

Gernot Hauke and Mirta Dall'Occhio

Emotional Activation Therapy (EAT): Intense work with different emotions in a cognitive behavioral setting

ABSTRACT

Activation and escalation of fear within the framework of exposure therapies is generally seen as distinctive predictors of the success of behavioral therapies. Nevertheless, in the general practice of cognitive behavioral therapies (CBT), direct induction of emotions can probably be regarded rather the exception than the rule. To expand the traditional procedure we propose an experiential format with the aid of which emotional processes can be induced. We will present a well-structured process that allows intense emotional work in seven steps. The body can support the process of emotional activation and regulation. Many studies regarding embodied cognition have found that movements of parts of the body or the whole body, gestures and mimics are related to people's evaluations as well as motivational and emotional processes. Especially by instructing persons to take a special body posture, mimic and breathing pattern will lead them to experience distinct emotions. We use these findings to create embodiment techniques for a new and activating approach regarding deep emotional work. Starting with a client's concrete problematic situation we construct with him an emotional field. Problems of emotional over- or underregulations are identified. Adequate regulatory strategies are developed and experienced also with the aid of the body. Emotional mastery may help to match the intensity of the emotions with the client's goals. A case example is presented.

Keywords: emotional activation, cognitive behavioral therapy, embodied cognition, emotion regulation

1. Emotional activation as an effective ingredient

In the general practice of cognitive behavioral therapy (CBT), direct induction of emotions can probably be regarded rather the exception than the rule. SAMOILOV and GOLDFRIED (2000) even go as far as to say that this has remained "terra incognita" in both research and clinical practice. On the other hand, we have known for a long time now that activation and escalation of fear within the framework of behavioral therapy exposure treatments can be essential predictors of the success of therapy (FOA and KOZAK, 1986). WATSON and BEDARD (2006) compared the

therapy results of CBT clients with those who had completed an experiential therapy. The CBT client group showed a significantly poorer outcome combined with a substantially lower emotional processing depth. Inspired by results in basic research, in recent years researchers have been focusing more on the significance of emotional processes as effective factors in therapy. Independently of the respective therapy approaches, clinical research has found that the emotional activation, its intensity and the processing of the emotional experience in therapy, are decisive for its success (GREENBERG and SAFRAN, 1987; BEUTLER et al., 2000; IWAKABE et al., 2000; WHELTON, 2004; ZNOJ, 2004; WATSON and BEDARD, 2006). Independently of disorder-specific therapy concepts or specific mental disorders, emotion-related interventions increase the efficiency of psychotherapy (MOSES and BARLOW, 2006; BERKING et al., 2008). In the following we describe an experience-oriented procedure with the aid of which emotional processes can be induced in the setting of cognitive behavioral therapies. We develop a work format with which problematic associations between stimuli, reactions and meanings are replaced by less problematic associations. These alternative associations ultimately make new experiences possible, which we support within the framework of a targeted process.

2. Clinically relevant aspects of emotion

A first working definition characterizes emotions as current states of individuals, differing in terms of quality and intensity, which are aimed at an object, give the persons concerned a characteristic experience, and often lead to physiological changes and certain types of behavior (MEYER et al., 1993). An essential part of the therapeutic work consists in the components of an emotional episode and their functions (SCHERER, 2005):

- Evaluation of objects and events (appraisal component)
- System regulation (neurophysiologic component, physical symptoms)
- Preparation and orientation of actions (motivational component, impulses to act)
- Communication of intentions (expression component, motion, language)
- Monitoring of the inner state and of the interaction with the environment (experience component, subjective perception).

With a close eye on this interaction, BARRETT and CAMPOS (1987, p. 558) conceive of emotions as mutually oriented processes of the generation, maintenance and/or interruption of relationships between the individual and the external or internal environment (BARRETT and CAMPOS, 1987, p. 558). Every form of interaction between the individual and his environment is accompanied by a "family" of different emotions (FOGEL et al., 1992).

2.1 Activation of emotions

The individual is the architect of his own emotional experience (BARRETT, 2006; BARRETT ET AL., 2007; FRIJDA, 2007; HOLODYNKI, 2006; RUSSELL, 2003). A constructivist approach towards

describing this process assumes that our brain is constantly creating mental states such as emotions; physical states etc. using what is referred to as situated conceptualizations (Barrett, 2006; Barsalou, 2009). Three information sources are combined: sensory stimuli outside of the body, sensory signals from inside the body, i.e. the somato-visceral stimulation – the so-called internal milieu – as well as previous experiences, i.e. memory content and categorical knowledge of the respective learning history (see Fig. 1).

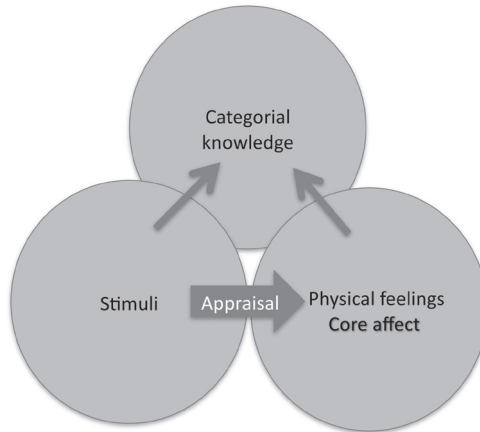


Fig. 1: Activation of emotions

Fig. 1 illustrates the process somewhat more clearly. External (e.g. a certain trigger situation) and internal stimuli (e.g. an imagined trigger situation) are evaluated with the aid of an appraisal process which directly causes a somato-visceral stimulation, and the interoception registers a change in the internal milieu. This is referred to as the core affect (RUSSEL and FELDMAN-BARRETT, 1999) and describes a direct reaction that indicates whether objects or events are helpful or harmful, rewarding or threatening, and requires the individual to accept or reject something. It thus functions as a kind of neurophysiological barometer that reflects the relationship of the person to the flow of ever-changing environmental conditions. These form the basis for consciousness. Alongside this valence dimension, the core affect is also characterized by an arousal dimension. This refers to feelings such as excited, active, tense versus calm, quiet, sleepy. Thus the core affect can be represented in a two-dimensional circumplex (RUSSEL, 2003). The resulting core affect, commonly and appropriately known as the gut feeling, communicates feelings of motivation or lack of motivation as well as a certain degree of activation. Although not entirely determined, it is connected with continuous automatic evaluations or "primary appraisals" of the situation. The way people conceptualize their affective condition depends, of course, on their knowledge about the emotion which is being developed. For example, individuals could experience their core affect as a particular type of fear, anger or

nervousness – depending on which conceptual knowledge they bring to the situation. Thus the emotional experience is not only affectively pleasant or unpleasant, but also conceptually registered and conscious, e.g. as anger.

2.2 Let the body help: effector pattern

The activation of emotions with the aid of the body plays a central role in EAT. At an early stage, there had already been indications that the induction of emotions with the aid of emotion-specific facial expressions is possible (EKMAN et al., 1983). The importance of the facial muscles was also more clearly worked out in the by now classical studies by STRACK et al. (1988), where it was not the test persons themselves who caused their own facial muscles to adjust, but a manipulation from outside. This led to the conclusion that even the perception of a physical change can lead to a change in emotional experience (STRACK et al., 1988; SOUSSIGNAN, 2002). In recent years it has been quite impressively verified that, alongside the adjustment of the facial muscles, other physical activities such as bending or stretching the arms, certain motions of the whole body, postures etc. can have a significant influence on mental regulation. Even apparently insignificant physical activities obviously place the mind – in what might be called a bottom-up approach – in a state which is not only clearly reflected by measurements of motivational and emotional variables, but which also has a significant effect on neuro-endocrinological measurements such as testosterone and cortisol values (overview by PRICE et al., 2012).

In the 1970ies – clearly well ahead of their time – the working group around SUSANA BLOCH managed to characterize six basic emotions: joy-laughing, sadness-crying, fear-anxiety, anger, erotic love and affection by setting certain breathing patterns, postures and facial expressions (BLOCH and SANTIBANEZ, 1972; SANTIBANEZ and BLOCH, 1986). The authors recorded the breathing motions, muscle activity, pulse, blood pressure, physical expression and subjective perception. First a group of test persons was hypnotized and led to experience intense emotional situations. Another test group was made up of drama students who were asked to place themselves in emotionally charged life events they had experienced. From the recorded complex visceromuscular reactions, a selection was made of those that manifested especially clearly through the changes in breathing motions, facial expression and posture. The resulting prototypical configurations of these three features, which are, in principle, under arbitrary control, are referred to as emotional effector patterns. Now it was possible, by precise execution of physical activities such as setting breathing rhythm and posture and creating the facial expression, to generate a certain target emotion (BLOCH ET AL., 1987; BLOCH, 1989). Respiration obviously plays a leading role in the activation of the emotional pattern. Even from our everyday experience we know that this assumption is plausible. Anyone who experiences fear, rage, sexual arousal or sadness will not only notice a clear change in his breathing pattern, but also several other distinguishing features. This is why it was hoped that a quantification of the respective respiration parameters would lead to an even deeper insight (BLOCH ET AL., 1991). Here it was

possible to register important emotion-specific differences. In addition, the evaluation of the data invariably showed a temporal development, which begins with a mechanical, almost robotic phase. After some time, however, the complete effector pattern can be seen and the subjective perception is experienced with increasing clarity. In this phase, the complete emotional scheme is activated. SUSANA BLOCH systemized the instructions for emotion induction, prepared them didactically and developed a training program entitled "AlbaEmoting" and aimed particularly at introducing actors to working with authentic emotions (BLOCH, 2006).

Table 1: Instructions for the activation of certain emotions (Bloch, 2006)

STEPOUT: A simple attentiveness exercise that generates an emotional zero point. This exercise is central as it makes the generated emotions controllable, and is experienced by many participants as a kind of emergency exit. The stepout is always carried out before and after every exercise in order to avoid an "emotional hangover".

BREATHING: The participant breathes slowly in through the nose and out through the slightly opened mouth. At the end of exhalation, he can consciously take a short break. Movement of the arms synchronously with the breathing can extend the exercise.

BODY POSTURE: Standing upright, the feet spread to the width of the shoulders and parallel, the knees slightly flexed, the participant fixes his gaze on a fixed point at eye level some meters away.

FACIAL EXPRESSION: Relaxed, eyes not closed, gaze fixed at eye level on a point on the wall.

ANGER

BREATHING: Rapid, deep and gasping breaths through the nose (saw tooth pattern); breathing is 3-4 times deeper and faster than when at rest.

BODY POSTURE: Muscles are tense, especially the shoulders and arms, tendency of forwards motion (attack).

FACIAL EXPRESSION: Lips pressed tightly together, neck tense, eyes narrowed, a piercing gaze with eye contact fixed on the other person.

FEAR

BREATHING: Short, rapid, gasping breaths through the mouth, first as in a reaction to fright, then short exhalation through the mouth which is not deep or complete. Then immediately again short, sharp, rapid breaths and so on, giving rise to halting, flat chest breathing.

BODY POSTURE: Tense, tendency of backwards motion (flight).

FACIAL EXPRESSION: Lips, cheeks and neck tensed, eyes wide open, gaze fixed on source of danger or sweeping around looking for the source of danger.

SADNESS

BREATHING: As when crying, sniffing breaths in steps through the nose. Slow, deep exhalation through the slightly open mouth, possibly making a sound (light sigh); it is important that the lungs are completely evacuated. The participant keeps breathing out until the sniffing inhalations almost start automatically.

BODY POSTURE: Loose, the body is allowed to collapse or “melt” when breathing out.

FACIAL EXPRESSION: Loose, relaxed, cheeks hanging, lips loose, eyebrows slightly raised and together at the middle.

JOY

BREATHING: Deep inhalation through the nose then rapid exhalation through the slightly opened mouth making a “ha, ha, ha” sound.

BODY POSTURE: Generally loose and relaxed, flexible, upper body rocks slightly back and forth, then is completely left to itself, whereby the body then begins to rock back and forth in sharp, sudden movements.

FACIAL EXPRESSION: Mouth open, sides of the mouth turned upwards but lips not too tense.

There is no comparably elaborated approach in scientific psychology (see BOITEN et al., 1994; PHILIPPOT et al., 2002). The physical activities described not only change the internal milieu, the core affect, but also activate conceptual knowledge (e. g. by setting a certain posture, facial expression), which means that the respective emotional scheme is completed and then perceived (see Fig. 1). Typically, the corresponding images and thoughts also arise when the effector patterns are practiced. Of course, having been developed for actors, this training method cannot be simply applied directly for psychotherapeutic purposes. We integrate the method of emotion induction in a targeted process, placing special emphasis on the creation of an anchoring context (HAUKE and SPREEMANN, 2012). We are not concerned with achieving perfection in the depiction of an emotion. Rather, we place value on the induced physical and mental processes, yielding indications for diagnosis and correction of the emotional self-regulation.

2.3 Primary and secondary emotions

Once emotions have been activated, this can cause various reactions in the individual himself. It is helpful, especially in the clinical context, to distinguish between primary and secondary emotions. Primary emotions are normative, adaptive and universal types of reaction within a given context, e.g. anger at a barrier to need fulfillment. Secondary emotions, e.g. anxiety, are a reaction to these primary emotions (GREENBERG and SAFRAN, 1987; SULZ, 1994; FRUZZETTI et al., 2008). They are learned responses to a primary emotion. This can be represented in a reaction chain (SULZ, 1994; HAUKE, 2013):

- Primary emotion, triggered reflexively by the situation (e.g. rage)
- Primary impulse to act, which is a part of this reflex (e.g. attack)
- Anticipation of possible (usually intended or learned) consequences of the intended action (e.g. being rejected)
- Secondary emotion, which is directed against the impulse (e.g. anxiety, shame, guilt) and helps the individual to refrain from acting on it

Within these reaction chains, the primary emotion for the respective situation is a prototypical emotion with emotion-specific physiological and behavioral components and a matching core thematic issue. Thus we can understand, for example, when a person reacts angrily to unjust treatment by another person. Whether this angry reaction is also adaptive in a certain situation depends on several conditions. If it triggers massive counter-aggression, or if there is the danger of losing an important reference person, then the individual has a problem, especially if he feels inferior at this moment. Thus it can happen that a biologically adaptive emotion no longer appears socially functional. In order to prevent the undesired consequences and ensure emotional survival, the primary emotion has to be stopped. Effective counteractive emotions include, for example, anxiety, shame and guilt. Such learning processes lead to a situation where management of the primary emotion – in the example here it was rage – no longer takes place and the emotion usually cannot be functionally used. In principle, any prototypical emotion can be a primary emotion. For example, a person could primarily experience painful grief as the result of a loss. From his learning history, however, the person knows that he cannot allow the resulting inability to act to take over and instead reacts – in the sense of a conditioned emotional response – angrily. Here the core affect or the gut feeling is interpreted as anger with the aid of the conceptual knowledge and the information about the triggering situation (Fig. 1). The anger is then the secondary emotion. Here again the effect of the first, basically adaptive emotion is interrupted or even completely suspended. With the aid of the conceptual knowledge and the information about the triggering situation, the core affect or the gut feeling is interpreted as anger (Fig. 1). Secondary emotions obviously cause a series of maladaptive reactions. The self-regulation of the person no longer corresponds to the original trigger (e.g. highly excited and aggressive instead of calm and subdued). The signals being sent to the environment trigger the corresponding reactions (e.g. counter-aggression), with the result that the person receives a completely inadequate social response to the triggering situation (e.g. experience of loss), and so on.

2.4 Differentiate emotions

Some patients are quite capable of distinguishing their emotional experiences on a high level of differentiation. With astounding precision they can identify and describe diverse nuances of their emotional experiences. Others, however, are only capable of circumscribing their perceptions with qualities such as "I feel good" or "I feel bad". People who are not good at describing their emotional experiences more precisely will not be able to use emotions as the source of

a wide range of action-related information either. Patients with a less pronounced capacity for differentiation are also more likely to simply bear any physiological perceptions accompanying the emotional stimulation, to misinterpret them or even to reinforce them. They are floating, so to speak, in the ocean of the core affect. The emotional process is not completed; as the trigger conditions have not been appropriately allocated, access to conceptual knowledge is obstructed, the conceptual knowledge is imprecise, and so on. On the other hand, people who can differentiate their emotions generally tend to be substantially better at managing negative emotions. They have a greater diversity of regulation strategies and, eventually, are also considerably more successful in their efforts to cope with negative emotions (BARRETT ET AL., 2001; KANG and SHAVER, 2004). These findings support the assumption that well developed emotion identification skills generally increase psychological flexibility and, in particular, promote good self-regulation. In therapy it is often necessary to strike a balance between the three information sources – trigger conditions, core affect and practical knowledge – in order to identify a core thematic issue (LAZARUS, 1991) (see also Fig. 1). In connection with high stress levels and intense negative emotions, there should be an especially high need for an efficient regulation of emotions (BARRETT ET AL., 2001; GOHM, 2003). Anyone who has difficulties identifying emotional states and describing them in a differentiated manner is more likely to use unfavorable strategies for the regulation of negative emotions, such as abuse of alcohol and other drugs, binge eating etc. (TAYLOR ET AL., 1997). These maladaptive regulation strategies represent a kind of emergency solution. As there is no access to the emotions, the information contained therein cannot be used to develop suitable solution alternatives for difficult situations. This means that, for example, anger has to be actually perceived and identified as such for an emotional core thematic issue to be accessed, which in turn contains instructions for action to deal with the situation. Instead, the individual resorts to emergency regulation strategies such as binge eating, alcohol abuse etc.

2.5 Regulation of emotions

Emotional activation can help a person to experience emotions in their respective perception quality and in their effect on the activated person himself and his momentary environment. Although this is already a major therapeutic advance, further measures are necessary in order to ensure permanent behavior modification. The objective is, after all, to enable the patient to manage his emotions and the related targets more functionally than before. In other words, this means that the patient's self-regulation and – as a special case – his emotional regulation are improved. In connection with emotion regulation, THOMPSON (1994) cites extrinsic and intrinsic processes used to monitor, evaluate and modify emotional reactions. In particular, the temporal development and the degree of emotional intensity should be coordinated in such a way that the corresponding targets can also be achieved. GROSS and THOMPSON (2007) cite a total of 5 intervention points at which individuals can regulate their emotions. (a) Situation selection, (b) situation modification, (c) attentional deployment, (d) cognitive change and (e)

response modulation. These aspects can be readily implemented in behavioral therapy. They are used in particular in the last step of our approach that we refer to as “emotional mastery”.

3. The working protocol in EAT

In our method emotional activation takes place in two ways:

- by scenic imagination and
- by deployment of the effector patterns.

In so doing, we observe the behavior therapeutic principles of mindfulness deployment, exposure and discrimination learning (Fig. 2).

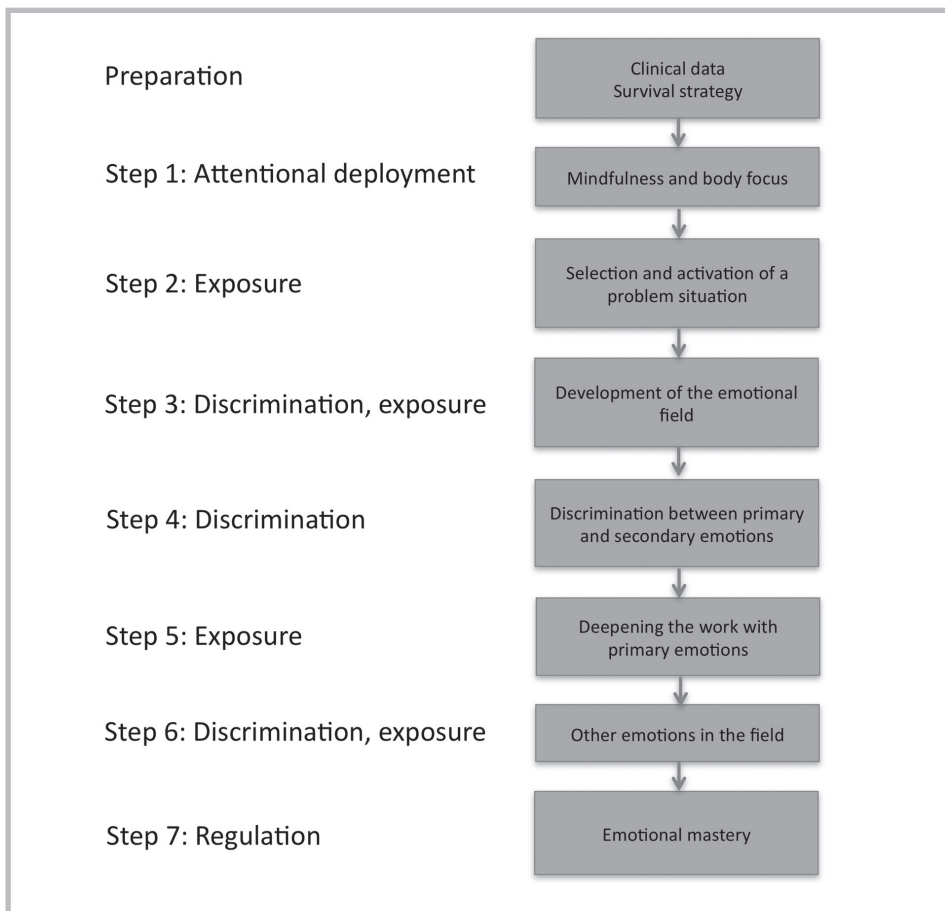


Fig. 2: Steps of Emotional Activation Therapy (EAT).

Patients have to learn how to perceive the diversity of their emotions and to identify them, particularly in problem situations. By direct perception they experience the effects of primary and secondary emotions as well as the diversity of other emotions involved. A prerequisite of this is that they can bear unpleasant or often avoided emotions. In addition, they also have to experience how different impulses to act of diverse emotions “feel” for their core thematic issue to be reliably identified. The final step is concerned with linking emotions and targets. The “mastery of emotion” ultimately describes the ability to use emotions functionally for the achievement of personal targets in the relevant problem situation.

Preparatory work and survival strategy. First the usual behavior therapy data is collected, e.g. learning history, behavior observations, data on symptoms and their history etc. This data is then used to develop what is called the survival strategy. It reflects dysfunctional behaviors in terms of the fulfillment of central needs and thus contains important information for working with EAT. The survival strategy is a generally unconscious cognitive-affective scheme boiling the patient’s problem down (HAUKE and SULZ, 2006; HAUKE, 2013). Variations of such schemes are also used in other methods (e.g. ROUSSOS et al., 2005; YOUNG et al., 2005) and are just as helpful here.

STEP 1: MINDFULNESS AND BODY FOCUS

In many cases patients are unable to either identify or discriminate between their emotions. Emotions are often directed imprecisely at situations and objects and are only perceived as more or less diffuse physical sensations. This module is aimed at teaching the skills to perceive, identify and discriminate between emotions. As Fig. 1 shows, three sources of information must be used well for this purpose:

- the triggering situation
- physical sensations
- conceptual content anchored in the memory

Patients thus learn skills of attentional deployment by mindfulness and systematic self-observation (HAUKE, 2006).

Table 2: Exercises to train “mindfulness and body focus”

- Regular exercises “mindful breathing”
 - Body scan
 - Variation of body postures, motion, respiration; observation and description of the resulting physical sensations
- Behavior-analysis diary

Training of mindfulness towards thoughts and emotions is characteristic of behavior therapies of the third wave. The focus here is not so much on changing cognitive content (e.g. LINEHAN,

1996; TEASDALE, 1999; HAYES, 2004). Rather, the patients are supported to get into emotional contact with situations that are difficult for them, and observe the arising thoughts and emotions, without evaluating them, resisting the impulses they contain, and not reproaching themselves for them. If the patient succeeds in adopting a mindful attitude towards difficult experiences, this already initiates a change in behavior: the former trigger is linked with a qualitatively new behavior. Mindfulness unconsciously generates an intensive physical reference, which is very valuable. After some time, the focus on the breathing or the body scan leads to a more differentiated perception of interoceptive and proprioceptive signals. By establishing a mindful body focus, such sensations are captured and condensed to form a theme. In this way the trigger side can be identified and the identification of the emotion prepared (see also Fig. 1).

Features of target achievement with this step: The patient perceives differences in the physical reaction depending on motion style, motion direction and speed of the body, and depending on the depth and frequency of breath. He experiences himself as the observer of mental processes.

STEP 2: SELECTION AND ACTIVATION OF A PROBLEM SITUATION

Patients come to therapy with concrete problems. Concrete problem situations are also the starting point for entry into emotional experience. An essential criterion is that the client feels as far as possible the same way as he felt in the situation originally experienced. A form of scenic imagination has proven useful here (HAUKE, 2013). Fig. 3 shows a diagram of the procedure. The aim is to allow the patient to experience the situation in the here and now, even to taste it. If the description of the problem is initially very broad and largely "cognitive", the experience should be narrowed down to a significant situation.

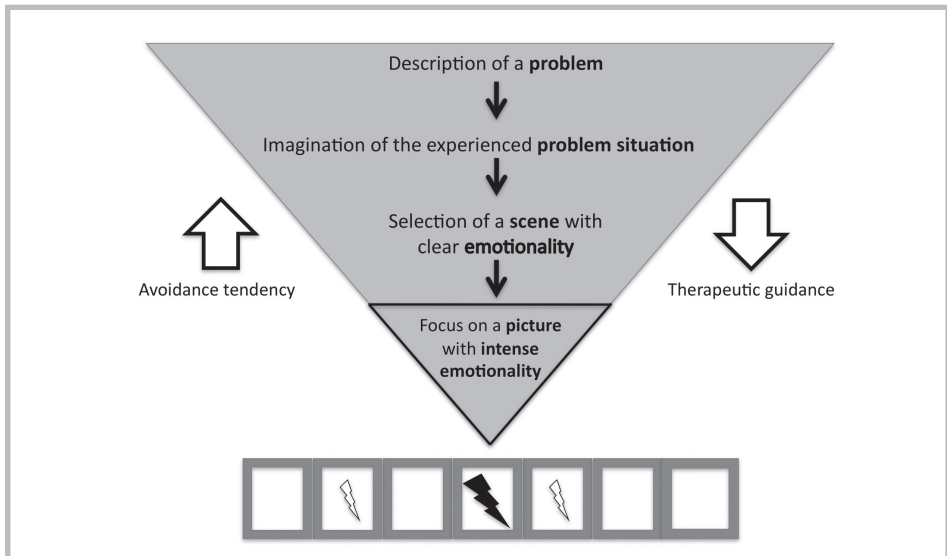


Fig. 3: Emotional activation by scenic imagination

A situation is significant when the difficult experience is clearly palpable in the imagination. This narrowing down to a significant situation is illustrated by the funnel in Fig. 3. At the end of this step, patients should have filtered out an image from the “situation film” that most clearly reflects the relevant experience. The therapist watches out for avoidance tendencies and steers the attention as casually as possible back to the events in the “situation film”.

Features of target achievement with this step: The patient feels like he did in the original situation. The target is achieved even if physical reactions and mental processes occur in a weaker form.

STEP 3: DEVELOPMENT OF THE EMOTIONAL FIELD

The patient’s experience is now brought into the therapy room, where an open, empty, delineated area – a field – is made available. Both persons are standing; the therapist slightly behind or beside the patient. Now the positions are established. They are spatially separated and therefore easy to differentiate. This makes processes of comparison or discrimination easier. During work the patient can concentrate on one position while keeping an eye on all the other positions as necessary. At the same time a field of action is being prepared.

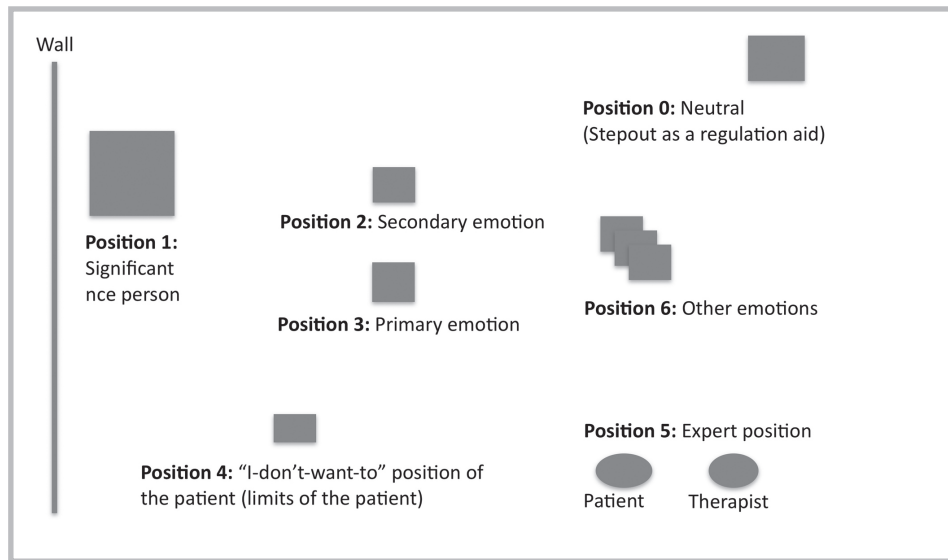


Fig. 4: Positions in the emotional field. Their spatial location is determined by the patient.

At first, the focus of attention is on the position of the significant person(s) imagined in the emotion-triggering situation (Position 1 in Fig. 4). A piece of paper with the name of the person(s) is placed at the wall. Now the patient projects the significant reference person onto the wall, describing the person with posture, facial expression, clothing etc. and putting a typical

sentence in the person's mouth. Now the attention of the patient is steered towards what is happening inside him, in particular the physical reactions, e.g. core affect, tensions, minimum motion impulses backwards or forwards etc. The triggering situation is left to one side for the moment in the interest of this focus.

The emotions occurring are named, and then noted down by the patient and positioned in the field. Again the attention is steered towards the body and its impulses. Often other emotions may arise (Position 6). The patient also notes these down and the notes are distributed in the room. The first emotion named is generally the secondary emotion. Now the therapist describes the other positions designated by the patient on the floor: Position 0 is designated as a regulation aid. If an emotion becomes too overpowering, the patient is guided here with a physical exercise to gain control of it. As the player in the field, the patient can question the sense of the game. Perhaps he feels overstrained and wants to avoid his momentary experience. This is where the "I-don't-want-to position" (Position 4) comes into play. This allows the patient to consciously decide on an avoidance reaction of varying duration. This is expressly legitimized, and the danger that patient and therapist are secretly working against each other is thus minimized. At the suggestion of the therapist or the patient, both switch to the expert position (5). Here both of them reflect on the events in the emotional field. The therapist plays the role of the psychological expert, the patient the role of the expert for his own life. These reflection processes are meant to sharpen the patient's understanding of his inner processes: "How do I deal with certain emotions?" "Why do certain emotions play a larger role in such situations?" This rather metacognitive activity helps to prepare the patient for the seventh work step. This is about the competent deployment of the patient's own emotions in the achievement of targets. *Features of target achievement with this step: The patient has confronted himself with the significant reference person. The description of his experience tends to be more detailed and colorful than the description from imagination. He has precisely understood the various positions in the field and has named at least one emotion.*

STEP 4: DISCRIMINATION OF PRIMARY AND SECONDARY EMOTIONS

The patient leaves the expert position (5) after he has granted his explicit consent to a deepening of the process. He is asked to stand at the position of the secondary emotion (2). In order not to disturb the awareness of the patient, the therapist stands beside or slightly behind him, having first agreed on the spatial distance with him. The patient is now helped to focus his attention on the reactions of his body and his inner processes. The therapist focuses her attention on the patient's body: the slightest tensions, motion impulses, changes in facial expression and gestures provide important clues. In this way it can be recognized to what extent the secondary emotion is beginning to develop, e.g. when the patient's body moves back slightly. If the clues are clear enough, the therapist introduces the respectively appropriate effector pattern (breathing, body posture, facial expression) by miming it. As necessary, she carefully corrects these parameters in the patient, which generally leads to a reinforcement of the emotions and

to a more intensive form of emotion exposure. After about 1.5 minutes the process is gently brought to an end. Images can appear as well as thoughts and emotions. The patient describes the content of these; they are not subjected to any further comment or analysis. Instead, an attentive attitude of observation is supported. After the exposure of the secondary emotion, the primary emotion typically appears. In addition to this, other emotions that have not even been mentioned up to now can come into play. The patient notes these down on a piece of paper and positions this somewhere in the room. Now both patient and therapist go back to the expert position to talk about what has happened. They focus in particular on the impulses to act of the primary emotion and reflect on the role of the secondary emotion. The therapist makes sure that the conversation does not drift too far away from the here and now.

Features of target achievement with this step: The patient has exposed himself to the secondary emotion until the primary emotion appears. Further emotions can arise and be positioned in the field.

STEP 5: DEEPENING THE WORK WITH PRIMARY EMOTIONS

A reaction chain can now be drawn up in the expert position (Hauke, 2013; see Table 3).

Table 3: Content of the reaction chain of the problem situation

Reaction chain	Questions
Problem situation (=behavior available for need fulfillment)	What is it about, who is involved, what is happening where and how? What is happening to me? What frustration, what injury do I experience?
Primary emotion	What is the first emotion that flashes up? What will happen if I allow myself to experience it?
Primary impulse	What impulse will arise if I yield to this first emotion – what would I love to do?
Anticipation of the consequences	What will be the consequences for me and my relationships in the situation if I yield to this impulse?
Secondary emotion (counteractive emotion)	What emotion will actually arise and what effect will it have on me?
Observable behavior	What behavior am I showing to the outside? What signal am I sending with this to the persons involved?
Symptom formation	What symptoms have manifested in me? What effect do they have on me?

This again illustrates the special role of the secondary emotion that helps, after all, to stop or avoid the primary emotion in the problem situation. In addition, the conditions of the learning

history that have led to a linkage of primary and secondary emotions can also be made clear. The survival strategy of the patient qualifies the primary emotion as a “forbidden urge”. Showing or disclosing it uninhibitedly would have endangered the emotional survival. The important thing is that the patient feels and acknowledges that the primary emotion is right and fitting in the current problem situation. At this point it is suggested to the patient that he should become more familiar with this emotion in the protected framework of the field. The argument here is that only what is familiar loses its horror and can be competently used eventually. Once the decision in favor of deepening the work with the primary emotion has been reached, the patient places himself at this position (3), with the therapist again standing close by. The therapist mimes the three features of the effector pattern, whereby it is important that the patient begins with low intensity in order to be able to properly perceive any changes in his body. As the primary emotion is typically a frequently avoided one, the patient may need special support by the therapist in this exposure exercise. Verbal instructions, e.g. regarding floor contact of the feet, supportive measures such as a hand on the back etc. can be very helpful here. Often the patient can say what he needs. In any case, the respective measures must first be agreed with him. When the exercise is completed, the patient returns to the neutral position (0). Then the process is reflected upon in the expert position. The aim is that the patient makes the primary emotion “his own”. For this purpose it is often necessary that the patient occupies the position of the primary emotion and is then encouraged to practice the effector pattern in varying intensity. Every exercise is concluded with a switch back to the neutral position (0). In this way the patient learns that he is able to regulate the primary emotion by the mental-physical activity pattern of the stepout. He no longer needs the secondary emotion for this. The process of accepting and regulating the primary emotion is reflected upon again and again in the expert position (5).

Features of target achievement with this step: The patient is able to distinguish between primary and secondary emotions and regulate each separately by means of the stepout. He no longer needs the secondary emotion to regulate the primary emotion.

STEP 6: DEALING WITH OTHER EMOTIONS IN THE EMOTIONAL FIELD

As mentioned above, during the work with primary and secondary emotions other emotions frequently arise (Position 6). For example, alongside anger as the primary emotion, and fear as the secondary emotion, sadness and affection may also occur. At first glance this may seem as if the person is likely to lose track. The opposite is actually the case, however. In fact, due to the different degrees of arousal and impulses to act now forming in the field, the overall problem of the selected situation becomes clearer. Due to the different directions of the corresponding impulses to act, initially a paralyzing inability to solve the problem or to act manifests itself. The occupation of the respective positions in the field, which is also accompanied as necessary by exercising the respective effector pattern, helps to a great extent to support and validate the patient in experiencing the problem situation. The patient illustratively experiences that the emotional field is basically an emotional network: the problem situation usually contains several

emotionally competent anchors for attentiveness. Depending on which aspects the attention fixes upon, the patient experiences not only one or two, but three, four or even more emotions. It is also possible that fragments of his life history will arise. In the problem situation, for example, the significant reference person (Position 1) with his/her demanding appearance could trigger anger as a primary emotion and fear as a secondary emotion (Positions 2 and 3). At the same time, however, certain aspects of the facial expression might induce friendly or even affectionate emotions (Position 6), perhaps linked with sadness (Position 6) at not having been physically close for so long etc. Memories and inner pictures of learning history experiences can arise. On the one hand, the content of the various emotions becomes clear. On the other hand, there is an overall picture: "You are obstructing me in fulfilling an important need and this is making me very angry. At the same time I am afraid of showing my anger, because I am afraid you would leave me. I love you so much and am so sad that we have not exchanged affections for such a long time." By being represented in the emotional field, these emotions now also have a spatial presence. They can be observed one after the other or in parallel, but they can no longer be ignored.

Features of target achievement with this step: Fulfills the requirements for successful emotional regulation. The patient is now familiar with his emotions in the field; he has clearly experienced their various features. He is able to expose himself to them and no longer has to avoid them. He can observe the development and the course of events in himself, and is familiar with their cognitive-affective core thematic issues.

STEP 7: EMOTIONAL MASTERY

So far, the patient's attention during work in the emotional field (as of Step 4) was again and again brought back to his inner, physical-mental processes. Now emphasis is increasingly put on the outer features of the problem situation. The patient has to learn how to use the emotions he experienced more competently in order to achieve his targets. The emotions in the emotional field are now brought together in a table. In the next step both patient and therapist think about which themes and targets in the concrete problem situation are linked with the various emotions. The results are summarized in a table (Table 4).

Table 4: Some examples of the content of the emotional field and related targets.

Emotion	Targets
Anger, rage (Position 2: primary emotion)	Controlling the intensity of the anger to put appropriate emphasis on a demand.
Fear (Position 3: secondary emotion)	Learning to accept and bear fear until its intensity declines.
Affection (Position 6)	After clarification of the anger-related issue, showing this relationship-strengthening emotion: "Alongside my anger, I also feel drawn to you."
Sadness (Position 6)	Showing the sadness and addressing the loss: "This problem created a distance between us."

First primary and secondary emotions (Positions 2 and 3) are dealt with, later the other emotions (Position 6). The expert position (5) again marks the metacognitive perspective; here the patient talks about what he experienced. The subsequent process then essentially goes through three phases: exposure, experimentation and decision (see Table 3). What has been learned up to now as well as possible starting points for emotion regulation is taken into account here (see Chapter 2.5). Within the framework of exposure, the patient again imagines the problem situation. He places himself facing the wall onto which the significant reference person is projected (Position 1). The experimentation phase is essential for the patient to get a feel for influencing factors and possibilities of emotion regulation. Executing the emotion pattern in different degrees of intensity gives the patient essential regulation experience. The patient has to make a decision after he has attempted various alternatives in the room and discussed them with the therapist. He chooses the version that appears most promising in terms of achieving his target.

Table 5: Step sequence for the elaboration of a favorable emotional regulation

Exposure	Experimentation	Decision
<p>The problem situation is imagined, the interaction partner is projected onto the wall. Spontaneously adopted position in the room, body posture and impulsive physical motions are registered. Does the patient feel larger or smaller than the reference person?</p>	<p>With spatial proximity and distance, body postures and motions of varying speed, tensions, diverse intensities of the respective effector patterns, loudness, attentional deployment, focusing on various features of the situation, helpful, situation-relevant self-instructions.</p>	<p>What is to be the motto of the situation? Shaping: selection of suitable situative circumstances. Selection of a functional action with suitable facial expressions, gestures, motions, posture, position of the body, language and a matching intensity of the emotion pattern. Observation of the self-regulation, observation of the effect of signals, assuming an attentive attitude.</p>

In our work we try to make sure that what has been learned up to this point is also used on an everyday basis. In this context we refer to an action project. The implementation of the patient's new skills is prepared in the therapy. For this purpose both patient and therapist draw up a plan that also takes account of the occurrence of possible setbacks. This considerably increases the probability of target implementation (OETTINGEN and GOLLWITZER, 2010).

Features of target achievement with this step: The patient is able to regulate himself and his interaction with the aid of the emotion in such a way as to achieve his target. He has implemented his skills in an action project.

4. Experience-activating method in EAT

Emotional work also means working with memory content. This is necessary to allow identification of the emotion during interaction with information from the trigger side (see Fig. 1). Accordingly, the method used in therapy should support activation of the memory content. This procedure results from concepts developed in neurobiological research and papers on “grounded/embodied cognition”. The total content of the brain that can be regarded as the result of the interaction of an organism with the emotion-triggering situation (DAMASIO, 2010) is recorded: (1) sensorimotor patterns of visual impressions and the associated eye and neck motions, motions of the whole body etc., (2) sensorimotor patterns associated with physical contact and the handling of the situation, (3) sensorimotor patterns linked with older memories of this situation and (4) sensorimotor patterns that trigger further emotions related to the situation. These components are integrated and result ultimately in our memories. A core statement of the “embodied cognition” research community is that during the process of understanding cognitive concepts, e.g. those of the emotion anger, or those of authority, closeness etc., a mental simulation takes place. This represents a restoration of the personal experience with the aid of these sensorimotor patterns when the person tries to remember, to understand or grasp something (BARSALOU, 2008). Simulation can be regarded as the restoration of perceptive, motor and introspective states that were already acquired during the physical presence in concrete situations. As a result of these simulation processes the body is set in motion in a certain way. Accordingly, obstructing the respective muscle groups also inhibits the processing of the corresponding emotions (NIEDENTHAL, 2006; NIEDENTHAL et al., 2009). With the aid of our procedure, the body is given the space to include this activation. We thus extend the usual framework (HAUKE, 2013). Patient and therapist are not permanently stuck in their chairs, but frequently stand up to allow the body to express something emotionally significant in the room and to show the corresponding physical forms of expression. The “Emotional Field” method offers the ideal framework for this and is extremely helpful not only for the understanding of problem situations, but also for the development of target realizations. The motion of the body in space can be used in a differentiated manner for the examination and amplification of emotional states. Thus it has been shown that emotional proximity or distance bears a relation to the corresponding spatial distance. We apply this in the positioning of the patient in front of the projection. The vertical dimension can also be used to trigger emotions of empowerment or powerlessness. Also, in the sense of a favorable future, the forwards direction in space should always be maintained in the development of target states (NATANZON and FERGUSON, 2012), etc.

5. Clinical case

The case relates to Hans, a 58 year old writer. He suffers from anxiety dysregulation all day long that became worse in the last few months. He has been married for 28 years with Margaret, a clinical doctor. They have a 26-year old daughter who left the house 3 years ago.

Hans says that his angst is worst in the morning, when he wakes up. After taking a shower he feels slightly better. He expresses his need of spending more time with his wife, of having more intimacy and physical contact. He describes his difficulties, for all these years, getting more of this kind of attention from his wife. He values their marriage despite this specific point. His cognitive affective survival strategy:

Only if I always keep my standards low regarding the obligingness of others, privilege the others, **and never** show anger and limits to the others, never show honestly my unvarnished needs, **then I maintain** having a place and the feeling of being seen **and avoid** being rejected and abandoned.

STEP 1: Mindfulness and body focus. The patient was first shown how to mindfully observe his breathing and physical reactions. He is asked to practice this at home for 5-10 minutes twice a day. In a next step the therapist directed the patient's attention to the more precise observation of diverse interactional situations. Here he was trained for the appearance of even light physical symptoms occurring.

STEP 2: Selection and activation of the problematic situation. The patient imagines the situation. He imagines himself lying in the bed, just woken up in the morning, realizing that his wife has already left the bed and is doing physical exercises in the next room. His view is shifted to the closed door. He describes abdominal tension, angst and pain in his waist and pelvic area. The patient smiles while describing the scene. At this point the patient's attention is directed by the therapist back to the experience of the scene. He is asked to focus his attention to the immediate physical reactions that appear.

STEP 3: Development of the Emotional Field. The client is asked to project the concrete figure of his wife on to the wall (clothing, facial expression, typical sentences) and to take a position in front of her. Then the "neutral" and "I-don't-want-to" positions are introduced into the emotional field. Now the patient is asked to return his attention back to his wife's figure on the wall. He is asked to focus on his felt size compared to his wife's. He visualizes himself smaller than her. Then his attention is directed back towards himself. Now he is encouraged to describe his physical and later his mental processes regarding this projection. He mentions that he feels heat in his cheeks, stomachache and pain in the chest, paralyzed and with tension in his body. He associated this with the emotion of "shame". He is instructed to note that down on a piece of paper and put it on the floor. He tightens his body and moves it backwards; he says that he feels "fear" of being rejected by Margaret. This is written on a piece of paper and put on the floor. Once the body's signals clearly confirmed this the therapist introduces the effector pattern of fear and carefully validates upcoming memories. She explains to the patient that they are important but may be treated later, redirecting the patient's attention to his body processes again. After a while he

expresses anger and the wish to shake Margaret. "I am angry with her, she doesn't hear me, she doesn't pay attention to me". The piece of paper with "anger" written on it is now put on the floor. "I don't want this, I am sad about our situation". "Sadness" is now written on a piece of paper and put on the floor. The patient expresses his wish to move to the "step out". After exercising the neutral position the therapist proposes to move to the "expert position". Here the patient is asked to look on to the processes which occurred. Several outcomes appear: "Since the beginning of my childhood I have been used to hide my wishes", "I have learnt to direct my attention primarily to others, never to make clear what I need", "I'm only able to take other people's leftovers", "I'm not able to say no!" These findings were compared with the cognitive affective survival strategy.

STEP 4: Discrimination between primary and secondary emotions. As the patient feels more connected to the emotion "shame" he wants to start the working process with this emotion. He moves to the corresponding position on the floor. There he feels connected with his wish to tell Margaret that he is ashamed when he has to ask her for physical contact and tenderness and might be rejected by her. Again he feels his body paralyze and tense. He says "I want to get out", and moves a step backwards. Now "fear" comes up again and the therapist asks him to move to the corresponding position. At this position in the emotional field the therapist introduces the emotional effector pattern to deepen the activation of fear. After a while the patient expresses "Margaret, you are supposed to stay with me when I need you, you are my wife". Developing an approach tendency and a different degree of tension he powerfully moves forward saying "I don't want to be angry with you". To bring this change to his conscious awareness the therapist redirects his attention to his body. Given the intensity of the process and the amount of information the patient is now guided to the "neutral position" to be able to talk about the process in the metaperspective way offered by the "expert position".

STEP 5: Deepening the work with primary emotion. Therapist and patient formulate a reaction chain. The patient identifies anger and rage as primary emotions, which are interrupted by the fear of losing his relationship. This corresponds to his learning history. His parents could not cope with his elder brother who was chronically ill. The patient was not allowed to bother them. Then he is guided to the position of "anger" and is instructed to execute the corresponding effector pattern.

STEP 6: Dealing with other emotions in the emotional field. Now other emotions have to be explored. "Shame" and "sadness" are in the field, the patient explores them, images and memories appear. In the "expert position", creating a meaning of these emotional experiences completes the exercise.

STEP 7: Emotional mastery. Now a table is drawn up allocating the emotions of the field to thematic issues and targets. So-called "negative" emotions are not removed or reduced, but

taken as important signals with respect to action projects, which were observed in terms of difficulty and urgency.

Table 6: Different emotions in the patient's Emotional Field and related targets

Emotion	Targets
Shame	Recognize intimacy needs. Stand the feeling of shame and address the needs to the partner.
Fear	Stand the feelings of fear. Perform behavioral experiments in order to provoke fear and test the connected beliefs in the reality of everyday life.
Anger	Allow feeling the anger and showing it in a functional way, which helps to reach the goals in the specific situations.
Sadness	Allow feelings of sadness, the related previous experiences and share them with other persons. Make yourself to be seen and especially visible with your needs of intimacy.

Here the first aim to be reached was that the patient was able to connect with the feelings shown in Tab. 6 and then to discriminate them. Next, both patient and therapist decided to perform a behavioral project with steps of varying difficulty. Action plans and techniques such as role-play, visualizations, etc. helped to prepare the patient to approach real situations. With the aid of the effector patterns different degrees of emotional intensity were attempted the aim of optimizing self-regulation as well as regulation of interaction.

Hans realized that he very often behaves in a way which is very comfortable to others, especially to Margaret. His cautious hints about his needs were often simply pushed aside by her. So the expression of anger in an adequate way and the setting of limits regarding her mindless behavior in the couple's intimacy were important. The patient was encouraged, within the session, to test different possibilities of expressing anger in combination with various discussion contents. Ultimately, he decided for a particular option. Patient and therapist developed an action plan also considering problems that might arise. The joint evaluation of what was experienced showed that the patient was satisfied with the course of the conversation. Then further projects regarding different persons and situations were arranged. The patient had almost avoided showing sadness in the past. Here the corresponding effector patterns were used in the session to help him to expose himself to the disappointments and emotional injuries he had experienced. The overcoming of this kind of experiential avoidance made him feel much stronger in his role as a male and helped him to present himself more clearly.

6. Conclusion

With our procedure we complement the cognitive-behavioral tradition whose method is aimed primarily at removing negative or symptomatic emotional reactions to events that trigger stress (BECK ET AL., 1979, GOLDFRIED, 2003). In our procedure, however, we attach a more favorable connotation to the so-called negative emotions, for example with regard to their signal character. We share this more positive view regarding emotions – including the negative ones – with humanistic approaches (GREENBERG and SAFRAN, 1987; AUSZRA and GREENBERG, 2007). In keeping with the tradition of CBT, we also work according to the exposure principle, thereby allowing the patient to obtain corrective information (see FOA and KOZAK, 1986; RACHMAN, 2001). However, we go beyond the frequent issue of fear and, with the aid of the effector patterns, also allow selective exposure experiences with other specific emotions. The mindful approach with regard to difficult emotional experiences that can modulate a negative emotional reaction (SEGAL et al., 2002; TEASDALE, 1993, 1996) is important to us. Nonetheless, we deploy mindfulness primarily in the sense of introducing a certain observer mode with respect to physical and mental processes in order to learn more, first of all about the related emotional processes. Fully in keeping with the mindful basic attitude, we do not make any distinction between positive and negative emotions. If sufficient clarification is accomplished, e.g. the unfavorable regulation of primary emotions with secondary emotions recognized, the patient returns to the emotional experience and uses it to achieve current targets. Further empirical studies are necessary here.

7. References

- Auszra, L., Greenberg, L.S. (2007): Client emotional productivity. *European Psychotherapy* 7, 139-152.
- Barrett, L.F. (2006). Solving the emotion paradox: categorization and the experience of emotion. *Personality and Social Psychology Review*, 10, 1, 20-46.
- Barrett, L.F., Mesquita, B., Ochsner, K. N., and Gross, J. J. (2007). The experience of emotion. *Annual Review of Psychology* 58, 373-403.
- Barrett, K., and Campos, J. (1987). Perspectives on emotional development: II. A functionalist approach to emotion. In J. Osofsky (Ed.), *Handbook of infant development* (2nd ed., pp. 555-578). New York: Wiley.
- Barrett, L.F., Gross, J., Conner, T., Benvenuto, M. (2001). Emotion differentiation and regulation. *Cognition and Emotion*, 15, 713-724.
- Barsalou, L. (2008). Grounded Cognition, *Annual Review of Psychology* 59, 617-645.
- Barsalou, L.W. (2009). Simulation, situated conceptualization, and prediction. *Philosophical Transactions of the Royal Society of London: Biological Sciences*, 364, 1281-1289.
- Beck, A.T., Rush, A.J., Shaw, B.F., and Emery, G. (1979). *Cognitive Therapy of depression*. New York: Guilford Press.
- Berking, M., Wupperman, P., Reichardt, A., Pejic, T., Dippel, A. and Znoj, H. (2008). Emotion- regulation skills as a treatment target in psychotherapy. *Behavior Research and Therapy*, 46, 1230-1237.
- Beutler, L. E., Clarkin, J. F., and Bongar, B. (2000). *Guidelines for the systematic treatment of the depressed patient*. New York: Oxford University Press.

- Bloch, S. (1989). Effector Patterns of basic emotions: An experimental model for emotional Induction. *Behavioural Brain Research*, 33, 317.
- Bloch, S. (2006): *The alba of emotions – managing emotions through breathing*. Santiago: Ediciones Ultramarinos PSE.
- Bloch, S. and Santibáñez-H., G. (1972). Training emotional 'effection' in humans: significance of its feedback on subjectivity. In: S. Bloch, and R. Aneiros (Eds.) *Psicobiología del Aprendizaje*. Santiago: Publ. Fac. Med., Univ. de Chile.
- Bloch, Susana, Pedro Orthous and Guy Santibañez H. (1987): Effector patterns of basic emotions: A Psychophysiological method for training actors. *Journal of Social and Biological Structures* 1, 1 19.
- Bloch, S., Lemeignan, M., Aguilera, N.(1991). Specific respiratory patterns distinguish between basic emotions. *International Journal of Psychophysiology*, 11, 141-154.
- Boiten, F.A., Frijda, N.H. and Wientjes, C.J.E. (1994). Emotions and respiratory pattern: review and critical analysis. *International Journal of Psychophysiology*, 17, 103-128.
- Damasio, A. (2010). *Self comes to mind: Constructing the conscious brain*. New York: Pantheon Books.
- Ekman, P., Levenson, R. W., and Friesen, W. V. (1983). Autonomic nervous system activity distinguishes among emotions. *Science*, 221, 1208-1210.
- Foa, E.B., and Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20-35.
- Fogel, A., Nwokah, E., Dedo, J.Y., Messinger, D., Dickson, K.L., Matusov, E., Holt, S.A. (1992). Social process theory of emotion: A dynamic systems approach. *Social Development*, 1, 2, 122-142.
- Frijda, N.H. (2007). *The laws of emotion*. Mahwah: Erlbaum.
- Fruzzetti, A.R., Crook, W., Erikson, K.M., Lee, J.E., Worrall, J.M. (2008). Emotion Regulation. In W. T. O'Donohue, J.E. Fisher (Eds.), *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (pp. 174-186). New York: Wiley.
- Gohm, C.L. (2003). Mood regulation and emotional intelligence: Individual differences. *Journal of Personality and Social Psychology*, 84, 594-607.
- Goldfried, M.R. (2003). Cognitive-behavior therapy: reflections on the evolution of a therapeutic orientation. *Cognitive Therapy and Research*, 27, 53-69.
- Gross, J.J., and Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.J. Gross (Ed.), *Handbook of emotion regulation* (pp 3-24). New York: Guilford Press.
- Greenberg, L.S. and Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition and the process of change*. New York: Guilford Press.
- Hauke, G. (2006). Self-regulation and Mindfulness. *European Psychotherapy* 6, 19-52.
- Hauke, G., Sulz, S. (2006). *A 3rd Wave Therapy in Europe – Strategic Brief Therapy (SBT)*. München: CIP-Medien.
- Hauke, G. and Spreemann, J. (2012): *Wie der Körper bei der Arbeit mit Emotionen hilft. Embodiment in der Strategisch Behavioralen Therapie (SBT)*. *Psychotherapie* 17, 2, 268-278.
- Hauke, G. (2013). *Strategisch Behaviorale Therapie. Emotionale Überlebensstrategien- Werte-Embodiment*. Heidelberg; New York: Springer.

- Hayes, S.C. (2004). Acceptance and Commitment Therapy and the new behavior therapies. In: Hayes S.C., Follette V.M., Linehan M.M.: *Mindfulness and Acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford Press.
- Holodynski, M. (2006). *Emotionen. Entwicklung und Regulation*. Heidelberg: Springer.
- Iwakabe, S., Rogan, S. and Stalikas, A. (2000). The Relationship Between Client Emotional Expressions, Therapist Interventions, and the Working Alliance: An Exploration of Eight Emotional Expression Events. *Journal of Psychotherapy Integration* 10, 4, 375-401.
- Kang, S., Shaver, P.R. (2004). Individual differences in well-differentiated emotional experience: Their possible psychological implications. *Journal of Personality*, 72, 687-726.
- Lazarus, R.S. (1991). *Emotion and adaptation*. New York: Oxford University Press.
- Linehan, M. (1996): *Dialektisch-Behaviorale Therapie der Borderline-Persönlichkeitsstörung*. München: CIP-Medien.
- Meyer, W.-U., Schützwohl, A. and Reizenzein, R. (1993). *Einführung in die Emotionspsychologie*. Band I. Bern: Hans Huber.
- Moses, E.B. and Barlow, D.H. (2006). A new unified treatment approach for emotional disorders based on emotion science. *Current Directions in Psychological Science* 15, 3, 146-150.
- Natanzon, M. and Ferguson, M.J. (2012). Goal pursuit is grounded: The link between forward movement and achievement, *Journal of Experimental Social Psychology* 48, 1, 379-382
- Niedenthal, P.M. (2006). Embodying emotion. *Science*, 316, 1002-1005.
- Niedenthal, P.M., Winkelman, P., Mondillon, L., and Vermeulen, N. (2009). Embodiment of emotional concepts. *Journal of Personality and Social Psychology*, 96, 1120-1136.
- Oettingen, G., and Gollwitzer, P. M. (2010). Strategies of setting and implementing goals: Mental contrasting and implementation intentions. In J. E. Maddux and J. P. Tangney (Eds.), *Social psychological foundations of clinical psychology* (pp. 114-135). New York: Guilford.
- Philippot, P., Chapelle, C. and Blairy, S. (2002). Respiratory feedback in the generation of emotion. *Cognition and Emotion*, 16, 605-627.
- Price, T.F., Peterson, C. K., and Harmon-Jones, E. (2012). The emotive neuroscience of embodiment. *Motivation and Emotion*, 36, 27-37.
- Rachman, S. (2001). Emotional processing, with special reference to post-traumatic stress disorder. *International Review of Psychiatry*, 13, 164-171.
- Roussos, A.J., Etchebarne, I. Waizman, V. (2005). *Un Esquema Clasificadorio para las intervenciones en Psicoterapia Cognitiva y Psicoanalitica*. Facultad de psicología. UBA. Secretaria de investigaciones, Anuario de Investigaciones 13,
- Russell, J.A. (2003). Core affect and the psychological construction of emotion. *Psychological Review* 110, 1, 145-172.
- Russell, J.A., Feldman-Barrett, L. (1999). Core affect, prototypical emotional episodes, and other things called emotion: Dissecting the elephant. *Journal of Personality and Social Psychology*, 76, 805-819.
- Samoilov, A., and Goldfried, M. R. (2000). Role of emotion in cognitive-behavior therapy. *Clinical Psychology: Science and Practice*, 7, 373-385.

- Santibáñez, G. and Bloch, S. (1986). A qualitative analysis of emotional effector patterns and their feedback. *The Pavlovian Journal of Biological Sciences*, 21, 108-116.
- 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: Guilford Press.
- Sulz, S. (1994). *Strategische Kurzzeittherapie: Effiziente Wege zur wirksamen Psychotherapie*. München: CIP-Medien.
- Teasdale, J.D. (1993). Emotion and two kinds of meaning: Cognitive therapy and applied cognitive science. *Behaviour Research and Therapy*, 31, 339-354.
- Teasdale, J.D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depression. *Behaviour Research and Therapy*, 37, 53-77.
- Thompson, R.A. (1994). Emotion regulation: A theme in search of definition. In N. Fox (Ed.), *The development of emotion regulation: Biological and behavioral considerations Monographs of the Society for Research in Child Development*, 59, 25-52.
- Scherer, K. (2005). What are emotions? And how can they be measured? *Social Science Information*, 44, 695-729.
- Soussignan, R. (2002). Duchenne smile, emotional experience, and autonomic reactivity: A test of the facial feedback hypothesis. *Emotion*, 2(1), 52-74.
- Strack, F., Martin, L., and Stepper, S. (1988). Inhibiting and facilitating conditions of the human smile: A non-obtrusive test of the facial feedback hypothesis. *Journal of Personality and Social Psychology*, 54(5), 768-777.
- Taylor, G., Bagby, R., Parker, J. (1997). *Disorders of affect regulation*. Cambridge: Cambridge University Press.
- Teasdale, J. (1999): Emotional Processing, three modes of mind and the prevention of relapse in depression. *Behavior Research and Therapy*, 37, 53-77.
- Watson, J.C. and Bedard, D.L. (2006). Clients' emotional processing in psychotherapy: a comparison between cognitive-behavioral and process-experiential therapies. *Journal of Consulting and Clinical Psychology* 74,1, 152-159.
- Whelton, W.J. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology and Psychotherapy*, 11, 58-71.
- Young, J.E., Klosko, J.S., Weishaar, M.E. (2005). *Schematherapie. Ein praxisorientiertes Handbuch*. Paderborn: Junfermann.
- Znoj, H.-J. (2004). Die therapeutische Beziehung aus verhaltenstherapeutischer Sicht. In W. Rössler (Ed.), *Die therapeutische Beziehung*. Berlin: Springer.

Correspondence address

Dr. Gernot Hauke

Centrum für Integrative Psychotherapie (CIP), Munich, Germany. gernothauke@arcor.de
Lic. Mirta Dall'Occhio, Centro Hemera, Buenos Aires, Argentina. mirtadall@gmail.com