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The Role of Enhanced Emotional Awareness in Promoting Change Across Psychotherapy Modalities

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Although there is widespread agreement that emotion plays an important role in effecting change in psychotherapy, exactly how it plays a role is uncertain. A way forward is to draw upon the preclinical literature for guidance in bridging basic science with clinical application. Here we focus on the promotion of emotional awareness, the recognition and description of one's own emotional experiences, as foundational to change across a variety of psychotherapy approaches. We begin by focusing on emotion from a preclinical perspective, highlighting how automatic emotional responses provide instantaneous adaptation to changes in interaction with the environment. We distinguish these responses from awareness of them, which makes changing them possible. We then briefly refer to a body of empirical research on levels of emotional awareness that can be used to understand and measure clinically relevant change in emotional awareness. Next, the role of emotional awareness in how change occurs is considered from the perspective of 3 different ways of doing psychotherapy: current cognitive–behavioral approaches, emotion-focused/experiential psychotherapy, and psychodynamic psychotherapy. All 3 modalities consider the developmental process of enhancing emotional awareness to be necessary but not sufficient for change, potentially serving as a common factor comparable in importance to the therapeutic alliance. In consideration of the broader question of how emotion contributes to change, this new perspective highlights the need to further examine the relative importance of emotion expression per se versus the awareness that precedes emotional expression or arises in the symbolization process inherent in verbal expression.

Keywords: emotional awareness, cognitive–behavioral therapy, emotion-focused psychotherapy, psychodynamic psychotherapy, change processes

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Emotions serve a vital function in human life by providing an ongoing assessment in real time of the extent to which needs, goals, and values are being met or not met in interaction with the environment. This evaluation is closely linked in time and content to adjustments in physiol-

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ogy, behavior, thought, and experience needed to adapt to changing circumstances (Levenson, 1994). Emotional states are typically activated automatically, that is, without intention or effort, and are linked to actions that serve an adaptive function (Frijda, 1986). For example, fear is associated with avoidance behavior to prevent harm; anger is associated with approach behavior to stop unwanted actions by others. Expressions of emotion including facial expressions and gestures as well as overt behavioral actions convey information to the external world, regulating relationships and potentially interacting with the conditions that created the change (Darwin & Prodger, 1998). Emotions are also associated with the motivation that fuels these actions. For example, if something gives a person pleasure, they tend to continue to do it; if it causes pain or distress it is avoided (Thorndike's Law of Effect; Thorndike, 1927). Although emotions serve an adaptive function in this way, it may not be appropriate to express them in the social circumstances one is in (Gross, 1999). Moreover, emotional states may be unwanted and inconsistent with one's conscious needs, goals or values (Bowins, 2004).

When emotional experiences are unpleasant or painful, they are often avoided. What is natural and automatic is for people to take steps to shield themselves from emotional pain, using maladaptive solutions such as substance use or actions that gratify needs in the short run but are maladaptive in the long run. These and other avoidance strategies perpetuate the problem because the adaptive responding inherent in emotion is not harnessed and put to use (Barlow et al., 2017; Greenberg, 2015).

Unlike the automatic processes just described, conscious awareness of emotion potentially adds an additional element of adaptive control. Awareness of emotion involves attending to and reflecting upon one's automatically generated bodily experiences. Attention and reflection permit extraction of information inherent in the emotional response that tells a person what the interaction meant to them and what they need in that situation (Greenberg, 2015). This links directly to the conditions that elicited the response in the first place and is especially helpful in a psychotherapy context. Awareness also makes it possible to do something with the information. For example, one can incorporate the information into conscious decision making or change one's behavior in accordance with a new understanding of what one needs in that situation. These considerations help to explain the conclusion of Burum and Goldfried (2007), who stated that a general goal of psychotherapy is to improve emotional awareness.

A key challenge with emotional awareness, however, is that attending to one's emotional experience heightens that experience (Thompson et al., 2011). Being a psychotherapist requires special training, in part because overcoming defenses and other avoidance strategies constitutes a threat to the client. A trusting therapeutic alliance is needed to help clients tolerate and examine emotional experience based on the faith that it will be helpful (Iwakabe, Rogan, & Stalikas, 2000). Psychotherapy training also provides much needed theory and skills that address what to do with emotions once clients become aware of them.

An additional relevant feature of emotional awareness is that the knowledge acquired by attending to and reflecting upon emotions can be cumulative. This means that what one knows about emotional experiences will influence the information obtained when one attends to and reflects upon one's experience at any given time (Lane & Schwartz, 1987). This caveat applies equally well to therapists and clients alike. Individual differences in emotional awareness therefore likely have an important influence on the conduct and outcome of psychotherapy. Here we draw upon an empirically validated theoretical framework of emotional awareness to guide our discussion in this area.

Theory of Levels of Emotional Awareness

Lane and Schwartz (1987) proposed that an individual's ability to recognize and describe emotion in oneself and others, called emotional awareness, is a cognitive skill that undergoes a developmental process similar to that which Piaget described for cognition in general (Lane & Schwartz, 1987; Piaget, 1937). A fundamental tenet of this model is that individual differences in emotional awareness reflect variations in the degree of differentiation and integration of the schemata (implicit programs or sets of rules) used to process emotional information, whether that information comes from the external world or the internal world through introspection. Emotional awareness is considered a

separate line of cognitive development that may proceed somewhat independently from other domains of cognition (Lane & Schwartz, 1987; Lane & Pollerman, 2002).

The model posits five "levels of emotional awareness" that share the structural characteristics of Piaget's stages of cognitive development and constitute a continuum ranging from global undifferentiated to more differentiated and integrated states (Piaget, 1937). The five levels of emotional awareness in ascending order are awareness of physical sensations, action tendencies, single emotions, blends of emotions, and blends of blends of emotional experience. Each level is associated with specific characteristics including the subjective quality of emotional experience, the degree of differentiation of emotion, the ability to describe emotion, the degree of self-other differentiation and the capacity for empathy. See Table 1 for a description of the five levels.

Unlike stages of cognitive development, which were thought to emerge sequentially in development, the levels constitute modes of functional organization that can shift in either direction at any time. From this perspective, the different levels can be used to describe momentary states (Versluis et al., 2018). However, each level has a coherence and stability of its own, and individuals tend to function at or near a consistent level. Thus, the trait level of function is the level at which a given individual typically functions, which is what is traditionally measured by the Levels of Emotional Awareness Scale (LEAS).

Table 2
LEAS Scoring

Terms used	Level score
Cognitions: justified, disbelief, attentive	Level 0
Bodily sensations: sick, sleepy, dizzy	Level 1
Action tendency: feel like punching a wall, feel like crying	Level 2
Negative or positive valence (undifferentiated): good, bad, low	
Specific, discrete emotion: happy, sad, afraid	Level 3
Uses two or more Level 3 words for self or other	Level 4
Both self and other are at Level 4 and terms used are not identical	Level 5

Research Using the Levels of Emotional Awareness Scale

The LEAS is a written performance measure that asks a person to describe his or her anticipated feelings and those of another person in each of 20 vignettes described in two to four sentences (Lane, Quinlan, Schwartz, Walker, & Zeitlin, 1990). A reliable 10-item version is also available to be used on its own or for test–retest purposes. Scoring is based on specific structural criteria aimed at determining the degree of differentiation in the use of emotion words (the degree of specificity in the terms used and the range of emotions described) and the differentiation of self from other. The scoring involves little or no inference by raters (see Table 2; Note: clinicians may find that these guidelines

Table 1
Levels of Emotional Awareness

Characteristics of five levels of emotional awareness
Level 1—Somatic sensations/visceromotor activity: Emotional experience at this level consists of bodily sensations. Individuals describe somatic sensations or are unable to provide a description of their experience.
Level 2—Action tendencies/somatomotor activity: Emotional experience at this level consists of actions or action tendencies (approach or avoidance, self-injurious behavior, etc.) and is described similarly. These action tendencies have an associated valence (e.g. feeling globally good or bad) that is undifferentiated.
Level 3—Individual feelings: At this level individuals experience emotion as a discrete and specific emotional feeling state. The description of emotion is one-dimensional and often stereotyped ("I feel angry").
Level 4—Blends of feeling: This level is characterized by the capacity to have feelings that are opposed to or clearly different from each other; e.g., feeling sad yet hopeful.
Level 5—Blends of blends of feeling: At this level the individual has the capacity to appreciate complexity in the experiences of self and other simultaneously. The individual at this level is also able to appreciate the multidimensionality and nuance of the other's feelings by imagining oneself in the other's situation, unbiased by one's own emotional state.

can be used to estimate a client's level of emotional awareness from their spontaneous verbalizations). A glossary of words at each level has been prepared to guide scoring by hand. A digital version of the scale (http://www.eleastest.net/) is available for online administration and immediate computerized scoring (Barchard, Bajgar, Leaf, & Lane, 2010).

A variety of studies have been conducted using the LEAS in healthy volunteers and clinical populations. Much psychometric, behavioral, neuroimaging, and clinical evidence supports the validity and utility of the levels of emotional awareness construct. Six studies have demonstrated significant increases in LEAS scores as a result of clinical interventions (Burger et al., 2016; Killgore et al., 2020; Montag et al., 2014; Neumann, Malec, & Hammond, 2017; Radice-Neumann, Zupan, Tomita, & Willer, 2009; Subic-Wrana, Bruder, Thomas, Lane, & Köhle, 2005). In addition, in a study of 54 patients with panic disorder randomized to CBT or manualized psychodynamic psychotherapy, higher LEAS scores at baseline predicted greater improvement in both modalities (Beutel et al., 2013). These findings indicate that trait emotional awareness of the client may be a powerful variable that influences psychotherapy outcome. To date, however, the reasons for this association have not been established. More details regarding research with the LEAS can be found in the online supplementary material.

Given the strong empirical foundation of the levels of emotional awareness construct and its established relevance to psychotherapy, we now aim to examine how emotional awareness contributes to the change process. To do so we consider the role of emotional awareness in effecting change from the vantage point of three distinct forms of psychotherapy with differing theoretical backgrounds: third-wave cognitive–behavioral, emotion-focused/experiential, and psychodynamic psychotherapies. For each modality we address how the problems for which clients seek help involve limitations in emotional awareness and the degree to which change occurs as a result of a developmental process of becoming more emotionally aware. By discussing the applicability of the levels of emotional awareness construct to three very different types of psychotherapy that are each discussed in relatively pure form, we aim to establish the foundation for the claim that enhancing emotional awareness is an integrative concept that transcends any given modality.

Awareness of Internal Experiences in Current Cognitive and Behavioral Therapies

Current developments in the conceptualization of psychopathology (e.g., the complex network approach; Borsboom & Cramer, 2013) challenge the validity of the medical illness model and question its utility as it applies to psychotherapy. Based on these perspectives, it has been recently suggested that instead of targeting specific disorders or syndromes, cognitive–behavioral therapies need to focus on theoretically derived processes (Hofmann & Hayes, 2019). Following earlier theoretical perspectives (e.g., Samoilov & Goldfried, 2000) and research endeavors (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996), Hofmann and Hayes (2019) suggest that therapeutic processes are theory-based and empirically supported change mechanisms, which may underlie the attainment of a wide range of immediate and long-term goals in treatment. Such broad therapeutic processes constitute the basis of specific treatment procedures—the actual interventions and techniques utilized in psychotherapy. The ability to be aware of one's own emotions and describe them (Lane & Schwartz, 1987) can be regarded as such a basic process, which is manifested in many forms of cognitive and behavioral therapies. For example, cognitive restructuring, the core intervention for coping with negative thinking in traditional cognitive therapy, typically includes a requirement to identify the emotion associated with the target negative cognition and rate its intensity (Beck, 1995). Most notably, however, awareness of emotions—as well as other forms of internal experiences such as urges or thoughts—is the hallmark of more recently developed cognitive and behavioral treatments.

In most current cognitive–behavioral approaches, changing unwanted or aversive psychological experiences (e.g., the nature of emotions or the content of thoughts) is not encouraged. Instead, theoretically based treatment strategies (e.g., acceptance, mindfulness, metacognition) aim primarily at changing the individual's relationships with such experi-

ences, as well as the impact they have on behavior. Broadly speaking, these therapies help clients challenge the general rule that aversive experiences need to be controlled or replaced, and that they necessarily lead to unhelpful and problematic consequences such as avoidant or impulsive behaviors. Therefore, therapies such as Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002) or Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) facilitate a general attitude of experiential and behavioral willingness as a primary mechanism of change. These treatments emphasize the awareness and active acceptance of all types of internal experiences, including those that are perceived as aversive or unwanted, in order to lessen the regulatory power they have over behavior. Much of the treatment in ACT explicitly focuses on decreasing experiential avoidance, or the unwillingness to tolerate unwanted emotions and other forms of internal experiences. Experiential avoidance is considered a transdiagnostic factor that underlies a wide range of difficulties and psychological disorders, ranging from depression and anxiety to addictions and suicidality (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Thus, many interventions are specifically designed to facilitate the willingness to recognize, identify, and endure distressing emotions and other types of unwanted internal experiences. Because of its important role in effective functioning, the willingness to endure difficult and unwanted experiences is emphasized in current major models and theories of mental health, such as the psychological flexibility model (Bonanno & Burton, 2013; Kashdan & Rottenberg, 2010).

A stance of awareness of one's own feelings of distress is an essential aspect of a wide variety of treatment procedures in contemporary cognitive–behavioral therapies, including in core behavioral interventions such as in vivo exposures. Exposure interventions have always promoted openness and active attention to the external environment and particularly to target feared stimuli, at least to some extent (e.g., Foa, Yadin, & Lichner, 2012). Also, a number of exposure-based treatments have long been focused on directed exposure toward key aversive internal experiences, such as panic-like sensations (Barlow, Craske, Cerny, & Klosko, 1989) or traumatic memories (Foa, Hembree, & Rothbaum, 2007). Interestingly, however, in current cognitive–behavioral therapies, awareness of internal experiences is emphasized also in exposures to feared external stimuli and situations. For example, several contemporary models of in vivo exposure (e.g., Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014) explicitly ask clients to change their attitude toward distress, from an intolerable state that necessarily needs to be avoided, to an unpleasant inner state that may be acknowledged as such, but still tolerated and in certain contexts even pursued.

A number of controlled studies examined the utility of interventions that are based on therapeutic processes akin to emotional awareness. The results of these studies indicate that when people closely attend to their aversive internal experiences, they may subjectively report experiencing higher rates of distress, while still showing essential behavioral gains (e.g., Katz, Breznitz, & Yovel, 2019). Such findings suggest that engagement with internal aversive experiences may not result in immediate relief of subjective discomfort. However, they also indicate that such enhanced awareness of one's distress can still lead to a stable and long-term improvement, which can be generalized to new, real-world environments. This pattern of findings is consistent with the psychological flexibility model (Kashdan & Rottenberg, 2010), which emphasizes reduction in experiential avoidance strategies and enhancement of goal-directed behavior—rather than improvement in personal discomfort. These findings are similarly in line with current cognitive–behavioral models of therapeutic change such as the inhibitory learning model (Craske et al., 2014). Practically, these findings suggest that explicitly directed emotional awareness is a valuable therapeutic procedure that may enhance the long-term beneficial effects of core procedures in CBT, including commonly used behavioral interventions such as in vivo exposures.

In current cognitive and behavioral therapies, attention is typically directed to aspects of the emotional experience that are relevant to the first three levels of awareness (Lane & Schwartz, 1987). For example, in MBCT (Segal et al., 2002) meditation may be focused on bodily sensations, and during exposures to feared objects or situations, it is possible to ask the client to verbally label the aversive emotions that arise (Kircanski, Lieberman, & Craske,

2012). However, higher levels of awareness of internal experiences (i.e., Levels 4 and 5) are also addressed in current cognitive–behavioral approaches. For example, the strong emphasis on paying close attention to the present moment in mindfulness-based treatments facilitates awareness to one's own internal experiences, but also to the contingencies of the external environment, including to other people (Hayes et al., 2012; Segal et al., 2002). Moreover, in ACT, clients are sometimes explicitly taught that seemingly conflicting emotions or other types of internal experiences such as motivations, desires or feelings can co-occur (Hayes et al., 2012). People often tend to assume that this is not the case, and this notion may be reflected in statements such as: "I love my wife, but I sometimes get so angry with her," or "I really want to do this, but I have so little energy." The way this is practically done in psychotherapy is by directly "attacking" the key word *but*, which reflects this implicit assumption. Specifically, clients are asked to repeatedly replace the word *but* in such statement with the word *and* (e.g., "I love my wife, and I sometimes get so angry with her;" "I really want to do this, and I have so little energy"). The goal of this ostensibly simple exercise is to help clients realize that feeling (e.g.) both love and anger toward the same person is possible, and therefore the corrected statement probably reflects the present state of mind more accurately. Such repeated exercises are designed to lead to the general recognition of the possibility of the coexistence of any seemingly opposing emotions, feelings or motivations at the same time, and thus to the active awareness of such blend experiences and ultimately to their acceptance. Perhaps most importantly, it helps clients acknowledge the restrictive and sometimes even paralyzing effects that the original *but* statements have on behavior. The corrected ones may sometimes sound somewhat awkward (e.g., "I want to go out, and I feel anxious"). However, because they are descriptive rather than proscriptive, they do not put any limits on potential courses of action. Consequently, the feeling of anxiety does not preclude going out, and the feeling of anger toward one's spouse is perceived as much less problematic or threatening (Hayes et al., 2012).

Enhanced awareness of unwanted internal experiences is explicitly and strongly emphasized in contemporary acceptance-based cognitive–behavioral therapies. It has been argued, however, that this broad therapeutic process is to a large extent common to other forms of CBT as well (e.g., Arch & Craske, 2008; Hofmann, Sawyer, & Fang, 2010). For example, the primary strategies aimed at coping with distressing cognitions in traditional cognitive therapy (CT) and in ACT, cognitive restructuring and cognitive defusion, respectively, appear to be very different from each other. In cognitive restructuring, distressing thoughts are subjected to a logical disconfirmation process with the aim of replacing them with more adaptive and less negatively biased cognitions (Beck, 1995). In sharp contrast, in cognitive defusion the content of distressing thoughts is not challenged. Instead, clients perform a variety of strategies aimed at accepting the experience of such cognitions, without any direct attempt to challenge or modify their content or the frequency with which they occur (Hayes et al., 2012). Thus, this process aims at changing the ways clients interact with cognitions or relate to them, by creating contexts that do not emphasize their unhelpful literal and emotional aspects. Indeed, the results of a laboratory-based study (Yovel, Mor, & Shakarov, 2014) that directly focused on the efficacy of cognitive restructuring and cognitive defusion indicated that both were similarly efficacious in dealing with negative thinking. This intriguing similarity may be informative, as it suggests that the primary cognitive interventions of CT and ACT are closer than they appear to be. That is, both essentially entail a distanced, almost "scientific" approach-oriented attitude, in which clients are explicitly instructed to pay close attention to their distressing cognitions and emotions and to identify and describe them in writing (Beck, 1995; Hayes et al., 2012). Such an approach is clearly incongruent with unhelpful strategies such as avoidance or suppression (Arch & Craske, 2008; Hofmann et al., 2010). Thus, even though CT and ACT encourage clients to employ different types of strategies to deal with their negative thinking, they both first ask them to identify and describe their undesirable internal experiences. In sum, notwithstanding the differences that exist between different forms of cognitive–behavioral approaches, it appears that the key interventions that are aimed at coping with negative cognitions and their accompanying emotions in tra-

ditional CT and in acceptance-based treatments are based on the same basic process—namely the explicit facilitation of an active awareness toward these distressing internal experiences.

Emotion-Focused Psychotherapy

Theoretical Foundations of Emotion-Focused Therapy

Emotion-Focused Therapy (EFT) is a neohumanistic approach that sees emotions as the basic datum of human experience and as providing information, action tendencies, and motivation. We start with the idea that we have basic, evolutionarily given, emotional action tendencies but see that with development human emotions become much more complex. No longer are emotions viewed as simple, separate, independent processes with their own distinct, innate, physical correlates (Frijda, 1986). Rather, lived emotional experience rapidly becomes the product of a complex synthesis of many processes. Starting from some basic biologically given building blocks it incorporates, among others, attentional, cognitive, memory, motivational, and behavioral processes. Emotion thus is a complex multicomponent phenomenon.

A core feature of EFT's method of working with emotion is the distinction between conceptual and experiential knowing. In this view the emotions produced by deliberative cortical processes are not nearly as important in human function and dysfunction as are more basic emotions produced by the limbic and body-based homeostatic system. It is these latter systems that are more impenetrable to reason, harder to change by rational means, and what need our attention to achieve therapeutic change. In EFT we also argue that emotion can be changed and that the best way to change an emotion is with another emotion (Greenberg, 2015).

The instinctual body is a survival system designed to promote life, and the emotion system is highly related to this biologically based homeostatic system and is designed to keep the organism alive. To have a more complete understanding of human functioning we have to recognize emotion, and the homeostatic sensory body system as well as cognition, motivation, and behavior. The body has a will to live regulated by homeostasis and emotions emerged as an aspect of consciousness as the body's way of evaluating what would help us survive. Interoception and proprioception, the ability to sense internal states and bodily position and movement, are among the most fundamental ways we experience ourselves, right from birth. These processes remain important in guiding us throughout life. We constantly sense our bodies from the inside. We need to be guided by our body-based felt inclinations and to simultaneously be able to be aware of their guidance.

Thus levels 1 and 2 of the LEA framework are a crucial aspect of working with emotion. They are not simply low levels of awareness but are a crucial aspect of the full experience of emotion. Without these levels of experience we do not have visceral experience but merely conceptual experience. Conscious reflection on bodily felt experience is then needed for people to become consciously aware of what they are feeling. It is thus through a process of bringing cognition and language to emotion that we come to know ourselves and implicit, automatic, body-based emotional responses are made into explicit and progressively differentiated emotional feelings.

The EFT perspective thus is that much conscious personal experience and meaning derives from attending to, exploring, and making sense of implicit bodily felt self-organizations by a process of attention and reflection. LEA Level 3 begins the process of naming emotion in awareness. Conscious meaning is seen as being created by an integration of biology and culture, language-based reason, and bodily felt emotion via an ongoing circular process of symbolizing bodily felt sensations in awareness and articulating them in language, thereby making sense of experience (Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1995; Greenberg, Rice, & Elliott, 1993). There thus are two main streams that feed conscious experience. One coming from within is biologically based and affective in nature; the other from without is linguistically based and cultural in nature. Awareness of feelings involves a dialectical cycle of meaning construction enabling the translation of "lived" experience into "told" experience. This enables a person to understand what they are feeling and what the feelings are telling them that they need.

The LEA moves in Level 4 and 5 toward being more differentiated with Level 4 being able to recognize having feelings that are clearly different from each other and Level 5 being able to appreciate complexity in the experiences of self and other simultaneously and see the other's feelings in nuanced ways. While agreeing with differentiation of emotion as important, we add narrative construction in addition to emotion awareness as an important next piece in therapeutic change. This construction of narrative goes beyond emotion awareness and beyond differentiation into more complex meaning creation.

Types of Emotion

An important feature of working with emotion is the distinction between *primary* and *secondary* emotion on the one hand, and *adaptive* and *maladaptive emotion* on the other hand.

Primary adaptive emotion responses are a direct reaction consistent with the immediate situation and it helps the person take appropriate adaptive action. Such responses are to be brought into awareness in the manner described by the LEA levels. From EFT's neo-humanistic perspective, however, not all emotions are as functional, or organismically wise, in their fit with the current situation. In addition to primary adaptive emotion we define three other categories of emotion. In each category, consistent with LEA, awareness of emotion is important, but each category requires a different type of treatment after having been brought to awareness. So in this view awareness is necessary but not always sufficient for therapeutic change. In addition to primary adaptive emotion, *primary maladaptive* emotions are also direct reactions to situations, but they no longer help the person cope constructively with the situations that elicit them. These emotions involve responses stored in emotion schematic memory, based on past, often traumatic, experiences. They are essentially reactions to the past in the present. *Secondary reactive* emotions are emotions that follow some more primary response and obscure the original emotion. These may be thought of as defensive emotions. For example, a man who feels primary shame may show secondary defensive anger. Finally, *instrumental* emotions are emotions expressed in order to influence or control others. For example, crocodile tears may be expressed to elicit support.

EFT Practice

Helping clients gain conscious access to primary adaptive emotions, for example, anger in the context of mistreatment, sadness in the context of loss, is a key goal. Becoming aware of and symbolizing core emotional experience in words provides access both to the adaptive information and the action tendency in the emotion. Once people know what they feel they reconnect to their needs and are motivated to meet them. It is important to note that emotional awareness is not thinking about feeling, but rather it involves feeling the feeling in awareness. Only once emotion is felt does its articulation in language become an important component of its awareness.

Emotion awareness in EFT very much involves LEA's awareness of the generating bodily sensations and action tendencies (Levels 1 and 2) as well as forming them into specific feelings (Level 3) by symbolizing them in words. In EFT there is a focus on differentiating between surface secondary emotions (e.g., anger) and underlying primary emotion (e.g., fear or shame). This corresponds to arriving at differentiated feelings at Level 4. Emotions are also managed in different ways. They need to be developed by narrative elaboration into stories that help us make sense of self, world and other, be guided by cognition and regulated when overwhelming. EFT proposes an additional key therapeutic change process consisting of "changing emotion with emotion." This highlights that not only is arriving at what one feels by means of awareness and accepting emotion important but often leaving what one feels by transforming it is also important. EFT works on the basic principle that people must first arrive at a place before they can leave it. Thus, they need to feel fear to change fear, feel shame to change shame, but they then need to feel a new feeling to change the old feeling. Different emotion stimulation methods such as two-chair dialogues and other techniques are used that enable painful emotions to be activated, processed, and transformed by experiencing new emotions such as compassion, empowered anger, and the sadness of grief.

Transformation

Probably the most important way of dealing with emotion in psychotherapy in EFT involves the transformation of *emotion by emotion.* This applies most specifically to transforming primary maladaptive emotions such as fear, shame, and sadness of lonely abandonment with other adaptive emotions like assertive anger, sadness of grief, and compassion (Greenberg, 2015). Spinoza (1967) proposed that "An emotion cannot be restrained nor removed unless by an opposed and stronger emotion" (p.195). In EFT an important goal thus is to arrive at (and fully experience) maladaptive emotion, not for its good information and motivation, but in order to make it accessible to transformation. In time the coactivation of the more adaptive emotion, along with or in response to the maladaptive emotion, helps transform the maladaptive emotion.

It is important to note that the process of changing emotion with emotion goes beyond ideas of catharsis, completion, and letting go, exposure, extinction or habituation, in that the maladaptive feeling is not purged, nor does it simply attenuate by the person feeling it. Rather another feeling is used to transform or undo it. Although dysregulated secondary emotions such as the fear and anxiety in phobias, obsessive compulsiveness, and panic emotions may be overcome by exposure, in many situations in psychotherapy, primary maladaptive emotions, such as the shame of feeling worthless and the anxiety of basic insecurity, are best transformed by other emotions. This involves more than simply feeling or facing the feeling leading to its diminishment. Rather, for example, the withdrawal tendencies of primary maladaptive emotions are transformed by activating the approach tendencies in adaptive emotions of anger or contact/comfort seeking. Once the alternate adaptive emotion has been accessed it transforms or undoes the original state and a new state is forged. Often a period of regulation or calming of the maladaptive emotion in need of change is needed before the activation of an opposing emotion. Therapists can help the client access new emotions by focusing on what is needed and thereby mobilizing a new emotion (Greenberg, 2015).

In our view enduring emotional change occurs by generating a new emotional response not through a process of insight, understanding, cognitive restructuring, or overcoming avoidance alone, although all of these contribute to more lasting change. What is needed is activation of maladaptive emotion schematic memories of past childhood losses and traumas in the psychotherapy session in order to change these by memory reconsolidation (Lane, Ryan, Nadel, & Greenberg, 2015). Introducing new present experience into currently activated memories of past events has been shown to lead to memory transformation by the assimilation of new material into past memories (Hupbach, Gomez, Hardt, & Nadel, 2007; Lane, Ryan, et al., 2015). By being activated in the present, the old memories are restructured by the new experience of adaptive emotional responses to the old situation, all experienced in the context of a safe relationship. The memories are reconsolidated in a new way by incorporating these new emotional elements.

Psychodynamic Psychotherapy

The Goal of Creating Coherent Narratives

A key objective of psychodynamic psychotherapy (PDT) is "making sense" of symptoms or psychosomatic suffering by relating them to the inner world and important relationships of the client. PDT theory states that clients provide disrupted narratives about their individual history and their emotional states because their ability to symbolize their inner and relational experiences is impaired and/or they have no conscious access to parts of their inner world.

The term *mental representation* denotes the ability to express one's experiences either presymbolically—for example, by making sounds, movements or pictures—or symbolically with the help of words and the rules of language. Independent of the capacity to mentally represent experiences of self and others, anticipated or actual high affective arousal may activate defensive processes that block conscious experiencing of difficult-to-bear aspects of the self. Such defenses help clients avoid the painful conscious awareness of problematic aspects of their lives, albeit at the expense of the suffering that comes with their symptoms.

PDT theory holds that coherent narratives of past and present make a psychic symptom dispensable. In the construction of coherent narra-

tives emotions play an important role, as they immediately assess what is going on around and inside us and therefore make it possible to give meaning to the sensory input and bodily signals that fill our minds.

Two Disease Models

Psychodynamic treatment technique distinguishes between two disease models based on the quality or developmental level of the client's ego structure (DeWitt, Milbrath, & Simon, 2018; Fonagy, Gergely, & Jurist, 2002). With ego structural deficits, the mental representation of thoughts, intentions, and especially emotions are undifferentiated, relying on stereotypes and often presymbolic expressions. In the treatment of ego structural deficits, special attention is given to enhancing the ability to represent affects symbolically; for example, to experience them as feeling states that can be expressed verbally instead of as bodily states (Level 1) or action tendencies (Level 2). With regard to the theory of LEA, access to explicit levels of emotional awareness (Levels 3 and above) is a precondition for the construction of meaningful and differentiated narratives that help make sense of one's behavior in relation to self and others. The psychodynamic techniques for treating ego structural deficits are typically applied to clients with personality disorders, severe somatic symptom disorders, or early and severe attachment trauma.

The alternative disease model describes how "neurotic" symptoms arise if the intact ego is flooded with conflicted emotions. Defensive processes are activated that bias the experiencing of self and others in order to relieve high levels of affective tension. These intensified defenses partially compromise mental functioning and create symptoms in order to reduce inner affective tension. For example, obsessive–compulsive symptoms can be understood in part as a distorted narrative that has been produced by defense mechanisms in reaction to an inner conflict. If a client has to confirm several times that all electrical devices are deactivated to ensure that the house will not burn down, his attention is absorbed by this ordeal and shifted away from his burning anger toward a loved one. In so doing, he can retain a positive view of the relationship and avoid experiencing the fear that his anger will destroy the relationship.

PDT conceptualizes the obsessive–compulsive symptom and the client's conscious experiencing of an important relationship as one narrative that binds all the elements together. In the therapeutic process these elements are put in a new order that form a more coherent narrative. If the client is able to experience his anger toward the loved one as well as his fear that this anger will destroy the relationship, the obsessive need to prevent a fire in the house loses its function and becomes unnecessary.

In an individual client the symptomatology may be caused partly by ego structural deficits and partly by defenses that liberate the self from intolerable affective tension. In the diagnostic process ego structural capacities are evaluated to determine whether an impairment of these capacities restricts the client's ability to deal with inner conflicts adaptively.

The notion that clients differ in these capacities and that treatment technique has to be adjusted to the ego structural state has a long tradition in PDT. Eissler (1953) was one of the first psychoanalysts who recommended so called "parameters" (e.g., to combine psychoanalytic treatment with psychoactive medication or to regulate symptomatology with the help of treatment contracts and contingency plans) for clients with weaker ego structural capacities. With "supportive-expressive therapy" Luborsky (2000) proposed a manualized approach that alters technique to both facilitate the conscious awareness of inner conflicts and help to increase the ego structural level. The differences in treatment technique associated with these two PDT disease models will be described below beginning with the common foundation from which the treatment techniques originate.

Common PDT Techniques Across the Two Disease Models

PDT theory holds that the experiencing of self and self in relation to others that leads to symptom formation and "distorted" narratives involves feelings, thoughts, intentions, and memories that are partly consciously available and partly not. These elements form maladaptive patterns that motivate behavior, expectations, and experiencing in relation to self and others. The patterns are partly stored in implicit (not consciously available) and partly in explicit

(consciously available) episodic and semantic memory, derived from recurrent experiences of similar content and affective valence that become generalized. For example, a child asks mother for help, but gets none. Instead the mother humiliates the child by indicating that the child is too stupid to solve the task. This causes deep shame in the child. Multiple similar episodes become generalized to something like the following schema: "I want help from others but they humiliate me if I ask for help. To avoid shame, I withdraw and will not ask for help anymore."

PDT technique is guided by the idea that the distorted narrative can be reflected upon and challenged if the unconscious part can become consciously available. Asking clients to say whatever comes to mind (free association), a basic technique that characterizes all PDT approaches, makes use of the clinical observation that getting into contact with any element of the mental representation of a maladaptive pattern may lead to the (re)construction of the whole pattern. Once the pattern is reconstructed the client can reflect upon its meaning in the past and the present and make other more adaptive and rational choices in relationships.

The motivation to sequester parts of the maladaptive pattern from deliberate conscious availability is the reduction of psychic pain. Because free associations lead to hurtful memories there is mental activity that serves to avoid the deeper exploration of the maladaptive pattern, known as "resistance." To overcome the resistance, the therapist helps the client engage in "exploration" of his or her mind by evoking more detailed descriptions of memories, feelings, and fantasies and by "confrontation" of inconsistencies.

Another approach is "interpretation," which fills in gaps in the client's understanding of his or her reaction to a salient situation. Exploring, confronting, and interpreting "expose" clients to negative, sometimes overwhelming, emotions. Therefore, PDT technique emphasizes the need to foster a helpful therapeutic alliance. This is achieved by empathic monitoring of the client's emotional states.

From the perspective of LEA theory, PDT therapists try to differentiate explicit emotions and broaden the client's capacity to experience intense negative emotions. Simultaneously they try to make implicit emotions explicit. They evaluate the free associations of the client for indictors of hidden emotional content and through their interventions try to make this content explicit. By enabling clients to take the step from implicit (Levels 1 and 2) to explicit emotional awareness (Levels 3, 4 and 5), the therapist is often dealing with ego structural deficits involving hurtful emotions that were not previously formulated. With the help of empathic exploration, the therapist facilitates the client's ability to read his or her bodily sensations (Level 1) or action tendencies (Level 2) as indicators of affective arousal and gives this arousal emotional meaning (Level 3 and above).

Another important objective is to strengthen a client's capacity to experience emotional ambivalence. Here the therapist operates between Level 3, awareness of one feeling at a time, and Level 4, the ability to experience different feelings simultaneously. By deepening the capacity for experiencing emotional ambivalence, the therapist must deal with the resistance to acknowledging that there might be emotions associated with a special situation other than those that are consciously available.

Disruptions in the therapeutic alliance may indicate that the therapeutic work has touched upon anxiety-evoking thoughts or memories stemming from emotional ambivalence of which the client is unaware (i.e., if the client's conscious experience is unidimensional and thus at Level 3). Following a basic rule of PDT technique, the therapist will guide the client's attention to this disturbance and will help him or her explore its background, always ready to bring the client into experiential contact with negative emotions that likely contributed to the impasse.

From the perspective of PDT, repairing an alliance rupture (Safran, Muran, & Eubanks-Carter, 2011) is an integral part of the work with or in the transference. When "working with the transference" the therapist is always ready to interpret the therapeutic relationship as a reactualization of past relational patterns with important others with an emphasis on hidden emotions and intentions. By "working in the transference," the therapist ponders during the sessions how the past relational pattern is organizing the therapeutic relationship in the here and now. Importantly, she uses these reflections to inform interpretations of the client's difficulties in relationships with others or in relation to

herself. A transference interpretation will only be offered to heal an alliance rupture. Working with the transference aims to enhance emotional awareness and to make implicit emotions explicit and fosters the client's ability to tolerate emotional ambivalence.

Similar phenomena are at work with regard to the therapist's emotional responses to the client. Countertransference (Heimann, 2016) is an overarching term for all reactions of the therapist to the client. These reactions are subjective and often underpinned by undifferentiated emotions or bodily states (Levels 1 and 2). The therapist needs to evaluate if these states have been induced by the interaction with the client. If so, the therapist tries to give her inner state or countertransference meaning in the therapeutic relationship. For example, does the therapist suddenly feel tired because it helps the client to remain "numb" to his aggressive tension? The validity of such a conjecture may be tested through an interpretation. By drawing upon the therapist's countertransference experience, the therapeutic process is conceptualized as a construction of sense.

Variations of PDT Technique

Clients with ego structural deficits due to early attachment trauma can gain a coherent, mentally represented sense of self by interacting with another person who is able to understand and react properly to their psychic needs. Bion (1962), and later Fonagy and colleagues (2002), described this process as resembling that of the early interaction between caretaker and baby. By trying to read the baby's mind and communicate the "sense" he or she has made out of the baby's utterances, the caretaker lays the foundation for the baby's representational capacities (Fotopoulou & Tsakiris, 2017).

Consistent with this perspective, clients with ego structural deficits arising from traumatic experiences in their primary attachment relationships have a great deal of difficulty differentiating between the working relationship with the therapist and the transference relationship. Especially in the context of being emotionally aroused, they do not experience the therapist as someone whose behavior is similar to the behavior of their significant others. Here aspects of past traumatic experiences repeat themselves in the here and now (enactment) without the capacity for reflection. The client experiences the therapist as part of his or her relational world. In dealing with this, the therapist tries to strengthen the client's capacity to reflect upon the therapeutic relationship in the here and now (Bateman & Fonagy, 2007; Kernberg, Yeomans, Clarkin, & Levy, 2008). Transference interpretations do not explicitly relate the therapeutic relationship to negative experiences with significant others in the past. By working in the transference or sorting out her countertransference, the therapist makes use of her knowledge of the relational history of the client to enhance the client's understanding of the actual relational situation. Her primary goal is the enhancement of the client's representational capacities and thus the creation of a more coherent narrative.

In clients with sufficient ego structural capacities who suffer from neurotic conflict, the therapist's activities are targeted at making consciously available preconscious aspects of maladaptive and repetitive conflictual patterns. The therapist consequently interprets the free associations as indicators of the reactualization of a maladaptive relational pattern in the transference relationship in order to foster the experiencing and expression of feelings that the client habitually suppresses in the "transferred" relational conflict. The experience that awareness and expression of the previously blocked emotions did not destroy the therapeutic relationship enables the client to envision and experiment with new, less restricted ways of interacting with others. Such experiences can transform the recurrent maladaptive pattern and, with the aid of reflection and verbalization, enable the creation of a more coherent narrative.

Discussion

The modern era of psychotherapy began over a century ago with the concept that making unconscious thoughts and their associated emotions conscious was curative (Breuer & Freud, 1957). As noted elsewhere (Lane, 2018), this concept isn't wrong so much as incomplete. Based on a relatively new theory of change in psychotherapy that draws upon the emerging neuroscience literature on memory reconsolidation and the critical role of emotion in prioritizing and organizing memories (Lane, Ryan, et al., 2015), the process of activating old memo-

ries and the painful emotions associated with them is only the first of three steps in the change process. The second step is creating a corrective emotional experience while the old problematic memories are activated and available for updating, and the third step is practicing new ways of behaving and experiencing emotion in previously problematic circumstances. In this review we show that for three different approaches to psychotherapy, which differ greatly in their theoretical foundations and clinical applications, emotional awareness is necessary but not sufficient for change. Please see the online supplementary material for an illustration of how each of the three modalities would be used to enhance emotional awareness in the case of a 62 year-old man with depression.

Why should it be that emotional awareness is necessary for change? In all three approaches it is evident that painful emotions that are out of awareness are influencing thoughts, behaviors, decision making, and feelings in ways that are maladaptive in the client's current life circumstances. Here is where the levels of emotional awareness framework, and the distinction between implicit (Levels 1–2) and explicit (Levels 3–5) emotional processes, is particularly helpful. When emotions are processed at Levels 1 and 2, they are influencing thoughts, behaviors and decision making without awareness, and also provide the physiological foundation and bodily sensations for emotional feelings. Bringing them into awareness and putting them into words transforms the nature of experience, making it more differentiated, but also makes the emotional responses accessible to additional conscious cognition and decision-making processes. Each psychotherapy approach conceptualizes this implicit-to-explicit transition in somewhat different ways. Newer CBTs focus on overcoming avoidance strategies, which may be intentional or unintentional, followed by using awareness to inform new behavioral strategies corresponding to Step 3 in the three-step change process noted above. EFT focuses on overcoming the disowning of emotional responses followed by transforming emotion with new emotional experiences, corresponding to Step 2 above. PDT highlights that emotions may be implicit because of defenses, deficits or both, and then emphasizes both corrective experiences in the transference relationship with the therapist (Step 2) and the construction of a new narrative based on this lived experience that can be used as a roadmap for having more flexible construals and behavioral choices in previously problematic situations (Steps 2 and 3).

The distinction in PDT between defenses and deficits as a source of implicit emotion has important therapeutic implications. The developmental model of emotional awareness states that the ability to become aware of one's own emotions is a developmental process that requires attuned responding from empathic caretakers to enable a child to know what it is that he or she is feeling and what the feeling means in relation to what triggered it. Repeated experiences of this sort have a cumulative effect that promote a developmental process of progressive differentiation and integration in experience and awareness (Lane & Schwartz, 1987). Different types of psychopathology such as borderline personality disorder or alexithymia are thought to arise when this developmental process is impaired and are associated with deficits in one's repertoire of emotion concepts and verbal labels (Lane, Weihs, Herring, Hishaw, & Smith, 2015). Promoting awareness under such circumstances often requires formulating and differentiating certain kinds of emotional experiences for the first time (Stern, 2013), which can be quite challenging clinically. Defenses, on the other hand, assume that emotional experiences have previously been formulated and differentiated but are kept out of awareness through intentional (e.g., suppression) or unintentional (e.g., repression) mechanisms. Overcoming defenses is not easy but is easier than when both deficits and defenses are present. Given our conclusion that emotional awareness is necessary but not sufficient for change, this distinction has important implications for the types of clinical problems that can be treated with any given approach to psychotherapy, the methods of intervention required, the duration of psychotherapy, and the likely outcomes.

As noted above, Burum and Goldfried (2007) stated that a general goal of psychotherapy is to improve emotional awareness. We also noted previously that Beutel and colleagues (2013) showed that greater pretreatment emotional awareness is a predictor of better outcome for the treatment of panic disorder either by CBT or PDT. Both conclusions make sense if becoming aware of painful emotions that were previously hidden from awareness is a necessary step in the

change process. If so, this leads to at least two testable hypotheses. The first is that greater awareness at baseline leads to better outcomes in a variety of clinical conditions because it increases the likelihood of becoming aware of and symbolizing painful emotion during psychotherapy. A second hypothesis is that promoting emotional awareness in psychotherapy is a mediator of change across different approaches. This means that if emotional awareness does not increase change is not likely to occur, and that the more emotional awareness improves the greater the change will be. In support of the latter hypothesis, Pos, Greenberg, Goldman, and Korman (2003) showed that depth of experiencing of emotion in later sessions in the treatment of depression was a better predictor of outcome than depth of experiencing in early sessions. In doing such research it will be important to determine whether these hypotheses hold true across approaches. It will also be important to determine whether awareness consists of mindful or contactful awareness of emotion as defined in EFT, which includes attending, symbolization, congruence, acceptance, agency, regulation, and differentiation (Watson & Greenberg, 2017), or whether only some but not all of these features are necessary across approaches. Indeed, all of these elements are highlighted in EFT, whereas modern cognitive–behavioral approaches emphasize attention and acceptance and PDT emphasizes symbolization, differentiation, and narrative construction.

Although the discussion up to this point has focused on the level of emotional awareness of the client, the emotional awareness of the therapist is likely quite relevant to the success of psychotherapy as well. The ability of a client to become more emotionally aware is very likely influenced by the level of emotional awareness of the therapist, although no such research has been conducted to date. As a complement to the testable hypotheses mentioned immediately above about increases in client emotional awareness as a contributing mechanism and mediator of change, one might further hypothesize that between-therapist variability in their own emotional awareness predicts between-therapist differences in their average patient's change in emotional awareness, which in turn predicts outcome. Another testable hypothesis is that between-therapist variability in their own emotional awareness predicts between-therapist differences in their average patient's rating of the quality of the therapeutic alliance. Whether between-therapist variability in their own emotional awareness predicts their average patient's outcome (e.g., symptom reduction) independent of the effect of such variability on client emotional awareness or the client's rating of the quality of the therapeutic alliance are additional tractable empirical questions.

In conclusion, we have applied an empirically validated conceptual framework of levels of emotional awareness to explore how emotional awareness contributes to therapeutic change across approaches. We conclude that emotional awareness is necessary but not sufficient for change. In that regard it may be a common factor comparable in importance to a strong therapeutic alliance, which is similarly recognized as a necessary ingredient for psychotherapy to succeed but in itself is not sufficient to bring about change. The two are not unrelated as the developmental process of becoming emotionally aware, whether as a trait characteristic or as it applies in a state-related manner in a particular problematic situation, typically requires an attuned and empathic other who can provide support while facilitating the implicit-to-explicit transition in emotion processing (Paivio & Laurent, 2001). Indeed, a form of experiential brief dynamic psychotherapy for the treatment of affect phobia focuses in particular on the experiencing of (exposure to) painful emotions in the context of a safe and supportive therapeutic relationship (McCullough, 2003). Emotional awareness helps people understand what their experience means; psychotherapies differ in how they use that knowledge to adapt to the circumstances that generated the emotions in the first place and to prevent problems from recurring.

Within the broader context of a recent review on what works in psychotherapy (Norcross & Lambert, 2018), promotion of emotional expression is considered a process that "probably works." An implication of the current review is that results from studies of the association between emotional expression and outcome may be mixed because it may not be the expression of emotion per se that is necessary for change but rather the awareness that either precedes it or is acquired in the symbolization process needed for expression to occur. In this regard, it is notable that Gendlin (1982) observed that

"groping for words" during the initial intake session was more highly predictive of success in psychotherapy than glib, fluent descriptions of experience. The key difference is that if one attends to authentic bodily experience in the moment and then symbolizes that in words, one is engaged in promoting the implicit-to-explicit transition, whereas verbalizing preexisting conceptualizations of experience does not constitute a developmental process. This may help to explain why expression of emotion per se may not always promote change and highlights the importance of studying emotional awareness, being very specific about how it is defined and measured as well as the nature of the emotions being processed. In that regard, when exploring the role of emotional awareness as distinct from emotional expression in effecting change, it will be important to distinguish between the emotion categories highlighted in EFT, including primary adaptive, primary maladaptive, and secondary symptomatic emotions. Based on the recent memory reconsolidation model of change, one might hypothesize that awareness of primary maladaptive and secondary symptomatic emotions would be needed in preparation for their transformation through their juxtaposition with awareness of primary adaptive emotions, followed by the repeated practicing of new ways of behaving and experiencing emotion in previously problematic circumstances.

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