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Journal of Addiction Research and Adolescent Behaviour
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Open Access

Review Article

Accepting "change" in psychotherapy: from consciousness to awareness

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Received date: September 06, 2020; Accepted date: September 08, 2020; Published date: September 30, 2020

Citation: Perrotta G., (2020) Accepting "change" in psychotherapy: from consciousness to awareness, J. Addiction Research and Adolescent Behaviour 3(1); DOI: 10.31579/2688-7517/018

Abstract:

Accepting to face a path of psychotherapy is not in itself sufficient to achieve the goals set in the therapeutic agreement between patient and professional. The present work analyses the differences between "consciousness" (and knowledge) of one's dysfunctional state, "will" to achieve change and "awareness of change", passing through all the traps that the mind can set for us, starting from the alterations of the states of consciousness to the wrong perceptual processes (which rework the external sensory data collected by the sense organs) to the not necessarily dysfunctional use of defense mechanisms, the imperfect centering on the knowledge of one's own needs and requirements, the excessive rigidity of one's system of beliefs, certainties and mental constructs, the use of irrational ideas based on empirical data falsely considered correct, the subjection of social influences and conditionings to impressions and systematic errors determined by cognitive dissonances and social and moral disengagements. The present work then focuses on the goals that the therapist must achieve to help the patient in his or her process of awareness and acceptance of change, and on recent techniques focused on the patient's emotional and emotional needs.

Keywords: psychotherapy; consciousness; awareness of change

Contents of the manuscript:

1. Consciousness and its states

Accepting to face a path of psychotherapy is not in itself significant to obtain the desired results; unlike a drug, which acts a priori from the patient's awareness, psychotherapy is hinged in a system of consciousness and will be aimed at the goal to be achieved, according to the therapeutic agreement drawn up between the therapist and his patient [1]. In this perspective, the therapist must lead his patient towards a path of full, total, voluntary, and conscious awareness of his psychic status and of the internal processes that govern him, analyzing his functioning, his mental patterns, and his attempts at sabotage [2-3].

The term "consciousness", generically, indicates that moment of the presence in the mind of objective reality on which "awareness" intervenes that gives it meaning and meaning [4-5], reaching that state of "known unity" of what is in the intellect. [6]. The term derives from the Latin *conscientia*, which in turn derives from *conscire*, that is "to be aware, to know". (composed of *cum* and *scire*, "to know, to know") and indicates the awareness that the person has of himself and his mental contents; in this sense, the term "consciousness" is generically assumed not as a first stage of immediate apprehension of an objective reality, but as a synonym of "awareness" in its reference "to the totality of experiences lived, at a given time or for a certain period " [7].

The term "consciousness" entered the Italian language in the 13th century, but in the history of Western culture this term has taken on further meanings independent of that of "awareness" [8-9]:

1) In Ancient Greece, **Homer** claimed that consciousness is closely and intimately connected to the concept of the psyche, while in **Plotinus** it is the place of reflection and interiority. Stoicism had already highlighted the inner nature of consciousness, which manifests itself as a conversation of the soul with itself in the face of the "nonsense" of the world and its transient realities, the only way that remains for the wise man is to retreat into oneself which gives meaning to one's existence.

2) In **St. Augustine**'s Christian theology, the notion of conscience is linked to the ideal of truth and wisdom typical of wise men, while in **St. Thomas** it is the awareness of a feeling of morality and all this comes from the application of our knowledge or science to our actions.

3) In modern philosophy, **von Leibniz**, at the beginning of the 18th century, distinguished between perceptions and apperceptions, through which the former manifest themselves on a conscious level. In the 20th century, in step with the development of modern physics and neuroscience, several theories on the formation of consciousness were proposed, none of which have yet been experimentally proven; one of these was elaborated by the theoretical physicist **Penrose** and would imply phenomena related to quantum mechanics and the theory

of relativity. What is certain is given by the different representations of the same term, depending on the field in which it is observed, consciousness is understood in the following ways: the state of vigilance of the mind (in neurology), the act of consciousness concerning the conscious experience and subjective experiences of sensation (in psychology), the awareness of the plane of reality (in psychiatry), the function of understanding one's actions and the circumstances of fact happened and/or realized (in law and jurisprudence), the ability to distinguish good and evil to behave accordingly (in ethics) and the container to grasp fundamental truths, otherwise inaccessible (in philosophy).

4) In classical and modern psychology, consciousness (in the Freudian formulation, in German *Bewusstsein*) is a quality of the mind that usually includes other qualities such as subjectivity, self-awareness, knowledge, and the ability to identify relationships between oneself and one's surroundings. In common language, consciousness is understood to mean the awareness of the inner and outer processes of the surrounding environment, including the ability to interact with it; this is in contrast to unconsciousness. The expression "'levels of consciousness" instead indicates that consciousness seems to vary according to different mental states (such as imagination and daydreams). Unconsciousness is defined, by negation, as the mental state in which consciousness is absent. In some strands of thought, especially religious ones, consciousness does not die out after death and is present even before birth. But, just beyond common perception, consciousness is very difficult to define or identify. If classical psychology revolved around consciousness to the point that **Wundt** defined psychology itself as a "science of facts and states of consciousness", in the following decades researchers, among whom **Külpe** investigated above all the dynamic processes of consciousness. Psychoanalysis focused and defined the various states of the conscious, subconscious, and unconscious; Gestalt, instead, resumed the studies of dynamic processes associating and comparing them to those made on perceptions to develop its model of explanation of consciousness.

However, even today, there is still a tendency to confuse the concept of "consciousness" with that of "awareness", especially in the psychotherapeutic field:

a) "*consciousness*" is the cognition or knowledge of a given fact, event, action or circumstance, one's own or others', which draws the will of a given event. In turn, consciousness is distinguished from the "*will*", which is the precise and punctual psychic manifestation of the subject to realize that specific event. In synthesis, consciousness is the cognition or knowledge of a manifestation (for example, if I cook a food to which I am intolerant or allergic, I am aware that afterward, I will be ill) while will is the intentionality of wanting that particular manifestation (for example, if I eat a food to which I am intolerant or allergic, I manifest the will to take the risk -even negative ones- of the consequences of my actions, even if I am not ready to bear all that will result).

b) "*awareness*" refers to a deeper dimension of consciousness which, conscious and voluntary, takes on the consequences of one's own or others' actions, acting in the direction of the set objective, planning with lucid premeditation (for example, conscious and aware that by eating the forbidden food after I am ill, I accept every derived consequence of that action, also planning the following actions.

By dropping these theoretical terminological differences into a clinical plan, making them practical, taking a phobic or anxious patient as an example, we can, therefore, say that:

a) The patient is conscious if he is aware of his disorder and knows its contours, symptomatology, and dysfunctional manifestation concerning his reference environment.

b) The patient is present if he manifests the will to face his disorder, questioning and trusting himself, trusting and trusting the therapist.

c) The patient is aware if he is conscious and present and shows full decision making in reaching the goal set with the therapist, accepting the challenges proposed and intimately wanting to make the necessary changes to free himself from his dysfunctional condition. The patient is not only conscious and present (to the fullest extent of his will), but he develops a full conscious acceptance of what he decides, determining the achievement of the objective.

From the neurological point of view [10], the definition of "consciousness" takes on an even clearer connotation and is characterized by two specific components:

1) "vigilance", which is characterized by a waking state that is not necessarily associated with the awareness of what is happening in the world around us.

2) "awareness", which consists precisely in the awareness of the world around us and, in the most evolved condition, of one's being.

The state of consciousness is established by the good functioning of the two components. When one has vigilance without awareness the person appears with open eyes, a normal sleep-wake cycle without signs of contact with the environment. This condition is normally known as the "vegetative state". In the case of coma, in addition to awareness, there is a lack of vigilance so that the person has his or her eyes closed and has difficulty in providing even reflex responses (for example, reactions to the painful stimulus) [11].

2. The alterations of consciousness and conditioning

The "state of consciousness" can have a wide range of levels that are not uniquely classified: wakefulness; meditation and superconsciousness of the Hindu matrix; awake sleep; lucid dreaming; conscious derealization (daydreaming or daydreaming); sleep/dreaming; coma; hypnotic state; near-death experiences and mystical forms of dubious real origin; altered states of consciousness due to psychotic disorders or the use of psychotropic substances. The measurement, attempted in the field of neuroscience, is however linked to subjective parameters, and therefore it is not currently possible to proceed with scientifically reliable analyses or classifications [1].

The normality of the ordinary state of consciousness is dictated by biological and cultural needs; this ordinariness may, therefore, vary according to the cultural or environmental context in different parts of the world. Usually, the waking state is considered as an ordinary state of consciousness because it corresponds to a balance between the amount of information that reaches the brain and the amount of information that the brain itself can process. However, this is not a parameter to characterize it intrinsically, as it only emphasizes the ability to maintain control over the flow of information, but without defining the quality of processing. The waking state (or ordinary state of consciousness) is only one of the many possible structures that the mind assumes. And it can undergo oscillations in intensity and/or quality during a day, or a lifetime, of the subject concerned [3].

The state of consciousness, however, suffers only dysfunctional alternations of rework processes, as indicated in the examples of levels of consciousness, but it also suffers the effects of functional alterations due to processes that are not pathological but are more related to social and environmental conditioning, a consequence of the education given and the experiences lived; this happens in the hypothesis of incorrect perceptual

processes (which rework the external sensory data collected by the sense organs), in the hypothesis of not necessarily dysfunctional use of defense mechanisms [63], in the hypothesis of not perfect centering on the knowledge of one's own needs and necessities, in the hypothesis of excessive rigidity of one's own system of beliefs, certainties and mental constructs, in the hypothesis of the use of irrational ideas based on empirical data falsely considered correct, in the hypothesis of social influences and conditionings regarding impressions and in the hypothesis of systematic errors determined by cognitive dissonances and social and moral disengagements [12].

All these hypotheses must be assessed by the therapist and addressed in therapy, to allow the patient to consciously rework all the processes and arrive as soon as possible at the acceptance of his condition, with full awareness [13, 16].

3. Change in psychotherapy: "automatic thinking" and work on "consciousness of change"

The mechanism leading to change in psychotherapy partly depends on the goals of the therapy, and therefore the perspectives on the mechanisms of change often vary following these goals. A therapeutic relationship will probably not be effective unless there is an insight into what is happening in the relationship; at the same time, the relationship must provide an interpretative understanding of the patient's profound dynamics. Today it is recognized that there are multiple modalities of therapeutic action, which vary according to the patient as well as the therapist. Two different types of patients, which change in different ways, can be generically identified. Introspective patients are ideological and concerned with establishing and maintaining a viable concept of self, rather than establishing intimacy in the interpersonal field. They appear to be able to respond more to insight through interpretive interventions. In the other group, analytic patients are more interested in relational aspects than in self-development, and benefit more from the quality of the therapeutic action than from interpretation. Patients can change in many different ways, using different therapeutic mechanisms. The therapist can help patients to identify the different ways in which they reflect on themselves, the conscious attitudes they have towards their person, how they become aware of their emotions, and how they can tolerate them. Through interpretation, therapists also provide insight into a wide range of interrelated mental events: fears, fantasies, desires, expectations, defenses, conflicts, transference, relational patterns. In addition to interpretations, therapists provide observations from an external perspective, which can emphasize how certain habitual patterns of the patient reflect conflicts and emotional difficulties. This function of the therapist's observer function has somehow similar effects to the experience of those who manage to observe themselves from the outside, the equivalent of what others see us as. No matter how sensitive or intuitive the patients may be, the therapist always represents an external point of view, different from their own. A crucial element for therapeutic change can certainly lie in the patient's increasing ability to "find himself" in the therapist's mind. Through comments on feelings and non-verbal communication processes that are identified only by the therapist, the patient can begin to build a new self-image, based on the therapist's observations; implicit patterns can also become the object of conscious reflection. Another important mechanism of therapeutic action derives from aspects of the relationship between therapist and patient that do not specifically involve insight and interpretation. The experience of this new type of relationship can lead patients to internalize the therapist's emotional attitudes and to identify with his or her way of dealing with problems. The therapist can also be internalized as an internal presence that provides the patient with security and comfort. In the course of therapy, the function of the therapist is also internalized as a figure who contains and processes meaningful interactions. Finally, in addition to techniques aimed at feeding insight and mechanisms related to the therapeutic relationship, some opportunities may be useful to promote therapeutic change. These approaches include comparing dysfunctional beliefs, examining the conscious strategies the patient uses to solve problems, forms of self-disclosure that help the patient understand the impact it has on others, and interventions to confirm or validate their experiences. In all therapies, interactions between therapist and patient are accompanied by unconscious affective connections, but other forms of knowledge may emerge in moments of interpersonal connection between therapist and patient that is not symbolically represented or dynamically unconscious in the traditional sense. In other words, some of the changes that occur during treatment are in the field of knowledge and involve ways of acting, feeling, and thinking in certain relational contexts. Specific moments of understanding can also be remembered for a long time after specific interpretations have been forgotten. Psychotherapy can be considered as a new attachment relationship, which restructures memory elements related to attachment. Patterns stored in memory can be modified through new interactions with an emotionally involved therapist; at the same time, the memory involving conscious narrative processes is modified by interpretative understanding. Finally, it should be remembered that the expressive-supportive continuum of interventions does not explain all therapeutic changes. Many - and perhaps the fundamentals - moments of encounter between therapist and patient occur outside the "technical" sphere and spontaneous human responses by the therapist can have a powerful therapeutic impact [14-15].

Therefore, the dichotomy between automatic thoughts and conscious thoughts emerges, the first consequences of behavioral patterns learned and consolidated over time (of which the patient is not aware, although in some cases conscious) and the secondary consequences of re-elaborations at a conscious level to be able to work on the empirical data and the consequences traced by subjective trajectories, according to **Kelly** and **Ellis**' settings. This is a dichotomy that the therapist must necessarily face to help the patient in his process of acceptance and maturation to change, starting from the cognitive data of the subject's psychic functioning [3].

The terms "top-down" and "bottom-up" are used more and more frequently to indicate conscious, executive, voluntary, declarative thinking as opposed to automatic, emotionally charged, associative thinking, determined by bodily sensations, difficult to control voluntarily. On the one hand rational thought, on the other hand experiential, psychic-body, intuitive thought. These second ones are only partially present in the consciousness and in this sense they coincide in part with the unconscious term used as an adjective, they are processes that are not processed at the higher level, evolutionistically more recent than the brain, remaining on the archaic or intermediate level and only through the recursiveness of information between motivational systems that unites the three levels in a bidirectional way, they can reach the awareness [36].

Traumas and adverse life experiences, however, cause alterations in the normal functioning of the nervous system by blocking the normal processing of experience and processes that activate different components, sensory, cognitive, emotional, semantic, bodily, become dysfunctional. The impairment of the normal psychological functioning consequently leads to a difficulty in elaborating and integrating subsequent experiences in a unitary and coherent way, determining in the most serious cases a disorganization of the integrative functions of the consciousness [43]. The malfunctioning of the higher mental activities does not allow to face the patient's difficulties through top-down interventions and requires the application of approaches and techniques defined bottom-up that act on the evolutionary mental functions more archaic [35].

What emerges, however, from the theoretical debate, and clinical experience is that to produce change it is necessary to act on both high and low processes, integrating strategy and techniques, even if the path of integration is still to be followed. A contribution to this debate proposes

the distinction between fast and slow thinking by dealing with judgment, decision making, and systematic errors that are made in conditions of uncertainty. Some reflections on fast thinking and slow thinking In many psychopathological disorders some biases mainly concern what the Israeli psychologist calls system 1 or fast thinking. Decisions dictated by intuitive preferences often contravene the rules of rational choice, according to the "Prospect Theory" fast thinking operates automatically with continuous processing of associative memory and without voluntary control. This conceptualization would seem analogous to what is meant in the literature by the bottom-up level. System 2 (slow thinking) instead directs attention to complex and demanding activities. This system is rational. The automatic operations of system 1 (impressions and sensations) generate complex ideas but only system 2 processes thoughts in an ordered series of stages, therefore it operates at the top-down level. The functions of the two systems according to the author are distinct, but can be interconnected. Some examples concerning fast thinking and slow thinking can make us understand how interconnection can lead in some particular situations to transform bias and heuristics into rational decisions and weighted choices concerning the consequences, in other words, to transform automatic negative thoughts and irrational ideas to bring back the physiological activation related to them within the tolerance window that allows to regulate emotional states functionally. With fast thinking we orient ourselves towards a sudden noise, we read traffic signs, we understand a simple sentence of our child. Slow thinking makes us focus our attention on the voice of our partner speaking to us, search in our memory to recognize a landscape, park the car, control the logic of an argument. In system 2 the processes, attention, memory, thought, in system 1 are preponderant sensations and perceptions. The interaction between the two systems is determined by the activity of one that provides stimuli for the other. When system 1 fails to respond as it usually does, it asks for help from system 2 which intervenes to remove the impasse, correct the error, or, if you like, invalidate fast thinking. The two systems operate with minimal effort and efficiency.

Normal operation allows for appropriate predictions to be made to system 1 in known situations, but under conditions of uncertainty, it is more likely to make systematic errors that can often generate suffering. On the other hand, perceptual or cognitive illusions show that it is impossible to turn off system 1 but it is also necessary to consider that it would be maladaptive to question our intuitive thinking. This would, however, lead to other kinds of errors. A fair compromise should lead us to recognize the frames where the error can nest, try to avoid it, especially when the error is so serious as to question the order of the system and above all learn from it to take knowledge to a higher level. System 1 and System 2 affect both the content and mental processes and can lead to good adaptation or pathological dysfunction in patients and appropriate errors or maneuvers in therapists. It is precisely on the latter that we want to focus our attention by taking up a subject we have already dealt with [31].

In a self-organized system, the Self connects and re-elaborates experience through self-referential processes. The error represents a perturbation that activates a construction that removes homeostasis and within a critical theory tries to go beyond what appears to identify higher levels of knowledge. The error, making the coherence of experience impossible, moves the system towards the modification or abandonment of the paradigm, reorganizing the meanings on functional modalities, and contemplating the error itself as an evolutionary possibility [18, 39].

There have been many theories on the brain: dualistic (**Descartes**), mechanistic (**De la Mettrie**), reflexological (**Pavlov**), function localization, modular architecture (**Fodor**), connectionism and motor theories (**Weiner**) that have not yet given definitive results on psychic phenomena, although new methods and new investigation tools have recently enabled us to have very in-depth and specific, valid and reliable information. Neuroscience, however, is not yet able to provide data on the internal mechanisms of the brain that can explain its functioning. It is possible to expect interesting developments from research, even if in recent times a certain discouragement prevails concerning the results achieved so far and, in parallel with the considerable number of researches carried out, there is increasing criticism about the theoretical and methodological approach of these studies. Currently, neuroscience risks to exchange correlations with causal relationships and to analyze the functioning of the mind by reducing it to brain functioning, making a reductionism on a subpersonal level useless for psychology and psychopathology [17, 24].

One can share the thought that experience and learning are fundamental for adaptation and are parallel to organic and evolutionary change [26]. Brain functions are formed according to a continuous interactive and selective process. Sensory experience is recognized, classified, and categorized by the nervous system that constructs world maps. Experience modifies the brain, in particular the areas affected by the processes described above, with the possibility that those experiences generate information (contents) stored in memory that re-emerge in the presence of events that recall structures and processes responsible for the elaboration of affective-emotional responses. Ultimately, according to current knowledge, it would seem possible to state that mental and physical states are complementary and the former are emerging and recursively interconnected with the latter [19, 24].

A therapist, therefore, must let himself be guided by clinical intuition and be unscrupulous and creative in what **Popper** calls "the logic of discovery" in which system 1 is active, but then he must enter into what **Popper** always calls "the logic of justification" which requires a critical analysis in which system 2 is active. This second phase is the one that requires the most effort so it is the first to give in when working in situations of tiredness or stress. Paradoxically, free from the critical voice of system 2, one can experience a sensation of fluidity and effectiveness mixed with gratification for one's skill, which is similar to the sensation of being particularly good at driving that one has under the effect of alcohol which worsens performance, but even more so the critical capacity towards performance itself with a positive balance in terms of self-efficacy and car repair bills. A tired therapist makes more mistakes and feels better at the same time. The reflection on what we think and how we think is the subject of the debate that is developing recently among cognitivists. Similarity, contiguity, and causality are the three laws that **Hume** laid down at the basis of the association of ideas. Associative memory combines ideas into conscious and unconscious associations. We know that our emotions and behavior can be triggered by events of which we are often unaware. An important part of the therapeutic work has as an objective the improvement of self-reflexivity, monitoring thoughts, emotions, and behaviors to bring them to awareness. Some experiments show that if, for example, one is sensitized to thinking about old age one tends to act like old people, just as behaving like old people strengthens the thought of old age. The reciprocal links are frequent in the associative network "relate the past to the present and create expectations about the future". In the same way, we could say that a therapist who perceives the patient as irremediably ill and does not see in him positive resources, but only deficits and symptoms, will activate a factor of maintenance and chronicity. In causal terms, also, the stimuli we are subjected to have a considerable weight in decisions, system 1 provides impressions that can turn into convictions that guide choices and actions. Improving mastery skills allows us to identify the causes of our recursive and maladaptive emotional states and to intervene on the internal states from which they are generated, correcting associative bias that could make us believe that it is events that determine the intensity and duration of our emotions. Empirical, logical, and pragmatic disputing is also a very useful technique for this purpose [20-21, 31].

When the therapist succeeds in making the patient perceive and pay attention to the gains, motivation, alliance, and therapeutic work benefit greatly, but awareness and willingness to change must be anchored in the patient's survival instinct. Healing falls into the category of gains but the abandonment of the status quo, although symptomatic, is perceived as a loss: in essence, change, to be functional and to remain in time, must originate from the inside of the patient and not from mere advantages proposed by the outside, otherwise, time will corrode the motivations behind the drive for change, subsequently always proposing the same toxic patterns that made the patient fall back; the "attempted solutions" of strategic school are nothing more than proof of what has been said: the change, not originating from the inside but only from external factors, does not evolve in the implementation of functional techniques and methods to achieve the goal and the patient, despite the solutions approached to get to the change, always falls within the same toxic patterns [3, 13, 22].

4. Moving from "consciousness of change" to "awareness of change"

In the personal vocabulary of each one of us, there are words to which we attribute a positive and pleasant value, others to which we associate unpleasant or painful feelings and memories and others that remain "neutral", and leave us more or less indifferent from an emotional point of view. The word "change" is one of those words to which we inevitably associate emotionally connoted meanings, both in a positive and negative sense. For some of us, this word represents something pleasant, desirable, and of positive value, while for others it could be associated with unpleasant feelings of threat, psychological pain, or worry. The reason for these differences lies in our personal history, in the experiences that have slowly built within us that network of meanings and emotional values that remain unconscious but which, secret and very personal, underlies every word we use and colors it with an entirely subjective emotional tone [23, 25].

In every psychological path, whether it be growth, therapy, support, or awareness, change is the most important and challenging but also the least known and most misunderstood aspect. The aim of psychotherapy is precisely to initiate a process of inner change; in this sense, change takes on a more extensive meaning both in-depth and in breadth. It allows, in fact, through self-awareness and self-knowledge, to modify the patterns and automatisms responsible for dysfunctional behavior and indirectly, thanks to the maturation of a freer and more complete personal fulfillment, to make healthier and more suitable relational choices. This is why, when you decide to start a psychological path of growth and therapy, it is important to start considering change as an event that brings growth and improvement, not as an obstacle impossible to overcome or worse, as something threatening and destabilizing, freeing yourself first of all from those processes that involve interpretative errors and subjective re-elaborations adhering to the dysfunctional system of perception of the subject [13, 27-30, 37-38, 41-42, 46-47].

Resistance to change [2] is a reaction to change, defined in the manifestation of how the person tends to maintain a general homeostasis (i.e. the internal stability of an animated or inanimate system that tends to remain so even in the presence of external disturbances). But when the personal balance created after many arrangements no longer works, what happens? There will be a tendency to boycott himself and the therapy that aims to maintain that homeostasis achieved, however dysfunctional it may be, because it reassures the person and change is not easy. Change requires a great deal of energy, and first and foremost the emotional involvement of one's conflicting feelings which is in part painful, fearful, or burdened with guilt. First of all, sometimes it is not understood that change is necessary, and this misunderstanding is accompanied by fear of the unknown and uncertainty. Other elements of resistance are attachment to habits and lack of motivation, as well as the fear that it may be the wrong time. However, it is also true that the patient seeking help brings a share of resistance, but also a share of the therapeutic alliance because he feels the need to change some things; it is, therefore, essential to emphasize that the processes of change in psychotherapy imply the opportunity to express one's emotions, to acquire and practice new behaviors, attributing new meanings to one's experiences by fostering awareness and promoting interpersonal emotional learning. The process of change in psychotherapy implies the creative restructuring of one's world and each person changes with their rhythm. The process of change cannot be accelerated, but it requires that only the patient has expectations: the resistance suggests a struggle between conscious desire and the unconscious forces that hinder good purpose, and this is where the suffering originates. The essential objective for a good balance is to work on control and emotions that tend to limit change to change one's attitude towards the context, finding a state of inner balance at that precise moment in life, remembering that life itself is change [1, 40, 44-45].

*According to **Greenberg** [48], emotional change occurs through at least six processes briefly described below: awareness-raising, expression, regulation, reflection, transformation, and corrective emotional experience. These processes are facilitated when they occur in the context of an empathic relationship:*

a) *Awareness. Awareness of emotions is the most important principle in change. Becoming aware of the emotional experience and being able to verbalize it provides access to the adaptive information and the tendency of each emotion to act. Once the person knows what he or she is feeling, it relates to the needs that are signaled by the emotion and motivate him or her to meet them. It is useful, when working with awareness, to make a distinction between awareness of basic emotions and awareness of bodily sensations. This implies that we can be aware of feeling angry, sad, or frightened, or aware of a sense of danger, or a feeling of oppression in the stomach, or lightness, and so on. Emotions and feelings together provide us with a compass for navigating through our lives.*

b) *Expression. Expressing emotions in the psychotherapeutic setting does not mean venting, but rather involving the body in an action that helps to overcome experiential avoidance, loosens muscle tension, and generates neurochemical and physiological changes beyond awareness, changing the organization of the self and interactions with others.*

c) *Regulation. Another important process of change is to develop the ability to tolerate and regulate emotion in the moment you are experiencing it. The deliberate ability to regulate emotions involves processes such as identifying and labeling emotions, accepting and tolerating them, the ability to calm oneself, the use of breathing, and the ability to shift attention. Another important aspect of regulation involves the development of an observant self that can notice the emotion, taking a distance from it so as not to be at the mercy of it, especially when the emotion is very strong and intense. In this way, the person can observe, for example, his or her sadness after a mourning, with the same distance from which one observes a theatrical performance: this will not make the emotion go away, but will allow the person to stay there.*

d) *Reflection. Promoting reflection on emotional experiences helps people to make sense of their experience and promotes its assimilation into the processes of self-narrative. What we do with our emotional experience makes us who we are, so reflection helps to create new meaning and develop new narratives to understand the experience and see new possibilities.*

e) *Transformation. Another way to work with emotions in therapy involves replacing a maladaptive emotion, such as fear and shame, with a more functional emotion, such as assertive anger, sadness for pain, or compassion for oneself.*

f) *A corrective emotional experience. Finally, another way to change an emotion is to have a new experience that changes the meaning of an old feeling. New experiences that, for example, bring well-being to the relationship with the other in a person with social phobia, can correct archaic patterns of behavior and response.* ***Alexander****, a leading figure in the Chicago School, was among the first to bring the corrective emotional experience into treatment, a real experience thanks to which the patient achieved the emotional perception of no longer being a child in front of, for example, an almighty father*.

Another interesting contribution that helps to evolve the patient from simple knowledge and willingness to a real deep awareness is given by **Rosenberg**'s model of non-violent communication. [49] In summary, non-violent, empathic, non-judgmental communication is based on four steps:

a) *Observation*. I observe what is happening in the specific situation, what I hear and see being done, described in an articulated and specific way, without introducing any judgment or evaluation. "When you leave your clothes on the floor...".

b) *Feeling/Emotion*. What I feel when I look at what the other person has said or done. "I feel disrespected, disregarded, angry and sorry...".

c) *Need*. What my need (desire, value) is connected to the identified feeling. "I need (wish) to be considered about the hard work I've been doing all day, to be respected for how I strive to keep the house in order and take care of your things...".

d) *Request*. Ask specifically for something concrete that we would like the other person to do for us and that would enrich or improve our life or something about our need. "So I ask you, please, to leave your clothes on the chair... in this way I would feel recognized in what I have done... supported and respected by you".

Empathic communication, therefore, requires recognizing, accepting and overcoming the fear of showing one's vulnerability, that is, one's authentic emotions, one's pain, one's needs and desires, one's values, one's uniqueness. This allows you to share your respective vulnerabilities, to be understood while you can listen and understand the other. This means receiving the communication of the other as a gift, even when it seems like an attack or a judgment. Behind the attack and judgment, behind the aggressiveness, there are always feelings and needs of a vulnerable and needy soul or as the popular aphorism sustains: "behind every fierce mask, there is a man with his fears" [49]

5. Conclusions

Accepting to face a path of psychotherapy is therefore not in itself sufficient to achieve the goals set in the therapeutic agreement between patient and professional and it is central to keep in mind the differences between "consciousness" (and knowledge) of one's dysfunctional state, "will" to achieve change and "awareness of change", passing through all the traps that the mind can set for us, starting from the alterations of the states of consciousness to the wrong perceptual processes (which rework the external sensory data collected by the sense organs), to the not necessarily dysfunctional use of defence mechanisms, to the imperfect centring on the knowledge of one's own needs and requirements, to the excessive rigidity of one's own system of beliefs, certainties and mental constructs, to the use of irrational ideas based on empirical data falsely considered correct, to the subjection of social influences and conditionings with regard to impressions and systematic errors determined by cognitive dissonances and social and moral disengagements.

The goals that the therapist must achieve to help the patient in his or her process of awareness and acceptance of change are the key to the solution, provided that the patient's resistance is overcome with his or her help. Healing falls into the category of gains but the abandonment of the status quo, although symptomatic, is perceived as a loss by the patient himself: in essence, the change, to be functional and to remain in time, must originate from within the patient and not from mere advantages proposed by the outside, otherwise, time will corrode the motivations behind the push for change, subsequently always proposing the same toxic patterns that made the patient fall back; the "attempted solutions" of strategic school are nothing more than proof of what has been said: the change, not originating from the inside but only from external factors, does not evolve in the implementation of functional techniques and methods to achieve the objective and the patient, despite the solutions approached to achieve change, always falls within the same toxic patterns.

What is certain is that the discourse gets complicated when the patient is affected by a personality disorder, which by definition are "egosyntonic" (the patient is not aware of being affected by that disorder and is not able to fully accept it): in such hypotheses, one can also witness a process of awareness of one's psychopathological condition and a certain willingness to face one's status, but it is unlikely to arrive at a real awareness, with all the consequences of the case.

Achieving the appropriate level of awareness should push the patient to counteract the symptomatology suffered, to accept his condition to mature the evolution, implementing what has been agreed with the therapist, also understanding that it is he who maintains the toxic pattern, because the behaviors learned [65] that support the dysfunctional system "serve" indirectly to the patient to reconfirm his status, whether his functioning is neurotic, borderline or psychotic [13, 58].

This happens normally, in any psychotherapy, because the unconscious objective is not to upset the balance obtained by a new restructuring but to maintain the actual situation as much as possible: it will thus happen that, in an anxiety or panic or phobic disorder or any other psychopathological form [50-57, 59-62, 64], the patient will indirectly and unconsciously use the symptom to obtain a primary or secondary benefit unknown to him/her (for example, a person's attention or a relational advantage).

Being aware of this implies the acquired ability to discard this system, to innovate it and evolve it towards a series of functional and healthy behaviors.

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