men enter the scene and arrest the father. Then the therapist asks little Maria what she'd like to do and she wishes to go to the playground together. On the playground, the therapist asks Maria about her feelings. She says that it feels good to know that the father has been arrested; however, she's scared what will happen when he returns. The therapist offers her to take her to the therapist's home and stay there in the future. Maria feels much safer with this solution and they leave together to get to the therapist's home.

Chair dialogues can be used for the change of felt meaning as well. Emotional meaning can be changed by chair dialogues in which the healthy adult mode cares for the vulnerable child mode and fights the punitive parent mode—thus, the patient experiences in a highly emotional way that his needs are important and that self-deprecation can be reduced. As long as the patient himself does not feel strong enough to fight the dysfunctional parent mode or care for the vulnerable child mode, the therapists models the healthy adult mode or guides the patient to express it.

Another chair work format is so-called "historical role plays." In this exercise, the therapist and the patient play a traumatic biographical memory together as a role play, in which the patient takes not only the own role (usually as a child) but also the role of the perpetrator. This is particularly helpful, when a patients feels that he is bad or guilty because somebody treated him badly as a child; however, the respective parent figures did not intentionally harm him, but were too weak to protect him against abuse, or too emotional to offer stability and safety. By switching both into the perspective of himself as a child and of the parent figure, the patient experiences another meaning of the situation.

10.4.4 Intensify the Experience of Positive Emotions and Safe Attachment

Patients with mental disorders typically suffer from a high load of unfavorable emotions and often lack positive emotions. In reverse, positive emotions buffer against distress and are related high psychological well-being and self-esteem (Tugade, Fredrickson & Feldman, 2004). Many CBT interventions aim at increasing positive experiences, such as the training of positive activities. Patients with severe PDs, however, often find it hard to experience the respective positive emotions, as they feel mainly threatened, anxious, ashamed, or "odd" in social situations. However, social situations are most relevant to positive emotions, since positive emotions such as safety, love, or joy are usually connected to positive attachment experiences, and most positively evaluated situations are social in nature as well (Jacob et al., 2011).

Thus, ImRS exercises and chair dialogues are also used to intensify positive emotional experiences. The most effective technique is probably the reparenting part of ImRS exercises, after the parent mode has been battered. In the final phase of an ImRS exercise, the helping person/healthy adult mode offers support and positive attachment experiences, such as spending time together playing, talking, eating, etc. This is particular helpful for patients with very unsafe attachment and high anxiety in social situations, since they have the opportunity to engage in safe attachment-related emotions.

10.5 Current State of Research

Studies investigating the effectiveness of ST in patients with BPD according to the manual of Arntz and van Genderen (2009) demonstrated high effectiveness of ST as individual therapy in all BPD symptoms, with respect to functional impairment and secondary outcome measures such as measures of psychopathology (Giesen-Bloo et al., 2006; Nadort et al., 2009). Farrell, Shaw and Webber (2009) found high effectiveness of ST in BPD patients also in a group therapy setting. Since high negative affect and high emotional dysregulation are prominent features of BPD (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004), emotion-focused interventions were evaluated as extremely helpful. For example, patients' ratings of the therapy relationship were significantly more positive in ST as compared to transference-focused therapy (Spinhoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007).

A range of studies also investigated different facets of imagery and ImRS in other mental disorders than BDP. For example, negative trauma-related images are a central diagnostic criterion of posttraumatic stress disorder (PTSD). However, a growing number of studies show high presence of negative inner biographical images in many other psychological disorders, including obsessive–compulsive disorder (Rachman, 2007), agoraphobia (Day, Holmes & Hackmann, 2004), social phobia (Hackmann, Clark & McManus, 2000), and eating disorders (Somerville, Cooper & Hackmann, 2007). For social phobia, it has been shown that negative self-imagery has a causal role in the development and maintenance of social anxiety (Hirsch, Mathews, Clark, Williams & Morrison, 2006), and that negative images contaminate interpersonal interactions in various ways (Hirsch, Meynen & Clark, 2004). Inner images are clearly different from intrusive thoughts (Hagenaars, Brewin, van Minnen, Holmes & Hoogduin, 2010) and their relationship with emotion is closer than the connection between language and emotion (review in Holmes & Mathews, 2010).

Correspondingly, therapeutic techniques using imagery instead of verbalization probably have a greater impact on emotions (Holmes, Lang & Shah, 2009). Several studies showed surprisingly positive effects of ImRS on different disorders. It is successful in PTSD (Arntz, Tiesema & Kindt, 2007), even when prior exposure therapy had failed (Grunert, Weis, Smucker & Christianson, 2007), in social phobia (Wild, Hackmann & Clark, 2007, 2008), and in depression (Wheatley et al., 2007; Brewin et al., 2009). ImRS reduces also nonfear emotions, which are hardly treatable by exposure techniques, such as guilt, disgust, or anger (Arntz et al., 2007; Grunert et al., 2007; Mason & Richardson, 2010). In patients with personality disorders, ImRS can be effectively conducted both with present and past biographical situations (Weertman & Arntz, 2007).

A few experimental studies provide further evidence for ImRS. Results indicate that ImRS may indeed rather change the meaning of a conditioned stimulus than extinguish the association between conditioned and unconditioned stimulus ("new learning instead of extinction learning"). Hagenaars and Arntz (2010) used a trauma film paradigm, in which study participants watched a movie to induce

intrusive imagery, and afterward got different experimental "treatments" including an ImRS condition. As compared to unrelated positive imagery and mere exposure, ImRS was followed by significantly less intrusions in the following week. Dibbets, Poort and Arntz (2010) showed in a conditioning study less fear renewal after ImRS as compared to normal extinction, when the conditioned stimulus was again presented in a new context after the extinction phase. Two studies showed stronger induction particularly of positive emotions with imagery strategies as compared with cognitive strategies (Holmes et al., 2009; Jacob et al., 2011). Positive self-related imagery also seems to enhance the processing of positive self-representations (Stopa, 2010).

10.6 Discussion

This chapter summarizes the central ideas of emotion-focused work in schema therapy. Emotion-focused interventions in ST aim at clarifying, processing, and restructuring emotions. Different from exposure techniques, the rationale behind emotional change is not habituation, but rather to actively change the quality of emotions and thereby to change the meaning of the traumatic memories. Similar to exposure techniques, however, emotional interventions are discussed between therapist and patient and stepwise introduced into therapy. When emotional interventions are hindered by specific modes (e.g., a punitive parent mode forbidding the patient to engage), the function of the mode is discussed first and the mode is reduced step by step.

Schema therapists use interventions which have been developed by different experiential therapy approaches, such as psychodrama or Gestalt therapy. Different from some of these approaches, however, emotional processes are actively guided by the therapist in ST, who takes care that the patient feels safe. The therapy relationship is an important facilitator of social emotional learning. Thus, these emotion-focused techniques can also be used in the treatment of patients with severe PD who are at high risk of decompensation when emotional processes are stimulated. Although ST uses many emotional techniques, classical exposure exercises are seldom used. Only later in treatment, when the focus is more on the present, classical exposure in vivo can be used to address rigid situational avoidance. But even then, this will be supported by emotion-focused exercises to prepare the patient. One of the main reasons why ST doesn't often use exposure techniques is the developmental perspective that ST takes. For example, in processing childhood traumas, ST doesn't use prolonged imageary exposure to trauma memories, as one wouldn't send a child alone, without support, into highly threatening situations. Rather, one would first build a safe attachment relationship, bring safety into threatening situations, prevent trauma, and correct dysfunctional conclusions the child made.

Empirical studies indicate high effectiveness of ST in the treatment of BPD. A first RCT investigating ST for BPD in groups (Farrell et al., 2009) showed

excellent results. This may be due to the focus on positive attachment experiences with therapists and peers in the therapy group. A large international RCT testing effectiveness and cost-effectiveness of ST for BPD in groups[1] with a special focus on the therapy relationship is under way.

In other PDs, ST is also highly effective, albeit the effects do not reach the results of BPD treatment (Arntz, 2010). Building upon these positive experiences, clinical developments of ST for different disorders are under way (for example, obsessive–compulsive disorder; Gross, Stelzer & Jacob, 2012). Further clinical trials are necessary to test the effects of ST in other disorders.

With respect to imagery exercises, many further questions warrant for discussion. Is the use of revenge fantasies helpful or dangerous? Does fully processing a traumatic memory increase the effect of ImRS as compared to ImRS after partial processing of the trauma? How important is the induction of positive emotions during an ImRS, and how can it best be achieved?

ImRS is a widely used emotion-focussed technique which has already been subject to a number of empirical studies. Other techniques which are used in ST, such as chair dialogues or historical role plays remain understudied and call for further investigation, i.e. comparison to ImRS and classical imaginary exposure.

With respect to coping modes, we mostly referred to studies investigating experiential avoidance. The overlap between EA and coping modes has to be clarified. Last but not least, the general concept that emotion-focused interventions help to reduce coping modes over the course of therapy, is currently being tested in longitudinal studies).

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