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Insight and Self-Observation

Curative Factors in Dynamic Psychotherapy

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Insight and Self-Observation[1]

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The Development of the Concept of Insight in Psychoanalysis

Insight in Freud's Early Analytic Technique

In 1893 Breuer and Freud published a remarkable new theory of hysteria. Its central thesis was that "hysterics suffer mainly from reminiscences"—split-off or suppressed memories loaded with unspent affect were denied the usual release through associational pathways in consciousness enjoyed by normal affect experiences. Consequently, they pressed for discharge, leading to the formation of hysterical symptoms, which were symbols of the suppressed memories. The cure for the symptom was relatively simple. It consisted in restoring the memory, its accompanying affect, and the details of the surrounding circumstances to consciousness, where affect was able to dissipate through the various available nervous connections and to achieve catharsis by motor discharge in speech.

During this early period, Freud's concepts of neurosis and its cure were essentially mechanistic. The patient's role was passive: to obstruct the physician's view of the unconscious as little as possible. While the theory of cure placed great emphasis on consciousness, it did not require *active*

consciousness from the patient. Rather, the hidden memories were *made* conscious by the physician, who thereby effected a cure through the establishment of links between repressed affects and their normal discharge channels. One can compare the physician's role (as Freud often did) to the surgeon who would cut through the superficial tissue to excise a neoplasm. At first, the patient's passivity was sought through light hypnosis, a kind of mental local anesthetic.

Even when the patient's active though unconscious resistance to this cure forced Freud to replace light hypnosis with his forehead-pressure technique, and later with free association, his motives were to circumvent the patient's activity and to get the unconscious into consciousness. Any route which led to the conscious discovery of the repressed would do. The patient could remember directly, or the analyst could piece together the traumatic incident for him. But information from relatives or acquaintances would serve just as well (cf. the case of the "happily married young women," in Breuer and Freud, 1895, pp. 274-275).

Freud's contact with resistance gradually forced him to pay increased attention to the patient's role in bringing the unconscious to consciousness. With the advent of free association, Freud asked his patients to suspend their critical faculties by themselves (Freud, 1900, pp. 101-102). Physicians no longer exercised their will directly against the resistance; rather patients

would try to follow the "basic rule" themselves. Patients were confronted with the fact that it was their own task to contact their unconscious, and their own resistance that blocked their way. At same time, Freud's theory of cure became more psychological. The earlier theory of an automatic cure following the release of pent-up energies through restoration of the memory to consciousness fell away, and increased stress was placed on the control exercised by the preconscious system (*Pcs*.) over the unconscious system (*Ucs*.) (Freud, 1900, pp. 577-578). The work of analysis changed from a quick abreaction to a gradual—Freud called it "laborious"—mastery of the *Ucs*. by the *Pcs*.

Emotional Insight and the Importance of Experiencing

From this developing vantage point, Freud recognized his technique of twenty years before as "intellectualist" (Freud, 1913). He had discovered that patients must experience their resistances directly, and be convinced of the latter's power, before they can give them up. As patients yield their resistances, they are able to experience the emerging repressed contents directly. Without going through this process, the therapy becomes an "intellectualist" process, and the phenomenon Freud described as "knowing but not knowing" occurs. An intellectual knowledge of the repressed contents sits above and separate from the actual working of the unconscious conflict. The patient does not grapple directly with the *Ucs*., and so the *Pcs*. gains no

dominance over it. Freud found that direct experience with the resistance, leading to discovery of the repressed contents, is attained primarily through the transference neurosis. Patients are exposed to a "real but conditional" experience of their neurosis in the transference (1914); here their intellectual comprehension struggles with the repressed contents directly. This patient participation represents a considerable change from the dreamy hypnotized hysteric of the *Studies on Hysteria*.

It was not until 1934, after the advent of the structural theory, that the development of these ideas appeared again in the literature. The importance of vivid contact with the *Ucs.* is a significant theme of Strachey's landmark paper of that year, "The Nature of the Therapeutic Action of Psychoanalysis," in which he presents his concept of the "mutative interpretation." Interpretations are mutative only if they deal with active, living impulses. "Every mutative interpretation must be emotionally 'immediate'; the patient must experience it as something actual" (p. 150). Hence, to be maximally effective, the interpretation must be delivered when the impulse is active in the transference. In contrast, "the purely informative, 'dictionary' type of interpretation will be non-mutative, however useful it may be as a prelude to mutative interpretations" (p. 150).

Through the years, analysts have returned to this theme again and again. The danger of "dictionary" analysis threatens the analyst whose own

intellectualizing tendencies lead him to collude with his patient's wish to avoid the full range of mental experience. Beyond this problem, however, is the inherent verbal, intellectual nature of interpretation itself. As Bibring put in in 1954,

> The fact that interpretations are explanatory concepts carries with it the danger of intellectualization, ... a form of resistance in that the patient "accepts" interpretations on the basis of their plausibility, their ability to make sense (i.e., to explain certain clinical data), but without "feeling" that this is so; or when the patient adopts the analytic language and readily produces all kinds of interpretations with great ease but without any emotion, etc. [p. 758].

Richfield (1954) reviewed this problem on a more logical, philosophical level. Citing Betrand Russell, he points out that "There are two fundamentally different ways in which we can know things ... knowledge by *acquaintance* and knowledge by *description*" (p. 400). Knowledge by acquaintance involves a direct, experiential contact with the known subject. Knowledge by description, on the other hand, is "knowledge *about* that subject, and may be independent of any acquaintance with that same subject" (p. 400). Because therapy depends on the ego's recognition and mastery of alien contents, it must meet these contents on a direct, dynamic level, which requires knowledge by acquaintance. In the idea of descriptive insight we quickly recognize Freud's early (1913) concept of "knowing but not knowing."

With many others (Strachey, 1934; Bibring, 1954; Greenson, 1967),

Richfield stresses the importance of descriptive awareness (also called intellectual or "dictionary" interpretation, or clarification) in leading the patient to a more direct acquaintance with a conflict. The task of analysis is then to fill out the first descriptive awareness of these unconscious conflicts with direct, emotional experience.

There is, however, a complementary problem in analysis. Strongly *emotional* contact with a conflict may obscure the intellectual understanding of its meaning. Valenstein (1962) describes this as the defense of "aflectualization," which complements "intellectualization" and is prevalent in hysterics. We can see then that *emotional insight demands a balanced integration of emotional contact and intellectual comprehension into a full-bodied experience of the meaningfulness of an unconscious conflict*.

The Therapeutic "Split"

Patients experience their feelings about the analyst as real. Freud was painfully confronted with this fact in his abortive analysis of Dora (1905). The discovery of transference—the fact that the patient's feelings for the analyst are repetitions of old object ties from the past—helped solve this problem. Feelings for the analyst are real, but not *really* real. As Freud (1914) put it, transference "is a piece of real experience, but ... it is of a provisional nature" (p. 154). But the recognition of this fact places a special demand on the

patient. "The physician cannot as a rule spare his patient this phase of treatment. He must get him to re-experience some portion of his forgotten life, but must see to it, on the other hand, that the patient retains some degree of aloofness, which will enable him, in spite of everything, to recognize that what appears to be reality is in fact only a reflection of a forgotten past" (Freud, 1920, p. 19).

This problem was discussed by Strachey and Sterba in papers published side by side in 1934. Sterba proposed the term "dissociation of the ego" for the phenomenon Freud described. Strachey dealt in detail with the shifts in the ego which accompany the first phase of a mutative interpretation, in which repression is lifted and the ego gradually allows transference to develop. The second phase begins when the transference has developed into a vivid experience of feeling for the analyst and an interpretation is offered to the patient. Strachey points out that "the successful outcome of this phase depends upon his [the patient's] ability, at the critical moment of the emergence into consciousness of the released quantity of id energy, to distinguish between his fantasy object and the real analyst" (p. 146). The patient's reality testing is bolstered by the analyst's own sense of reality, which Strachey thinks is introjected into the patient's superego. This "auxiliary superego" gives advice to the ego which is "consistently based on *real* and *contemporary* considerations" (p. 140).

Sterba describes the dissociation in the ego that is required at the moment of interpretation.

> The subject's consciousness shifts from the center of affective experience to that of intellectual contemplation. The transference situation is interpreted, i.e., an explanation is given which is uncolored by affect and which shows that the situation has its roots in the subject's childhood. Through this interpretation there emerges in the mind of the patient, out of the chaos of behavior impelled by instinct and behavior designed to inhibit instinct, a new point of view of intellectual contemplation [p. 121].

This dissociation is followed by a process of synthesis or assimilation of the hitherto unconscious contents into the working life of the ego. Much of this assimilation occurs preconsciously over an extended period of time. Like Strachey, Sterba points to the superego as the prototype of the dissociated, observing ego, tracing the analyst's contribution to this function to the patient's superego identification with the analyst's more adult and realistic point of view.

The ego's ability to shift flexibly from the unreflective immediacy of transference and free association to a reflective contemplation of these experiences is a basic requirement for psychoanalytic therapy, and its importance has been recognized by virtually every writer on the subject (e.g., Stone, 1961; Loewenstein, 1963; Greenson, 1967; Stern, 1970).

Insight as a Process

In the early days of analysis, gaining insight was a reasonably simple matter. Pressure on the forehead or associations to a dream brought up the unconscious for the analyst's interpretation. But we can see that as Freud grew to appreciate the power and value, first of resistance and then of transference, and complemented these with the notion of working through, the acquisition of insight was recognized as a much more complex process. Sterba and Strachey offered the first systematic views of this process, gained from the organizing perspective of the ego-psychological, structural viewpoint. Reviewing their presentations, we see that during the analytic hour patients more or less lose themselves in their transferences and associations. When the analyst interprets, the patient's observing ego is reactivated, which lets the patient consider the interpreted material from a dissociated, detached perspective. The ego then reintegrates, bringing the new material into the everyday life of the ego.

Insight is thus a complex process that depends on the integrated, sequential operation of several different ego functions, which have been described by Kris (1956). Kris suggests that, in addition to the capacity for detached, objective self-observation, insight requires the use of controlled ego regression. As Freud points out, patients must actively suspend many of their logical and moral considerations during free association (1900, pp. 101-102). This suspension permits direct experience of the fresh material that arises for observation. Insight also requires control over the discharge of affects. Affect

must be accessible, it must contribute to a vivid reexperiencing in memory and the transference, but it must not overwhelm the patient or be channeled into acting out. Tolerance of unpleasant affect is a major requirement for insight and self-observation. Finally, Kris notes the importance of the integrative function of the ego in bringing insight into useful connection with the everyday functioning of the ego. Each of these components has its own pathologies that hamper the functioning of the insight process. Kris stresses that insights develop slowly in analysis, based as they are on repeated interpretation by the analyst. It takes a long time for the patient to make extensive use of interpretation. In the earlier stages of analysis, the synthesis is often quickly submerged by new anxieties and conflicts, and at best it proceeds preconsciously, if it proceeds at all. Insight has to be resupplied by the analyst when the interpreted conflict returns later. As patients gain increasing mastery, however, they are able to sustain their insights as the conflicts reappear in new guises.

Myerson (1960, 1963, 1965) has developed the extremely important concept of *modes of insight*. A mode of insight describes a certain *type* of insight, and it implies a certain *process* through which the insight is reached. Myerson (1965) describes two different modes of insight which appear late in analysis, and which are important in postanalytic self-analysis. He calls them "psychoanalytic insight" and "reality-oriented insight." Psychoanalytic insight is an internalized version of the analytic process itself, and leads to a dynamic

and genetic understanding of an unconscious conflict. The mode has four steps; (1) an active effort to understand the conflict, followed by (2) suspension of active attention and a move toward attempted mastery through fantasy, leading to (3) self-observation and then (4) reintegration. (We can see the imprint of Sterba's 1934 concepts on Myerson's thought.) To summarize a typical example from Myerson's 1965 paper: late in his analysis a patient found himself feeling very angry at his little daughter, who was misbehaving at a family party. The patient recognized the inappropriate strength of his anger and began to wonder about it in the analytic hour. Unable to make headway by a directed conscious approach to the problem, he allowed himself to have a fantasy which expressed some hostility toward his sister's daughter and some restitution to the sister. Next, the patient recognized the immediate significance of the situation: he was extremely angry at his daughter because she had rejected him. From this, he moved to sibling and Oedipal contexts—past and present-—in which he had experienced the same feeling, and which closely paralleled the fantasy about the sister's daughter.

There were thus four steps in the activation of this mode of self-awareness. The first was the recognition that some self-aspect needed to be dealt with further, and a beginning attempt at a direct cognitive confrontation with the problem. In the second, a specifically analytic tack was taken, allowing fantasies to arise by relaxing the vigilant cognitive and defensive

attitudes to the problem. As Myerson points out, it takes a good deal of courage and trust to abandon one's defenses and plunge into the analytic process when frightening content is involved. The third step came in looking at this fantasy from an analytic context that had been painstakingly constructed over several years of analysis, and the last step involved a reintegration of the new material into the ego.

The reality-oriented mode operates with much less openness to unconscious conflict. It begins with the patient's direct effort to renounce the conflicted part of himself. When that fails, a superego-ridden fantasy emerges, demonstrating regressive loss of mastery of the conflict. Because he is unable to master the conflict through fantasy, self-observation is activated, and the patient faces conflict over his impulse. But he does not allow himself to explore the conflict further through associations. Instead, he turns to the reality situation to separate his fantasy from the facts. In the first example given, the patient would have stopped when he recognized that it was his daughter's rejection that was upsetting him, and reminded himself that, rejected as he felt, there was little objective reason to be upset with her, so he might as well simply tolerate his feelings for her.

Although the patient may use the reality-oriented mode defensively, we can see that it has useful application in the clarification used to prepare for interpretation.

The Motives and Autonomy of Insight Acquisition

As Kris (1956) and Myerson (1960, 1963, 1965) have stressed, the acquisition of insight is often not an autonomous process. Freud's early expectation that patients' wish for cure would lead them to tell all was quickly dashed by the phenomenon of resistance. He came to rely on the power of the positive transference to overcome resistance (1913, 1914), although Dora (1905) made the hazards clear. But the wish to comply with the analyst has remained an important motive in the patient's struggle to follow the basic rule. The basic rule as an analytic ego ideal was first formulated by Sterba (1934) and Strachey (1934). Kris (1956) and Miller et al. (1965) have since stressed the role of compliance and identification in adopting analytic forms of insight and self-observation.

More generally, Miller et al. (1965) have reviewed the various influences the analyst may use to help patients observe themselves. The analyst may "stimulate and exhort" patients to activate their observational skills; interpret patient's difficulties with self-observation; actively instruct patients in self-observation; and serve as a model for identification through his or her own patterns of observation and insight.

Kris (1956) and Myerson (1960, 1963, 1965) provide useful discussions of defensive and pathological motives for the acquisition of insight. The entire process may gratify libidinal or aggressive aims. Kris, for example, points out

that insight gained in compliance with the analyst gratifies libidinal wishes for union with him or for his love and praise. The stability of these insights is linked to the positive transference. Certain aggressive aims are gratified by the wish to become independent of the analyst. This wish leads to premature efforts at self-analysis, and, as Kris puts it, "a by-and-large competitive attitude tinged by hostility holds the field."

Myerson (1960, 1963, 1965) is also concerned with the motives for insight and self-observation. He suggests that self-observation may be motivated by the wish to escape anxiety and guilt; it may be undertaken to restore happy ties to a loved one, or to cope better with a demanding or competitive reality. Myerson tends to imply that autonomous self-observation and insight are noble ideals to strive for: in compliance with the analytic process itself (Kris, 1956), the patient should be determined to know and master the unconscious, regardless of the pain and frustration involved.

Certain specific ego functions, components in the insight process, may also be distorted for dynamic reasons—for example, the tolerance of affect may be inhibited in an effort to avoid "messy" feelings. The interferences with insight acquisition that we have described are fundamentally motivational (i.e., dynamic in nature). These interferences are standard fare in every analysis and are generally responsive to interpretation. More serious interferences occur when profound conflict, hereditary deficit, or severe

characterological distortions stunt the component ego functions involved in insight acquisition. There may be deficits in any of the five major functions: the capacity for controlled ego regression, the tolerance and control of affect discharge, the capacity for reflective self-observation, and the integrative function of the ego. While it is clear that these different functions overlap, it is possible to consider them separately.

The regression-enhancing features of the analytic situation may precipitate the well-known problem of uncontrolled regression in certain patients. These regressions often disrupt the other ego functions involved in insight acquisition and place a severe strain on the therapeutic alliance. Recent studies (Atkins, 1967; Dickes, 1967; Frosch, 1967) suggest that these apparently uncontrolled regressions may be relatively circumscribed in many patients. Even patients whose regressions are broad, deep, and long-lasting may be able to work effectively in analysis (Atkins, 1967).

The capacity for reflective self-observation may be impaired, especially in impulse-ridden characters. Stern (1970) has recently described a "therapeutic playback technique" in which patients with weak self-observational capacities may relisten to an hour on a tape recorder. This allows them to listen to themselves more reflectively, supplementing their reflective self-observational skills.

The integrative function of the ego is implicated in all of the component ego functions involved in insight acquisition. As originally described by Kris, the integrative function serves to bring insights into working interrelation with the rest of the ego. The synthetic function may generate plausible insights from diverse free-associative data, but without the activity of the integrative function, these insights remain isolated from the ongoing activity of the ego and therefore useless (Kris, 1956). Recent work on the borderline patient, however (Kernberg, 1966, 1967), suggests that certain failures of the integrative function may be effectively influenced by analysis.

Self-Observation

As an introductory definition, we may describe the function of self-observation as the observation of any and all contents, characteristics, and activities of the person, and the relationships among these features. Self-observation is an ego function. Like any other ego function, it is defined by certain basic properties: the functions it performs; its relations to other functions of the ego and to the demands of the drives, the superego, and reality. Self-observation may thus be directed toward the other functions of the ego in the service of insight; it may be responsive to defensive needs, such as the denial of unpleasant affect; it may work hand in hand with the reality-testing function in the effort to differentiate objective reality from subjective preferences; and so on.

Like reality testing, self-observation by its nature operates in conjunction with the ego function of consciousness. While the contribution of consciousness may be minimal—self-observation occurs during dreaming, for example—the notion of preconscious, automatized self-observation raises thorny questions.

In relation to the id, self-observation may be libidinized in certain pathological forms of self-consciousness (narcissistic characters, inhibited forms of exhibitionism, etc.). It may be aggressivized through the superego in depressions and psychoses. It may be more or less affected by realistic comments and criticisms, and by the effects of one's own actions. Self-observation has more general stylistic characteristics as well. It may be impressionistic, subtle, psychologically-minded, outer or inner directed, shallow, penetrating, limited, honest, deep, spotty.

With this overview in mind, we may turn to a more detailed consideration of the function of self-observation.

Types of Self-Observation

Our introductory definition does little to illuminate the complexity of the self-observing function. Freud (1900) made an important early refinement with his distinction between self-observation and reflection:

> I have noticed in my psycho-analytical work that the whole frame of mind of a man who is reflecting is totally different from that of a man who is observing his own psychical processes.... In both cases attention must be concentrated, but the man who is reflecting is also exercising his *critical* faculty; this leads him to reject some of the ideas that occur to him after perceiving them, to cut short others without following the trains of thought which they would open up to him, and to behave in such a way towards still others that they never become conscious at all and are accordingly suppressed before being perceived. The self-observer, on the other hand, need only take the trouble to suppress his critical faculty. If he succeeds in doing that, innumerable ideas come into his consciousness of which he could otherwise never have got hold [1900, pp. 101-102],

Kris (1956) presents a modern description of a similar distinction:

> It might be preferable ... to distinguish two cases, the one in which the ego observes the self and the other in which it observes its own functioning. In the latter case, one of the functions of the ego, that of observing, may be thought of as pitted against others [pp. 451-452].

The first form of self-observation that Kris describes is closer to experience than is the second. This "experiential" self-observation is a report of whatever is noticed about the self at a given moment, when the person simply lets his or her thoughts flow. It is the work of a passive, free-associative, observing ego. The second is the more detached (cf. Sterba), reflective form of self-observation, which occurs when the ego is taking an active, organizing view of the functioning of the mind.

It is clear that the distinction between these two types of self-observation is not hard and fast, for the two extremes are joined by every

imaginable shade and degree. There is some reflective awareness of the self, and some conceptual editing in "experiential" self-observation—for example, the free-associative ideal is constrained by the need to remain comprehensible to the analyst (Kris, 1956). On the other hand, there is some affect in reflective self-observation; it is more than "detached intellectual contemplation." As we have seen, insight becomes effective only when it meets emotionally living material.

In general, then, we can imagine many other varieties of self-observation occurring outside analysis or going on unobserved within it. Chief among these is *silent* self-observation. Silent self-observation need not be communicated subsequently in the analysis, and, in fact, may make little use of words at all. Although Freud placed great emphasis on the importance of words in mastering the unconscious (see, e.g., 1900, 1923), it is not certain that the patient's capacity for therapeutically effective self-observation is limited by his verbal skills.

Self-Observation and Insight

Self-observation is not to be confused with insight, of which it is a major component, as Kris (1956) has pointed out. Insight is a *process* which makes use of the ego function of self-observation in both its experiential and reflective forms. The first provides material for understanding, and the

second makes an active effort to understand.

While self-observation often serves insight, it is worthwhile to consider it separately from its involvement in insight acquisition. A good deal of the self-observation in therapy does not serve the immediate goal of attaining insight. The patient or the analyst may observe aspects of the self which appear unrelated to the immediate themes of the therapeutic hour, but which in the long run contribute to the understanding of the patient. Self-observation serves many other masters as well. In cases of depression and obsessional neuroses, it serves the critical superego in its review of guilty deeds. It serves the narcissistic character in the admiration of the self, and so on. In any case, there is much to be learned from separating out the function of self-observation for direct consideration, with an eye to its contribution to the analytic process.

The Nature of Self-Observation

Before we venture into the analytic situation, however, we need to take a closer look at the nature of self-observation. Self-observation of the type I have called "experiential" is in many respects simpler than the "reflective" variety because its function is to report what is visible to the inner eye. It does not attempt new integrations, but instead faces the immediate flux of experience—not an easy task, but a cognitively less complex one. Even so,

there is a great range of individual differences in the complexity of the material observed, as well as in the breadth and vividness of the content covered. The obsessive patient typically focuses his observation on the minutiae of his mental life, to the exclusion of the broader gestalt and the emotional vividness of his experience. The hysteric tends to lose the complexity of experience in a rush of vagueness and emotionality (Valenstein, 1962; Shapiro, 1965).

In contrast to experiential self-observation, the hallmark of reflective self-observation is its organizing activity. In this respect it is the keystone of the insight process. The contents which have emerged in the "experiential" phase are recognized as elements in a larger, unifying frame of reference, or *context*. The search for or emergence of this context is the core of reflective self-observation.

A context is an organized cognitive system of meaningfully related contents. The meaning that relates the contents may be a specific fantasy and its dynamic, economic, genetic, structural, and adaptive correlates; it may be a certain trait and all the circumstances in which that trait appears; or it may be a certain reality situation and the feelings, impulses, and fantasies that situation arouses. In other words, a context places an isolated thought, fantasy, or chain of associations or behaviors in a meaningful setting. Experientially, this leads to an "understanding" of the fantasy, thought, etc.

The context established by reflective self-observation serves as an explanation of the behavior under consideration. For example, the day before a patient had a cystoscopy, she was unwilling to have intercourse with her husband. The evening after, she was depressed, felt inadequate and uninteresting, and had the following dream: An art museum was being plundered of its marble statues while its tough, masculine female curator struggled helplessly to prevent the loss. We may understand these disparate behaviors in the context of the patient's unconscious fantasy that she possessed a penis hidden in her vagina or urethra, which would be stolen from her by the intruding penis.

Rapaport (1957) and Kris (1950) also use the concept of context. Rapaport extends it to mean the underlying cognitive organization of a particular thought or thought process, making it possible not only to specify the exact context of a given self-observation, but also to group self-observations according to more general cognitive features that are embodied in each context.

The most relevant feature is the degree of intrapsychic focus in the self-observations. The simplest self-observations are relatively global, unsophisticated forms in which the role of intropsychic factors is little recognized—for example, "Pushy people are offensive to me." The most complex forms show an increasing appreciation of the contribution of the self

to experience, so that the locus of explanation shifts from the outside to the inside of the self. "Pushy people offend me" becomes "I don't like pushy people because they remind me of my older brother, who always used to push me around because he was jealous." It is clear that the differentiation of the intrapsychic dimension allows a subtler and more complex understanding of the contribution of external as well as internal factors in experience—especially the motives and limitations of others. For research purposes (Hatcher, 1972), it is possible to establish and rank groups of self-observations according to the extent and quality of their intrapsychic focus, and so to construct a hierarchy of increasingly complex "*modes*" of self-observation.

This close look at the cognitive features of self-observation illustrates how an ego function is composed of many complex and subtle characteristics. Closer examinations of many ego functions remain to be made. For example, consciousness, reality testing, and the integrative function are relatively unexplored. Furthermore, ego functions seem to overlap and interrelate to a remarkable degree, and a systematic exploration of these interrelations would be desirable.

Self-Observation in Analysis

Experiential and reflective self-observation have different but related

roles in analysis. A good deal of the early work in an analysis is directed at modifying experiential self-observation. As time goes on, as interpretive work moves to discover and create new contexts for understanding the patient's behavior, reflective self-observation becomes increasingly important.

Experiential self-observation is the process that provides the content of the analysis. When they begin analysis, patients have two obstacles to overcome in their attempts to communicate to the analyst. First, patients are usually ignorant of the analytic situation and unfamiliar with the unrestricted self-observation required of them. Second, patients' defenses interfere with their efforts to observe their inner experiences richly. They need to be taught, to a greater or lesser extent, how to observe themselves. Miller et al. (1965) have suggested that the analyst encourages patients directly, and indirectly by example, in their efforts at self-observation. The analyst must interpret the specific inhibitions in self-observation that restrict its scope or meaningfulness. He or she will design confrontations with character traits having similar inhibiting and distorting effects on self-observation.

These efforts help the patient's self-observation become more autonomous, both from internal conflict and from compliance with the analyst. Miller et al. (1965) trace a sequence of stages reflecting these changes in spoken self-observation (i.e., self-observation communicated to the analyst). The sequence begins with a compliant, externally oriented,

unemotional form of communication they call "reporting" and culminates in an autonomous, inwardly oriented, emotionally rich form they call "imparting."

The analyst builds his interpretation on the patient's self-observations by proposing a new or revised context in which the associations can be understood, thus replacing old, stunted contexts. From this point of view, one may consider the neurosis to be the result of the burden of infantile, fantasy-ridden, and often unconscious contexts. These old contexts are restructured and assimilated into new contexts through interpretation. Hartmann (1939) describes this role of interpretation:

> Defenses (typically) not only keep thoughts, images, and instinctual drives out of consciousness, but also prevent their assimilation by means of thinking. When defensive processes break down, the mental elements defended against and certain connections of these elements become amenable to recollection and reconstructions. Interpretations not only help to regain the buried material, but must also establish correct causal relations, that is, the causes, range of influence, and effectiveness of these experiences in relation to other elements. I stress this here because the theoretical study of interpretation is often limited to those instances which are concerned with emerging memories of corresponding reconstructions. But even more important for the *theory of interpretation* are those instances in which the causal connections of elements, and the criteria for these connections, are established. We cannot assume that the ways in which children connect their experiences, and which later become conscious in the course of psychoanalysis, could satisfy the requirements of the mature ego, not to speak of the requirements of a judgment which has been sharpened by psychoanalytic means of thinking [p. 63].

The new contexts contained in interpretations reflect more sophisticated modes of understanding and so provide a more accurate and detailed picture of the patient's behavior.

In the analytic hour, the analyst's interpretation serves as a signal, activating the patient's *reflective* self-observation. Patients listen to the interpretation and—more or less consciously—review their recent behaviors and associations in the light of the new context. At first, the patient's ability to take a fresh look at his or her associations may be shaky. The interpretation raises new anxieties and touches on deeper secrets; the review may quickly be abandoned to the preconscious level of thought (Kris, 1956). As time goes on, these new anxieties and secrets, too, are interpreted, and the original subject returns again and again. Each time, as the associations emerge from the preconscious, they are better organized by the new context offered by the interpretation (Kris, 1950). The patient is able to take longer, more searching looks at the material from the new context until it becomes a more or less readily available perspective whenever the conflict arises. This gradual assimilation of interpretations leads the patient to make ever-expanding use of more complex contexts of self-observation. Progress is made from nonautonomous experiential self-observation, distorted by inhibition and character traits, to more spontaneous, freely ranging, affectively modulated self-observation. Reflective self-observation, at first vague and rigid, becomes both more specific and more encompassing.

These improvements are by no means independent of one another—in fact, the distinction between reflective and experiential self-observation is more heuristic than real. Interpretations of the defenses that block free experiential self-observation often imply a hidden neurotic context. "You have to be silent because you are threatened by some angry feelings for me" is an example. These interpretations guide the patient's associations into an implicit context—in this case, transference fantasies about the analyst's reactions to anger. A subsequent interpretation of these fantasies might fill out the implicit context and contrast it with the reality of the analyst—for example, "My silence repeats your father's silent reaction to your anger, when you were afraid that he was holding back an explosive rage at you." The activated reflective self-observation will assimilate this interpretation, which will begin to organize the patient's feelings about his anger, so that the next time they arise, his associations will move more directly to the transference fantasies behind them. *This feedback process linking experiential and reflective self-observation may eventually result in a flexible transition between the two in the patient's continued self-analysis after termination*.

Self-Observation, Insight, and the Analytic Cure

It is striking how little has been written about the analytic cure, not to mention the role of self-observation and insight in its accomplishment. There is, in fact, a certain mystery behind analytic efficacy, despite Freud's

complaint (1937) that, on this subject, "the interest of analysts … [is] quite wrongly directed. Instead of an enquiry into how a cure by analysis comes about (a matter which I think has been sufficiently elucidated) the question should be asked of what are the obstacles that stand in the way of such a cure" (p. 221).

Certainly it is possible to construct a theory of cure based on what we see of the results of analyses that are deemed successful: in fact, it has been done repeatedly. Freud's famous statement (1933) about insight and the therapeutic effect of analysis puts the argument succinctly: "Their object is to strengthen the ego, to make it more independent of the superego, to widen its field of vision, and so to extend its organization that it can take over new portions of the id. *Where id was, there ego shall be*. It is a work of culture—not unlike the draining of the Zuyder Zee" (p. 80).

The concept of context described above helps articulate this process of ego mastery. Every thought, every fantasy, every behavior of any kind may be seen as organized in a larger context. Psychoanalysis searches out meaningful contexts that help the patient organize—or reorganize—his disturbing fantasies, thoughts, or behaviors. Searching out and articulating the unconscious (or pre-conscious) context for a set of thoughts and behaviors may be valuable to the patient in and of itself. The hitherto isolated behavior and thoughts, and the context which makes them meaningful, are linked up

with other systems of meaning and influence in consciousness, enhancing ego mastery. They are placed in perspective, to put it another way, and tend to lose their earlier poignancy because of it. The interconnection of contexts circumscribes the significance of any one context, making each a part of a meaningful whole.

Loewald (1960) conceptualizes the value of insight in somewhat similar terms and includes the fact that the search for contexts is a mutual effort led by the analyst.

> The patient, who comes to the analyst for help through increased self-understanding, is led to this self-understanding by the understanding he finds in the analyst. The analyst operates on various levels of understanding.... the analyst structures and articulates, or works towards structuring and articulating, the material and the productions offered by the patient. If an interpretation of unconscious meaning is timely, the words by which this meaning is expressed are recognizable to the patient as expressions of what he experiences. They organize for him what was previously less organized and thus give him the "distance" from himself which enables him to understand, to see, to put into words and to "handle" what was previously not visible, understandable, speakable, tangible. A higher stage or organization, of both himself and his environment, is thus reached, by way of the organizing understanding which the analyst provides [p. 24],

The particular context used at any given time in interpretive work may capture the phenomena more or less adequately. What we might call a "trait" context (e.g., "It is just like me to drop things in the kitchen") may capture a good deal less of the meaning of a parapraxis than an "analytic" context (e.g.,

"I need to be and feel clumsy in the kitchen to ward off the triumphant, guilty fantasy of being a better cook, wife, and mother than my own mother"). It is important to keep in mind, however, a point that Klein (1958) discussed in relation to the problem of "exact" or "accurate" perception. He argued that exhaustive perception is impossible because there are an infinite number of ways in which reality may be viewed. He suggested that the only useful criterion is that perception be effective for the purpose it serves. A similar argument may be applied to self-perception. We cannot claim *a priori* that analytic self-observation is better or more adequate than trait-level awareness. Rather, we must specify the conditions under which one is more satisfactory than the other. Neurosis is the condition that is most interesting from the point of view of psychotherapy research—and the question becomes: is analytic self-observation more effective than trait-level self-observation in overcoming neurotic difficulties? If the argument about the role of contexts in psychoanalysis is correct, the answer must be yes.

Wallerstein (1965) observes that, in our thinking about insight and its relation to cure, we make a "tacit assumption that the two develop together and in appropriate correspondence to each other—that is, that the achievement of analytic insights in the process of making the unconscious conscious is the constant and the necessary and the (implicitly) sufficient concomitant of the achievement of the outcome goals, to be able to live and to work" (p. 763). Perhaps this assumption requires further investigation.

Further Developments in the Study of Insight and Self-Observation

Analysts have continued to investigate the motives leading to insight, the process itself, and the manifold interferences in the effort to acquire insight.

A series of papers by authors from the San Francisco Psychoanalytic Institute (Weiss, 1967, 1971; Sampson, 1976; Bush, 1978) have stressed the mastery-seeking role of the ego in analytic work. Freud accounted for the emergence of repressed instinctual drives in the transference by the repetition compulsion and the tendency of the repressed unconscious to seek actual discharge in behavior, particularly following the analysis of resistance. These authors find that the ego plays a much larger role in bringing forbidden or dangerous thoughts, feelings, and wishes into play in the analysis. The ego wishes to master and integrate the repressed, providing thereby the forward push to the analytic work. On the other hand, the ego makes continuous unconscious assessments of the risks involved in experiencing the repressed more directly and consciously (Weiss, 1971).

These unconscious ego assessments are based on the unconscious ego's erroneous ideas of the dangers posed by the repressed impulses. These ideas are based on infantile experiences and fantasies involving fears of castration, loss of love, loss of the superego's love, and separation, which are the major motives for defense (Freud, 1926; see also Bush, 1978; Hatcher, 1980).

Analysis of defense and resistance involves detecting and integrating these unconscious fears of the ego, bringing them into connection with the judgment of the mature ego. The ego then feels safe in allowing the repressed more direct expression.

We should note that this approach must come to terms with the role of the press of the repressed for discharge and the repetition compulsion as motivators in the analytic process (Friedman, 1969, 1977, 1978).

These considerations have direct bearing on our understanding of the process of insight acquisition. They are one aspect of an increasing recognition of the unconscious and preconscious mental activity involved in acquiring and utilizing insight. Kris's 1956 paper is again a landmark on this path:

> Interpretation naturally need not lead to insight; much or most of analytic therapy is carried out in darkness, with here and there a flash of insight to lighten the path. A connection has been established, but before insight has reached awareness (or, if it does, only for flickering moments), new areas of anxiety and conflict emerge, new material comes, and the process drives on: thus far-reaching changes may and must be achieved without the pathway by which they have come about becoming part of the patient's awareness [p. 452],

Kris calls the conscious understanding *insight*, and leaves the unconscious (or preconscious) connections unnamed. Some authors have chosen to call these connections *unconscious insight* (Nagera, 1978), a

preliminary stage in the development of conscious insight. Kris's (1956) description of the "good hour" connects with this idea. The patient's preconscious ego organizes the themes of his material leading to conscious insight. These hours represent the culmination of much previous analytic work.

Part of the challenge posed by these ideas is that they suggest that extensive understanding can occur and significant changes result from the work of the unconscious (and preconscious) ego. Insight has been linked with consciousness since the earliest days of psychoanalysis. Nevertheless, in his recent article, Blum (1979) calls our attention to an early case report of Freud's (1893) in which he provides mutative insight to a hypnotized patient. Blum was not trying to demonstrate the point at issue here. But Freud's patient, a mother who could not breast-feed her child, did not recall the interpretation Freud made when she awoke from the hypnosis.

There is increasing opinion, then, that the contexts we have described above may be established and utilized for change outside of the patient's awareness.

The Anna Freud-Hampstead Center Symposium on Insight, held by the Michigan Psychoanalytic Society in November, 1978, resulted in many reviews and new contributions to the understanding of insight. Many of these

papers were published as a supplement to the *Journal of the American Psychoanalytic Association* (Volume 27). Hansi Kennedy's (1979) contribution developed an important and little-studied aspect of the insight process, investigating the developmental factors that limit the child's use of insight. Many of the ego functions required to acquiring insight are detailed by Kris (1956), and Kennedy reviews the child's slow development of these ego capacities. Children's use of insight is limited by their inability to tolerate painful affects and their dominance by the pleasure principle; by their limited capacity for distinguishing reality and fantasy and to assess, understand, and process external reality and cause and effect; by their egocentrism, concrete thinking, and lack of capacity for abstract thinking; by their tendency to act instead of reflect; by their lack of frustration tolerance; by the lack of conflict over some impulses; and by their belief in the omnipotence of adults. In his recent paper, Nagera (1978) demonstrates how frequently these same problems persist into adult life, limiting the use our adult patients can make of the insight process.

It is still the case, however, that "insight is a *sine qua non* of the psychoanalytic process and is a condition, catalyst, and consequence of the psychoanalytic process" (Blum, 1979).

Summary

Insight has been a key tool in psychoanalytic treatment since its earliest days. Analytic thought has come to view the acquisition of insight as a complex process, in which the ego function of self-observation is a major component. After tracing the evolution of this line of thought, detailed consideration is given to self-observation; its nature, its structure, and its place in the analytic process.

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Notes

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