THE PROBLEM OF INSIGHT: A COMPARISON BETWEEN CHILDREN AND ADULTS*

BY

Humberto Nagera, M. D.

(Professor of Psychiatry of the University of Michigan; Chief, Youth Services of the University of Michigan; Training Analyst, The Michigan Psychoanalytic Institute)

*This paper is a very extended version of my remarks as the Moderator of the Anna Freud Symposium on Insight. It took place in November, 1978 at Detroit. Papers were contrib— ited by Anna Freud (in absentia), Hansi Kennedy, Harold Blum, Peter Neubauer and Marianne Kris. It was first read in Span- ish in Monterrey, Mexico, on the occasion of the inauguration of the "Instituto de SaILud Mental. (December 1978).

A) GENERAL CONSIDERATIONS:

The definition of insight in the Webster's Dictionary is as follows: "1) the ability to see and understand clearly the inner nature of things, esp. by intuition. 2) a clear understanding of the inner nature of some specific thing. 3a) Psychol. awareness of one's own mental attitudes and behavior, b) Psychiatry. recognitio.n of one's own mental disorders." (p. 729) The first three definitions with slight modifications are representative of the use of the term in psychoanalysis.

Insight is frequently used as synonimous with understanding, with knowledge, be that of the descriptive or acquaintance type (to use Bertrand Russell's terms) , synonym of corn— prehension, of introspection, of a sudden realization o~ u~-~ (Standing, etc

The value of insight in psychoanalysis is well established and has been discussed frequently. Richfield (1954) for example, says: "The criterion of whether a given form of Psychotherapy is analytic has been made to rest upon the undoing of neurotic defenses through the achievement of insight, especially through the insight gained by the interpretation of resistances and derivatives impulses expressed by the patient in his transference." ~page. 390)

More recently Blum (1978) ~ Neubauer (1978) , Anna Freud (1978) and Hansi Kennedy (1978) have discussed extensively the question of insight and its implications for child and adult analysis.*

Nevertheless, insight remains an obscure subject. The origin of the term itself is not easy to trace. Further, through the years it has acquired a variety of meanings. Sandier et al. (1973) believe that the term was borrowed from psychiatry. It is no.t without interest to point out the fact that the term does not appear listed in the general inde~c of the Standard Edition. Bluxn (1978) found the tern in a passage of the Interpretation of Dreams. Personally I know only of a handful of occasions in which the term appears in Freudts work.

There are not only different degrees of insight, but many varieties of it. Thus, for example, we hear of deep, emotional, experiential or psychological insight as a contrast to superficial, verbal or intellectual insights. Richfield (1954) says about them: “If, for example, a person is aware that various psychological factors interfere with his social adjustments and the fulfillment of his capabilities, his recognition that he needs help in overcoming his adaptive limitations is considered to be a manifestation of insight. Such insight is helpful in diagnosis, classification, and prognosis, but it is considered to be of

*At the “Anna Freud Symposium” in Detroit, November, 1978.

comparatively insignificant therapeutic importance. These insights are generally considered to be “verbal” or “intellectual” and to differ significantly from what has been termed genuine “psychological” insights.

“Psychological” insights are said to consist of some understanding or appreciation of the motives and genesis of symptoms, but among this group of insights important d.if-~erences are to be noted” (p. 392)

Of course there is as well the question of patient’s insights vis a vis the therapist’s insights. In both cases, but particularly in the latter, the meaning is frequently that of understanding. But the word itself has some kind of mystical connotation.

Reid and Finewsiger (1952) concluded that “any instance of insight necessarily entails some cognitive act by which the significance of a pattern of relations is grasped. Insight is said to be cognitive as distinguished from the conative or affective states which do not, as such, express inferences, make claims as to truths, or yield knowledge.”

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The same authors distinguish among three groups of insight, the intellectual, the emotional (with a subvariety) and the dynamic insight -— they are defined as follows:

1) Intellectual insight:

"By 'intellectual' insight is meant a cognition in which neither of the terms in the relation whose significance is grasped by the act of insight is an emotion. Since it is granted that any insight is by definition intellectual, this variety is called 'neutral'. The insight is neutral with respect to emotion." (p. 397)

2) The emotional insight:

"This is said to be one in which some relevant emotion is a part of the subject matter grasped by the patient."

This type is to be distinguished from the type of insight that makes the patient conscious of some fact which then "cognitivelLy mediates" an emotion. In other words, "an emotional response is released or set off by an insight which, unlike the first variety of emotional insights, need not itself be about an emotion." (p.397)

3) The dynamic insight:

In their opinion this is the "summun bonuxn" of analysis." "Such insight is 'dynamic' in the systematic freudian sense of penetrating the repressive barrier and making the ego aware of certain hypercathected wishes that were previously unconscious." (p. 398)

It is said of it that it leads to therapeutic changes "through the 'economic' shifts brought about with their consequent alterations in the unconscious cathexes on 'thought—contents' at various levels of organization in the symbolic

behavior of the patient." (p. 399)

Richfield (1952) proposes instead of the above the terms "descriptive insights" and "ostensive insights" with meanings similar to Russell's knowledge by description and knowledge by acquaintance.

Myerson (1960, 1963, 1965) introduced the concept of modes of insight implying not only the type of insight but the process that leads to it. Thus, in 1965 he referred to analytic insights and. the reality oriented insights.

One other important problem that is not well understood is the very significant differences in the therapeutic results of the various forms of insight. Indeed, insights do not always lead to an improvement in the patient's condition but a significant deterioration of it. The best example of this is that of the negative therapeutic reactions.

Kris (1956) described the "function of insight" as the end product of a multiplicity of combined ego functions. He addressed the following as essential:

1) An ego capacity for self-observation particularly reflective or critical self—observation.
2) An ego capacity to control the discharge of affects.
3) An ego capacity to tolerate unpleasant affects.
4) An ego capacity for controlled ego regression.
5) An ego capacity to utilize the synthetic and integrative capacity for the purposes of insight.

In the same paper Kris (1956) added that in terms of insight there are enormous differences among individuals. “It is as if in every case the function of insight was differently determined, and its impact differently embedded in the balance of the personality” (p. 450).

B) THE REASONS FOR THE DIFFICULTIES OF ACQUIRING INSIGHT IN CHILDREN:

At the Detroit Symposium Mrs. Kennedy (1978) described some of the reasons that in her opinion interfere or make it impossible for the child to acquire insight, particularly in children under four or five years of age. To those she referred to I have added many others that seem to me relevant as well. The list that follows is valuable because we can immediately note that many such reasons influence very significantly the adult's capacity for insight, an aspect that will be discussed in detail later on in this paper.

1) The child's inability to tolerate painful affects as well as their automatic tendency to avoid them. This in—cludes too children in the latency period.

2) Related to the above is his tendency to turn into its opposite painful affects, i.e., sadness to joy as indeed happens in the case of a death such as mother or father.

3) related too to the first two points is the fact that the small child's mental processes are governed by the pleasure principle. The change to the reality principle takes years and even then it remains for some time in an unstable con-dition when in the presence of significant conflicts or anxiety.

4) The child's limited capacity for reality testing (in the sense of distinguishing his fantasies from reality) as well as his limitations to assess and understand external reality. Naturally, all this is very variable anddependson the age of the child. It is usually not much of a problem as latency advances.

5) The level of cognitive development at the various ages explains among other things, the restricted capacity of the child to assess, understand and process external reality. It makes too for a constrained capacity to understand the relations of cause and effect. In the small child that capacity is essentially non—existent and it only develops very gradually. It is generally well established during the latency period but much more so towards the end than towards the beginning~

6) The specific characteristics of children's thought processes at certain ages. When small it is characterized by concretism, magic and animism. The capacity for abstract thinking increases with age and is usually well established by latency though for some time there is some overlap between them. Furthermore, the capacity for abstract thinking re-gresses to concrete thinking for as long as the former is not well established or under the influence of traumas, conflicts and anxiety.

All this allows us to understand the little patient that Mrs. Kennedy (1978) refers to who says~happily to her therapist "'Let's throw all, the hurts out of the window' and proceeded to enact this with much satisfaction." Or the four year old Rose Mary when she suggests to the therapist that they ought to lock the monsters (of her fantasy) in the drawer so they will starve and be dead."

7) The typical tendency of the young child towards action. For this reason, his impulses and affects are retranslated immediately, without a reflexive pause, into specific behaviors, such as ~ embrace, a kiss1 a kick, or spitting, etc.

8) The restricted ability of the child to tolerate frustrations, postpone gratifications, accept substitutes and to sublimate. Progress in these areas is slow, but by latency all of them should be significantly present. Nevertheless, there is much variability as to the levels reached and in some cases observable defecits persist into adulthood.

9) In children, and more particularly so in the very young, the developmental processes take place simultaneously and multidimentionally. Thus, there is no real distance, no space among them in many cases. If we add their lack of concepts concerning time, such as before, now, after or yesterday

today, tomorrow or in the past, the present or the future we can understand that things are felt as compressed by the child. Given that in adult life the passage of time spac—iates events and experiences and given that in analysis ref-erences to the past (and its roots) play such a significant role we can see the difficulties that this introduces in the treatment of young children.

10) The limitations of language in the young child and the consequent restrictions in his capacity for verbalization. As the result of it, it is not easy for him/her to translate into thoughts (with words as symbols) his needs, impulses, affects, wishes and experiences and similarly to verbalize -- them. Thus, we can understand better not only his difficult-ies to “manifest’t insight but his difficulties to free assoc-iate as well.

12). The limited capacity for experiential, critical, sus-tained self—observation.

12) The egocentric tendencies of the child, particularly strong during the early stages.

13) The inability to regress in a controlled manner at the service of the ego.

14) The fact that for the child, many of his impulses and wishes are non—conflictual though the adults may consider them inappropriate given the age of the child and the edu-. cational requirements -

15) The child's need to use defence mechanisms such as displacement, negation and externalization to deal with conflict and anxiety. This is true too of the latency period and can persist in a more moderate form during adolescence. By that time the tendency to externalize is substituted in good measure, due to the ego advances, for the rationalizations and intellectualizations typical for that stage.

16) The belief of the young child in the omnipotence and omniscience of the adults.

of motivation

17) The lack or relative lack/in many of them for treatment.

Most of the variables mentioned are, as we noticed, the resultant of the degree of ego development reached at various stages with its concomitant functional capacities. As time goes by and as the child grows and develops he progressively approximates the functional skills of the adult.

Mrs. Kennedy (1978) believes that once the latency period is reached the child is functionally capable (at least to a degree) of acquiring insight. I share her opinion. Yet, as she says, the special characteristics of development during this stage are such that the latency child has to vigorously oppose many of the processes that will make possible the insight and the insight itself.

The adolescent is of course quite capable of insights but given some of the characteristics of the stage, he too —

like the latency child - must fight against it.

Perhaps more important is to call your attention to the fact that all the variables mentioned for~the child, where they are present for reasons of the stage of development, can be seen in isolation or in various combinations in our adult patients. This is due sometimes to specific ego defecits acquired during development that could not be mastered, and because at other times/some functions get caught in conflictive sit— uations that if unresolved satisfactorily will seriously interfere with such functions in the adult ego. It is these two sets of reasons that explain why many adult patients are as resistive to the acquisition of insights as are children, and in many cases for the very same reasons or very similar ones. It is my opinion that the careful study of the variables or factors in development that interfere with the acquisition of insight in children will contribute to clarify many of the difficulties in this regard that we freauently observe in our adult patients.* Here then, we can see another important contribution of child analysis to the analysis of adults. As Kris (1956) said: “the complexity of ego functions which participate in the process of gaining and using insight may well account for the wide variations of the impact of insight on individual cases.” (p. 453)

*This distinction between the acquisition and the use of insight by the ego will be discussed in another publication dealing with negative therapeutic reactions.

C) CLINICAL CO~ARISONS BETWEEN CHILDREN AND ADULTS:

Mrs. Kennedy's paper (1978) and my own experience as an analyst for children and adults have convinced me that the study of the specific difficulties that interfere with the acquisition of insight in children, lead us to find the prototypes of similar difficulties observed in our adult patients.

Thus, for example Kennedy (1978) while discussing some children's characteristics that of necessity interfere with their capacity to acquire insight says that "Under the immediate impact of strong feelings the young child will be quite unable to reflect; and he will often need to be controlled". This is the reason why as she points out 'The analyst's constant endeavor to put the child's wishes and feelings into words aims at channelling actions into thought and verbal expression". All the above is particularly true of children under five years of age since by latency the child is capable of exercizing much better contro Mm this regard. A little reflection show us some of the parallels with adults. The adult too, under the impact of strong emotions cannot function efficiently in analysis, and it is for this reason that in patients undergoing '~motional crises" of various types analysis may not be indicated for as long as it is present. In those patients already in treatment such "crises" may and frequently do become a temporary disruption for the analytic process. One reason for this is that the capacity for reflective or critical self—observation may be lost temporarily, absorbed as the patient is by the "crisis" itself. Obviously, in such circumstances the capacity ~or insight is highly compromised.

One other parallel that can be established is the one with the tendency of many adult patients for acting out. Naturally, the sources for acting out are many and variable, but in many cases are related to itnmaturities or deficits of the adult ego, that are for the child perfectly normal and the reason for his behavior. I am referring here to the imperative character of his drives and the limited controls he can exercise over them, his low frustration tolerance, his poor capacity to accept substitutes and to use sublimation.

But it is precisely all these variables that favour the tendency to act out in those adults that retain such characteristics. The tendency to act out is one of the greatest enemies to the capacity for insight both in children and adults.

Let us now consider the child's capacity for self—observation. Unquestionably, it is present in children three, four and five years of age though it may differ somewhat from that of the adult. The child can certainly tell us his feelings, but in contrast with the adult he cannot do so in the sustained, consistent and controlled form of the latter. He does it in the form of short lived sudden flashes and eruptions. But the child up to the age of four or five is much more in contact with his needs, feelings, wishes and impulses than the latency child, the adolescent and the adult. He is not only more in touch with them but communicates them readily. He tells us how much in love he is with his mother, or how he hates his father, or how he would like his younger sibling to he sent back, kill him, etc. We can understand this easiness in communication between his ego and his id,

if we consider that his super—ego is still not fully structured and functional and consequently somewhat tolerant of these impulses. It is possible too that such behavior is due to the combination of the imperative nature of his impulses concomitant with limited super—ego structuralization.

That the child of this age certainly lacks is the capacity for self—observation in a reflective, critical and sustained manner.

But, are children of this age incapable of insight? I do not think so, though it manifest itself in a different way and has imposed on its form of expression the limitations resulting (torn the degree of development achieved by the ego and as such, all thnse functional characteristics (such as fleeing from pain, etc) that are so well described in Mrs. Kennedy's paper.

As for the latency child and the adolescent there is no doub.t that they not only possess the capacity for self—observation hut that they can do so in a reflective and critical manner. Nevertheless, the developmental characteristics of these two stages are such that not infrequently they are forced to fight this function and the acquisition of insight.

This function of self—observation, especially reflective self—observation is one among many ego functions involved in the acquisition of insight, a fact well established by Kris (1956). It is perhaps the only one that has been studied in some depth, for exampLe by Hatcher (1973) in his paper "Insight and self—observation~~. Some more efforts in this direction will contribute to clarify some of the existent confusion.

If we consider briefly the adult situation in this regard we know that the capacity for reflective, critical self—observation is one

positive indicator for analyzability. We know as well that when this function is damaged either by primary reasons (ego deficits, marginal intelligence, etc) or by secondary reasons (type of conflicts and defenses used, etc.) treatment progress would be compromised ‘due to the con—strictions that such factors impose on the acquisition of “insight”.

Another variable already mentioned is the normal child’s tendency to actively avoid conflictual and painful situations and the universal tendency they demonstrate to externalize and negate such events. All analysts are well aware of many adult patients that retain these characteristics and behave, both in life and in the analytical situation, in a similar fashion. It seems as if such patients have a fixation to these stages, a fixation that favours the utilization of the mechanisms mentioned well pass the developmental stage where they are not only legitimate but normal. In such patients, sooner or later we come across the conflicts, traumas and events that in the genetic sense explain this abnormal tendency. Of course, we all know the difficulties that the excessive use of externalizations can create in terms of the acquisition of insight.

Mrs. Kennedy (1978) makes reference to the fact that if the conceptual skills of the child remain tied to magical thinking the treatment process is influenced by it as well as his capacity for insight. She mentions for example a little girl, six years old, who says about her therapist: “If he was really clever he would do magic.” We are thus reminded of the type of adult patient who expects the therapist to improve or cure them magically”, angrily rejecting every effort he makes to have the patient observe himself, free associate or make use of the interpretations.

These are patients that will wait indefinitely for the therapists ‘magic” and do not wish to work or suffer in order to resolve their emotional difficulties.

The same happens in the case of the child’s belief in the omnipotence of the adults. Thus, our inability to make things better quickly, to reduce the conflicts and anxieties, as well as our inability to gratify many of his needs, is erroneously interpreted as Mrs. Kennedy (1978) remarks. To him, we simply do not want to help, with the consequent aggressive and hostile reaction. Of course, this is true too of those adults who had retained such a belief and that for this reason add themselves to the number of patients that expect to be cured by “magic” means.

Other child patients that she mentions are incapable of talking during the sessions for some time because they feel extremely anxious, guilty or ashamed. This leads to a conscious withholding of information or a deliberated distortion of the facts for variable periods of time. It is my opinion that no adult analyst can avoid a “deja vu” experience in relation to all the above.

Now, let us look for a while at the role that egocentrism plays in children. We know that it is very marked up to the age of four or five. During this time every event is interpreted in reference to the child’s ego. Such a tendency diminishes gradually after the age mentioned but is still present to a lesser degree up to the age or ten or eleven. A more or less Important remanent of this is retained into adulthood where it attaches itself to the narcissistic elements present in any given personality whether normal or pathological. In some cases the persisting ego—centric component is significant and as such influences the type of personality, its pathology,

the capacity for insight and even the prognosis of the patient.

This egocentrism is a highly distorting factor that among other things interferes with understanding causality (cause and effect) and with the capacity to evaluate objectively external reality. ‘Naturally, failures in this regard are an important obstacle for the acquisition of “genuine insights”. I am using this term intently in order to differentiate it from “false insights”. I mean now those Connections made by certain patients — either spontaneously or after an interpretation by the therapist —, for defensive purposes. In other words, with the clear intention of avoiding genuine or significative insights. In this way they distort the aims and contexts of the interpretation, and manage to establish a number of false connections, aimed at reconstructing, in the genetic sense, a concatenation of events by means of which they try to explain and justify their behaviour, their symptoms and psychopathology, etc. Typically, these false reconstructions and the subsequent false insights are designed to absolve the patient from all responsability mostly through massive externalizations, where the “guilt” is placed on environmental factors or on the human objects of that environment.

The therapist is in fact surprised by the persistence of this behavior on the patient’s side as well as by his reactions when the therapist tries to point out his error, what he is actually doing and the reasons for it. It is one of rage and hostility coupled with accusations that the therapist is incompetent stupid or incapable of understanding the patient. Such a situation can be observed in various degrees of malignancy in patients with a variety of narcissistic problems where the idea of the self as perfect

must be maintained at any prize. This is true of some borderline patients with narcissistic problems, and even of some neurotic patients with a large narcissistic component, but in this latter case the patient's reaction is not as malignant and he responds to the appropriate interpretations.

Let us look now at the limited capacity of children for regression at the service of the ego, something that we require of adults during psychoanalytic treatment. But such regressions seem contrary to the basic purpose of development during childhood, since the trend is to leave behind, bury and master wishes, needs, gratifications and behaviors that become inappropriate as the child moves forward in his development. It is frequently said for this reason that at this age and in some ways analysis runs contrary to the developmental tendencies. To this we must add that the ego controls of the child over his impulses is precarious particularly where it has been acquired recently. The ego fears any regressive tendency feeling uncertain of its capacity to remain in control. This state of affairs, typical for children applies Co some adult patients with specific ego deficits, a situation that makes them fearful of losing control over their impuls~in general. Still in another casa,the ego fear is more specific and related to certain conflictual areas where ego control is maintained only at great expense. Naturally, when the analysis approaches such areas the ego strongly opposes the regressive tendency out of its fear of losing control.

Frequently, with the child (and some adult~ we can observe — either spontaneously through the regression or as the result of inappropriate content interpretations —, a break—through of instinctual impulses, a sudden

onrush of frightening phantasies with a total, or near total disruption of the ego.

If this happens frequently, the child may run away from his session in a marked state of excitation, even a panic, or in a mdre controlled manner by asking the therapist permission to go to the toilet, etc. The adult patient may stop treatment on the basis of various excuses and rationalizations, or more dramatically, in a kind of phobic state about the treatment and/or the therapist. La this group are included borderline patients with ego deficits, in whom certain types of content interpretations produce a paradoxical negative reaction. That is, they do not reduce the nature of the conflict or the anxiety present but have the effect of a seductive action and as such increase anxiety at times to traumatic proportions. It is this that explains the phobic reactions produced by some patients. Of course, the above is more acutely experienced in the case of children given their limitations in their abilities to control affects and impulses once they reach a certain height and given the demanding imperative quality of their needs. As Mrs. Kennedy (1978) says: “Under the iimnediate impact of strong feelings the young child will be quite unable to reflect; and he will often need to be controlled.”

One important difference between children (especially the small child) and adults is that in the former many of his needs, impulses and wishes are non—conflictual. The adult world may take objection to them either because of the age of the child or because of educational demands that are considered necessary. Obviously, the above makes the phenomenon of the insight much more difficult. But even in this area we notice some similarities with the

adult. I am referring here to those patients, where a given instinctual impulse or group of them are ego—syntonic. Thus, the ego and super-~ego attitudes towards them does not favor the process of insight in their regard. Certain types of perversions are typical examples. of what I have in mind.

One other basic difference between children and adults concerns the area of motivation whose importance can hardly be over—estimated. By contrast with the adult, many children are poorly motivated. This is partly due to the fact that many of his symptoms are ego syntonic and as such may disturb other people but not the child himself. But more important still is that the.child~s situation is covered by a protective shield.

Thus for example, if the child's symptoms interfere with his ability to work and adjust at the school, the teachers and parents may become concerned but there are not direct, immediate consequences for him. lEn sharp contrast, if the symptoms of an adult lead. to an interference with his capacity to work, the consequences are enormous and immediate. Given that this is the way he earns his life and the sustenance for him and his family (wife, children, etc. ~. we can understand the significant disruption that takes place automatically. We can understand too why there is such a marked difference in the motivation of the one and the other.

If we address ourselves now to Mrs. Kennedy's (1978) example where the child remarks to his therapist: "You will think that £ did this because of such and such a reason but you are wrong, I did it because of this, that or the other, etc.". This type of phenomenon is of common occurrence

in the treatment of adults. The same is true of those interpretations that are actively refused or simply ignored and where nevertheless the subsequent analytic material shows meaningful changes or where even symptomatic and behavioral changes may be observable; or those children where the need to comply is so prominent that they accept interpretations without any understanding; or those small patients that refuse to speak about specific subjects during the sessions because they would be reminded of painful events that they want to avoid; or those children during the latency period or adolescence that identify with the analysing function of the therapist but only in order to apply it to others; or the children~s preference for external solutions that alter the world or the objects in it (‘making everything pleasant) to the internal and most painful solutions; or finally the special difficulties that the handling of the transference poses in same cases. But none of the above fails to bring to the analyst’s mind innumerable similar examples from his adult patients. All this leads me to the conclusion that the differences between children and adults in terms of the forces or resistances that oppose the~.phenomenon of insight are at best minimal and possibly non—existent. The only difference is that the child is entitled to these reactions as a developmental right, a right to which the adult is no longer entitled. One has the definite impression that some among the multiplicity of reasons that can interfere with the manifestation of insight in children, prolong themselves into adulthood in one area or another and in various combinations, according to the vicissitudes of each individual’s development. And this is so in spite of the fact that

many of the ego “deficits” observable in the child (related to the stage of development) have been superseded in the adult.

We cannot but be surprised at the great complexity of the processes that lead to the acquisition of insight, the large number of variables that are involved in it and in consequence, the easiness with which the process can be interfered with or become inoperant.

Of course, in children many of these factors or variables are active symultaneously and may become cumulative in their effects thus blocking the possibility of the child’s production of insights similar to those of the adult in ideal conditions. In adults it is generally one or another of these various factors that interfere with the process but rarely all of them acting symultaneously.

The situation is further complicated because we take as the definitional model of the “insight” the phenomenon that becomes manifest in the adult under ideal conditions and this adult form we apply to the child concluding then that the child is not capable of “insights”. It is my opinion that the child produces “insights” but that its characteristics are quite different from the ones observable in the adult. The difference consists on the one hand, that in the child’s case the experience cannot be verbalized and certainly not with the adornments and elaborations that some gifted adults are capable of. And on the other hand, all the many factors already mentioned are strongly opposed to the contents of the insight entering consciousness that is, becoming conscious. If that is so why do we expect them to verbalize their insights and why do we conclude from their inability to do so that

the child, especially the latency child is not capable of producing insights? rt seems to me more logic to conclude, given that the processes that lead to insights and the consequences of it are — as we have seen — observable in children, that the child produces insights but that they have their own characteristics and references and are naturally different from those of the adult.

As Anna Freud (1978) says: “With children the bulk of their resistance, or at worst their total unwillingness to be analyzed thus stems from their ego’s age — adequate preference for clinging to its own methods for safeguarding or re—instating well—being and for their inclination to reject all others. Analytic insight belongs to the latter category, arid it taxes the therapist’s technical skill and ingenuity to lead his patients towards accepting it.”

0) THE ROLE OF THE PRECONSCIOUS EGO IN THE ACQUISITION OF INSIGHT:

The acquisition of insight is an ego function. It results from ego activities that combine in' various ways a multiplicity of its functions to achieve this aim.

Our actual knowledge of these functions is poor and this is particularly true of the organizational levels reached at the various ages and in the early stages of development. This applies too, to the synthetic and integrative functions of the ego that play such an important role in the production and acquisition of "insight". We can only be certain that the degree of structuralization reached in the young child is limited, a fact which of course influences and determines his functional capacities.

It would be very helpful from the structural point of view if we could determine which contributions are made to the process of insight by the unconscious ego, the preconscious ego and the conscious ego. It is my opinion that the greatest contribution to the phenomenon under consideration comes from the preconscious ego. I am referring here to the processes that lead to the insight and not to the end product, the insight itself in terms of the contents that finally reach and define themselves in the conscious ego. I believe with Kris (1956) that "some and perhaps all significant intellectual achievements are products or at least derivatives of

preconscious mentation." (p. 447)* If we accept this proposition and the need to differentiate between the process and the end product, we must accept too that our present knowledge of the functioning of the preconscious ego is in general very limited but even more so in the case of young children. Thus, a valid question in this regard would be at what point or at what age does the preconscious ego acquire the functional characteristics typical of the later stages? Could it not be the lack of certain functional capacities of the preconscious ego (and to.some degree of the conscious ego) that determine the child's inability to acquire insights of the adult type during the first three, four or five years of his life?

Yet, if this is true, how can we explain then the enormous successes that frequently follow the treatment of children in this age group? Possibly, the best answer to it to be found is the last paragraph of Mrs. Kennedy's paper when she says "The analyst's interventions organize and articulate what the child is experiencing. Whenever the analyst interprets and expresses 'his insights' in terms that the child is capable of understanding, some new integration will take place . . . The need to be compliant, the wish to please the

*See also, Kris, E., (1950) "on preconscious mental processes": Psychoanal. Quart., 19, 1950 (reprinted in Psychoanalytic Explorations in Art, International Universities Press, New York, 1952.

therapist and to get approval, will help reinforce a wish for understanding and this will ultimately contribute to treatment outcome." Of course, she applies the above to children in general though it seems to me particularly reiLe—vant for children under three or four years of age. Thus, what she says with the addition of other factors (that I ignore in this paper) are the ones that may explain the therapeutic success. But on the other hand we must note that her quoted statement applies in its entirity to the adult situation as well. Perhaps, it helps us to understand too the significant improvements that we frequently observe in adult patients that could not be characterized by their capacity to acquire insight.

In my judgment it is essential to distinguish between the capacity to produce or acquire insights and that the phenomenon become manifest — once it has occurred — in our conscious mind, as is expected typically of the adult cases. It is this type, variety, or form of insight, that analysts have chosen to define the term. It seems very likely that for this reason, the external manifestations of the insight (the verbalization for example) have been given undue weight at the expense of the very substance of the phenomenon that takes place internally and silently.

By the time the child is four or five years of age the general tendency seems to be to assume that the activities of

the preconscious ego are representative of the later stages, though somewhat limited still by the ego characteristics of the stage.

Once we have accepted that the "insight" is possibly the product of preconscious mentation it is appropriate to ask what then is the basis of the difficulty in the latency child to manifest insights in the adult model.

I think it possible and perhaps even necessary to postulate that the diffidulty at least in part, consists in raising the end product, the actual contents of the process of insight, the "insight itself" to conscious ego levels. In other words it seems that the preconscious ego of the latency child is basically capable of all the functions (though with some limitations) that in the adult leads to insights. Nevertheless,for some reason the actual contents of the insight rarely if ever reach the conscious ego. Could it perhaps be this the difference between the latency child and the adult in terms of the capacity to produce insights? If this were so, we could understand why he can not verbalize it or communicate it to the therapist since it does not reach consciousness. We have already seen in this paper many of the reasons that could either by itself or combined in various

ways explain why the work of the preconscious ego can not reach a conscious level in the child or even why he actively opposes the presence of such contents in consciousness.

Earlier, I stated that it seemed possible to me and perhaps even necessary to postulate that the difficulty in the latency child consists in his inability to raise the relevant preconscious contents of the insight into consciousness. Two important clinical arguments or reasons support this thesis. The first one is that though the child can not make manifest the insight in the model of the adult, the outcome of our interpretations even though they may be actively rejected by the child is a significant change, an improvement, a modification or even an erradication or disappearance of the symptoms, abnormal behaviors or a correction and even a lifting of ego restrictions and no less important a restoration of the normal processes of development.

The second reason comes from our experience with adults. Though it is generally true that those adult patients with limited capacity for insight usually carry a more reserved prognosis in terms of the result of treatment, all analysts are familiar with exceptions to this rule. In other words, patients in whom the conscious manifestations or expressions of insights are very transitory and at times just minimal or non—existent, patients that nevertheless improve markedly. I mean here those patients where the actual changes are legitimate and the result of the interpretative work, but I am

excluding those cases, where the improvement is a transference phenomenon or due to the excessive utilization by the patient, of the multiplicity of non—interpretative elements that form part of the analytic procedure whether we like it or not, such as corrective emotional experiences, support, etc.

Kris (1956), referring to the various degrees of consciousness reached by the insight said: “Interpretations 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 - drive on: thus far—reaching changes may and must be achieved, without the pathway by which they have come about becoming part of the patientts awareness” (p. 452).

All the above may suggest that “insight” as defined for the adult (reaching consciousness and verbalization) is a process with two stages. The first stage takes place in the preconscious ego (and as such is unconscious) . This is applicable not only to the process that of necessity is always unconscious but to the contents of the end product, the “insight itself”. In a second stage that may or may not follow the first one automatically that “content” is raised into

conscicusness.* The latter is characteristic for many adult insights, but not so for children. But as we have noted the large majority of adult “insights” do not’ reach conscious—ness,though they contribute in a very positive way to the treatment progress, reduce conflict and anxiety, etc. Suddenly we now face a contradiction with the definition of insight (in the sense of it being conscious), something similar to what happens in the case of the unconscious sense of guilt. Nevertheless, that in itself is no argument against the reality of the mechanisms involved, it only means that the term chosen to describe the process is unfortunately quite inadequate.

Another important consideration follows naturally from the above that is, that there are qualitative differences between various types of insight and particularly between the “insight” that reaches consciousness and those that remain unconscious in the dynamic sense. This is so much so that at present, — rightly or wrongly — , the non—plus—ultra among insights is the one in which consciousness partakes fully. This is the ideal of the psychoanalytic and dynamic therapies, at least at this point.

*Here Freud’s concept of another type of censorship (with a different function) between the preconscious and the conscious ego suggests itself.

E) INSIGHT AS A NEGATIVE FACTOR:

Up to this point we have mostly considered the positive value ascribed to the insight in the analytic and dynamic therapies. Yet, there are exceptions to this rule. The prototype here would be the negative therapeutic reactions where-the response to interpretations producing insight is not, as we would expect, a diminution of anxiety, shame, guilt or a step towards symptomatic improvement, but just the contrary. Instead of improving the condition of the patient worsens and deteriorates markedly, a response that repeats itself with every new acquisition of genuine insights.

Genuine insights, false insights or pseudo—insights can and are frequently used by patients as a resistance., as a defense-mechanism, with very detrimental results for the treatment.

Kris (1956) has described this in detail. Thus for example, he refers to the type of patient that is inclined to accept and make its own all of the analyst's interpretations and "insights" about the patient. In these patients, the integrative function is in itself operative, but not in an autonomous form. In fact, its aim is to win the analyst praise, or love, or a "fusion" with him/her. In other words, it is not only that the aim of insight is sexualized hut that the process itself is sexualized. In some cases, primitive phantasies hide behind this fusion. The danger of this type of insight among other things, as Kris (1956) points out is that it does not last beyond the period of the positive transference.

Other patients produce genuine insights with the sole aim of replacing the analyst and its function. These patients frequently have conflicts around the polarity activity—passivity, or severe passive—hon~sexual longings where the therapist' s interpretations are felt as ax~ intrusion, in fact "a penetration." The latter must be actively rejected, or instead the patient produces its a~n interpretations and/or insights, thus avoiding the "penetration." Still other patients will behave in a very similar fashion when they are riddled by conflicts around conpetition or conflicts with their aggression. that are never e~cpressed directly but by ir~ans of an intellectual contest where they try to beat their adversaries...

We referred earlier to the type of patient that distorts the interpretations of the analyst, recorrtining its elen~nts to produce its own insight" or rather its ~n "false insight". Externally this "false insight" may be accompanied by all the qualitative characteristics of the "genuine insight" including the classical aha!. Naturally, this patient is endeavoring to avoid the genuine insight that for one reason or another represents a serious danger to him. Many such cases are severe in nature aid frequently borderlines. The intensity of this "false insights" is such that on occasion they acquire many of the characteristics of a delusional idea or an organized delusion. When this is the case, treatxrent reaches a dead end. Every effort of the analyst to find a solution to the "impasse" lead to a paradoxical response. One is locked at as dull, with no empathic capacity, unintelligent and as such not able to understand the patient and his problems. In the end, when it is no longer possible to keep control over the situation the patient abandons the treati~nt

in a stage of rage and frustration. Frequently too, this type of patient will re—enter treatment with another therapist. All seems well up to the point where the central Conflicts of the patient are approached. At that point, the cycle repeats itself so that this type of patient would have been in treatment with three, four or more therapists at different times during his life.

There is the case too of the "brilliant" patient capable of ~roducinq "magnificent insights" that manages to seduce the analyst, who in turn rewards the patient with his own "magnificent insights". The treatment then becomes what can only be described as an "orgy of insights". Such situations are a massive exercise in intellectualization that in reality do not lead anywhere. Those analysts that have the experience of conducting second analysis may once in a while come across what I have described. What is surprising to us is the fact that the patient has vivid recollections of many of his insights, that are genuine enough in terms of its contents and yet the symptoms, behaviors, character and inhibitions present were not modified at all. This shows that though the insights may have been genuine in terms of the contents they were not experiential but intellectual in character. As you will expect this patient will try to re-establish the "orgy" of his first analysis with the second analyst. If the latter is not seduced and confronts the patient with the defensive character of his behavior the patient feels humiliated, becomes enfuriated complaining that we cannot

understand, or are stupid and lacking in talents. This type of resistance must be thoroughly dealt with before the analysis can proceed on its normal course.

The experience of patients in their second analyses frequently highlights the tendency to forget or repress the insights that resulted from the first analysis. On occasion this is so marked that the second analyst may well wonder. what became of the first four or five years of analysis. Nevertheless, as the re—analysis progresses the patient can and does recover many of the original insights. I wish only to add that children too tend to forget, at times completely, the contents of the treatment as time goes by. But here too we observe a great similarity with many adults.

As Kris (1956) says: "It seems that insight with some individuals remains only a transient experience, one to be obliterated again in the course of life by one of the defenses they are wont to uses'. (p. 453).

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