A psychotherapy that is based on the principle of unconscious conflict over persistent childhood impulses and recognizes the phenomenon of transference may be considered psychoanalytic. Whether pursued by means of the standard psychoanalytic situation or through various technical modifications, treatment according to psychoanalysis aims to help the patient overcome the untoward effects of his conflicts by expanding the knowledge of his "inner nature". This is what we understand by the term "insight".

During therapy, insight proceeds through several stages. It begins in the mind of the therapist. How he comes to understand something about another person's mind of which the person himself is quite unaware is by no means a simple matter. A considerable literature in psychoanalysis has addressed this problem. My approach this morning follows a number of contributions I have made to this literature, usually in collaboration with my colleagues, Dr. Beres and Dr. Brenner.

Basically, the therapist formulates an hypothesis, one that makes the best sense of the totality of the patient's communications. Such communication is transmitted to the therapist both verbally and non-verbally. Meaning is communicated not only through the content of the established elements of speech and gesture, but by means of the form, configuration, context and other elements I have described elsewhere (Arlow, 1979).
For the most part the therapist arrives at his insights intuitively. By this I do not wish to imply that there is anything mystical or supernatural about the process — although patients and students in supervision often respond to an experienced therapist's insights as if it were so. What I mean when I say that for the most part the therapist arrives at his insights intuitively is that usually he is not aware of the many complex procedures he has employed in correlating, integrating and synthesizing the data of the communications into understanding something new about the patient. In other words, most of the work of formulating insight the therapist has done unconsciously. The work was done or accomplished outside the purview of consciousness. The final result of this elaborate unconscious set of operations enters the therapist's consciousness and is experienced as a free association. From this has arisen the mistaken idea that every free association that occurs in the mind of the therapist is, of necessity, an accurate insight. On some occasions such new ideas, startling in how they illuminate the material and surprisingly unexpected in appearance, stimulate in the therapist the conviction that something mystical, something uncanny has taken place. There are, in fact, many therapists who maintain that when insight occurs in this fashion the phenomenon itself is proof positive that the insight is correct.

This is a debatable issue, one that cannot be dismissed off-hand. It is worthy of further investigation by means of detailed examination of the therapist's inner experience in response to the form and content of the patient's productions. Unfortunately since Freud, few analysts have been willing to give a detailed and possibly revealing account of their mental processes during therapy. The fact is that intuition plays a major role in
almost all insight and that such insights are usually accurate but unfortunately not always so (Beres and Arlow 1974).

No matter what form of technique he may use, every psychoanalytic psychotherapist has faced the dilemma of intuitive insight. On the one hand there is the danger of an undisciplined flight of fancy, of the intrusion of countertransference derivatives or the impact of an impressive article recently read and as yet incompletely digested. On the other hand, the therapist must learn to rely on his intuition. If he is not open to inner communication of this nature he will remain inhibited and fall back on dispensing safe, banal and ultimately ineffectual interpretations. Reiterating the obvious does not constitute insight. And for those who engage in psychoanalytic psychotherapy the situation is far more difficult than for those who enjoy the more secure setting of classical psychoanalysis. Because of the comparative infrequency of visits and the less stringent pursuit of free associations, the dynamic record of the conflicts of the patient in psychotherapy is frequently interrupted. Often this happens at crucial times so that discussion of the critical theme is not readily resumed. Perforce the gaps created by the missing material has to be filled in by the therapist's intuition. This factor alone renders the practice of psychoanalytic psychotherapy more arduous and exacting than that of classical psychoanalysis. It also places a greater burden of active self-consciousness and introspection upon the psychoanalytic psychotherapist. At one and the same time the therapist must exercise caution yet be ready to make tentative but daring use of intuitive insight.

Fortunately our knowledge of the dynamics of the process of insight comes to our assistance at this point. The treatment situation is an experience of shared intimacy;
giving and receiving confidences creates a bond of empathic identification between the two participants. Against this background after a period of time the therapist assimilates enough of the experiences that the patient has recounted to him to enable him, through the process of unconscious identification, to participate vicariously in the history that has been recounted to him. Unconsciously he fantasizes that he is the patient participating in the drama unfolding before him. Sometimes identification is made with the person who is the central object of the patient's account. In either way it is on the basis of this empathetic identification that intuitive insight becomes possible. Unconsciously, in fantasy, the therapist responds as if he were the patient. If the therapist's thoughts remain at this level we have an identification that may lead to countertransference, countertransference of a disruptive character. Under ordinary circumstances the empathic identification is broken off by the therapist automatically. Instead of thinking as the patient, he begins to think about the patient. It is at this stage in the development of the process of insight that some derivatives of the intuitive organization of the patient's data present themselves to the therapist's consciousness. They are perceived by the process of introspection (Beres and Arlow 1974).

I have been very careful in the phrasing of this last sentence because the end result of the therapist's intuition do not necessarily take the form of a concise or coherent insight. It is not a neatly processed formulation that can be transmitted to the patient as an interpretation. What the therapist experiences is an inner communication that has been stimulated by the process of responding to and organizing the patient's communications. This inner communication points in the direction of the coherent insight but is not necessarily identical with it. It is a step in the right direction.
The adumbrations of insight in the therapist's mind may take many forms. Often this depends on the therapist's personal style of thinking and communicating, usually influenced by the particular way that the patient presents himself. The therapist may become aware of the fact that the words of a song are running through his mind. He may find himself humming a tune or thinking of a joke, some line of poetry, an incident that happened to him, an experience with another patient, some article he read in a journal. The catalog is infinite. The point is that unless one is caught in some serious countertransference difficulty, whatever occurs spontaneously in the mind of the therapist represents some commentary on the patient's material. Coherent insight may follow almost immediately upon such thoughts, or in the case of the experienced analyst attuned to the significance of such seemingly random but nevertheless highly pertinent ideas, he will be able to grasp promptly the connection between these ideas and the unconscious message hidden in the patient's associations (Loewenstein 1956).

As I mentioned before, the derivatives of the function of intuition that appear in the mind of the therapist are by no means identical with insight. These derivatives have to be processed in a cognitive manner. The mind, however, is capable of working with incredible speed so that sometimes no sooner has an hypothesis occurred to us than we become aware immediately how many of the patient's psychological phenomena now fall into place in a coherent and meaningful whole. In other words, the hypothesis appears to be valid. We are convinced that we have gained a valid insight.

With experience, however, the therapist may come to apprehend those elements in the patient's productions that influence his perception and serve to determine the course of the intuitive process stimulated within him. The factors that enter into the process
resemble very closely what is involved in esthetic communication. (Beres 1957) (Beres 1968) (Beres and Arlow 1974) (Arlow 1979) have described the parallelism of the mechanisms involved in esthetic communication and in psychotherapy that make possible the unconscious communication of ideas, affect and fantasies. In both art and therapy the determining power of the unconscious fantasy is paramount. Most psychotherapy sessions may be compared to a poem or a novel, or perhaps best of all to a musical composition. Whether he is aware of it or not, the patient has a message, a wish, a fantasy creation, that he wants to, that he has to, communicate to the therapist. The wishful fantasy is the theme of the meeting. In one form or another it is communicated in the opening phrases of the session. It then recurs and is repeated. It is elaborated on in many forms, some overt, some disguised. It involves the analyst, figures from the present, figures from the past and it expresses itself through all the mechanisms known to us from dreams and literature. It makes use of allusions and symbols, similarities and opposites, and above all metaphor. Metaphor is an outcropping, of unconscious fantasy and if some of the elements of the metaphor are understood by the therapist in a literal sense, the therapist may be guided quickly and directly to insight into the patient's unconscious fantasy (Arlow 1979). But most important of all is the element of contiguity, the contextual continuity that bestows meaning beyond a manifest content of what is being expressed. Meaning is reached not only by metaphoral apprehension but by the significant placing of particular elements in the continuing record of psychic determinism.

However briefly, some mention has to be made of the connection between affect and the process of insight in the therapist. Following Brenner (1974) we recognize that an
affect consists of a feeling tone and a concomitant ideational content. As I described earlier (Arlow 1969) the ideational content usually takes the form of a specific fantasy. The ideational content of fantasy may or may not be conscious, very often it is not. As a consequence of the various mechanisms described above, the therapist's reaction to the patient's material may develop almost exclusively as an affective experience which he, the therapist senses, a mood with no apparent cause or ideational content. Once again experiencing such a mood is a derivative of an emerging insight, a consequence of the intuitive process. There are two possibilities. The patient may have communicated his or her own mood to the therapist or the feeling that the therapist senses — sadness, excitement, sexual arousal, frustration, whatever it may be, may represent the precise kind of feeling that the patient consciously or unconsciously wished to stimulate in the therapist (Loewenstein 1957). Either way, the affect must be understood as a consequence of the intuitive process and in doing so, the therapist comes one step closer to achieving insight.

The conclusion to be drawn from the previous discussion is the following. One can rely more comfortably on the insights obtained by intuition if these insights are brought in line, with the conclusions that can be reached by examining the nature and organization of the patient's communications. Beyond the patent, manifest meaning of the patient's productions are has to be attuned to the significance of the primary criteria for interpretation, namely, contiguity, repetition, similarity and opposites, figures of speech and above all, metaphor.

In order to demonstrate these principles, the following highly condensed clinical material is offered.
During this phase of the treatment the patient was speaking primarily of his attachment to older male figures. Treatment had been undertaken because of persistent smoking and the compulsive habit of seeking out prostitutes. Soon after the beginning of treatment, the patient had begun to feel very positively about the therapist. In the month before the material which is to follow, the patient described at considerable length his attachment to a somewhat older companion, a capable, exciting, rather dissolute person who was lots of fun and who loved to drink and to philander. Often he would invite the patient to join him in his philandering rounds. This material came up in the context of the patient's thinking about his older brother. He is very much attached to this brother who is nine years his senior and was a veteran of the second World War. To the patient he seemed like a real hero and in spite of some competitiveness and ambivalence, the patient calls his brother very frequently and they have long intimate chats about personal and business matters. It is clear that he has idealized his brother.

The discussion of the patient's attachment to his brother led to the recollection of many important incidents from the patient's early years. The adoring attachment to the older brother soon extended to the brother's friends and then to counselors at camp and to teachers. Of the brother's friends, one in particular caught the patient's fancy. His name was Tim. The older brother did not like for the patient to associate with Tim and he expressed his dislike in words which suggested that there may be something wrong or weird about Tim. Among other things, it had been said that Tim had been cruel to younger children. The patient, however, felt none of this. He was able to ingratiate himself to Tim and remembered in particular that Tim kept pet rattlesnakes in a cage underneath the porch of his house. As a token of the patient's special relationship to Tim,
he was permitted to be present when Tim fed the rattlesnakes, and on occasions Tim permitted the patient to participate in feeding the rattlesnakes.

Upon hearing this I had the thought, for a five or six year old boy to be feeding rattlesnakes seemed like a dubious sport. Accordingly, I decided to probe into this incident. I inquired what the rattlesnakes were fed.

The patient could not recall. He was perplexed by the question and at the next session, after consulting his brother, suggested that perhaps the snakes were fed small mice. To this he added immediately that his mother tried to discourage him from seeing Tim, intimating that there was something wrong in the association.

The material suggested to me that we must be dealing with some form of screen memory or a fantasy. Tim's reputation for mistreating children and the idea of feeding so phallic a symbol as a snake suggested that there may have been some homosexual aura if not experience connected with these events.

For the rest of the session the patient continued with the theme of other friends of the brother, school principal, an uncle who was very adept at mechanics and who taught him mechanical techniques, and other older figures to whom the patient attached himself in an admiring, subservient relationship, but a relation-ship in which he was permitted to observe and to learn a great deal from these more powerful figures. It was clear, and this was interpreted to him, that he had adopted in these early years of a role of a mascot.

At the following session the patient began by stating, "While putting on my shoes this morning I had an insight". Before revealing the insight he said, "I am not sure if I told you this material before, but it concerns my uncle, Sam, and the relation-ship between my father and Uncle Sam. Sam was a year older but he was always a sickly
child. He was one of a set of twins, the other died at birth. Everybody in the family was enlisted in helping Sam in the stationery shop that he ran." The patient ventured a guess that the shop really belonged to his father. Sam died at the age of 42. From the time of the funeral and for months, even years afterwards, the patient's father was inconsolable. He kept saying that it was impossible to go on living without Sam, that there was nothing to live for. The patient said he remembers hearing this expression at least 200 times and that he was deeply hurt by it. Finally he said to his father, "You have something to live for — you have mother, brother and you have me."

The patient continued. "Now for the insight that I had this morning." Sam, it develops, was an inveterate smoker. "Whenever you saw him there was a cigarette in his hand or a cigar in his mouth and, although my father detested smokers, it was all right for Sam to do so." The patient elaborated on this and then said that the insight that came to him while he was putting on his shoe was that by his heavy smoking he was imitating and thereby identifying with his Uncle Sam. "That's where I got my smoking habit. That was my insight."

Appreciating the sequence of the material and the contiguity of the themes, I asked the patient if he realized why he should want to identify with his Uncle Sam. After some thought and hesitation he said, "I wanted to be like him. I wanted my father to love me the way he loved Uncle Sam. He felt that without Sam life was not worth living, and I was envious." Then the patient added, "Now I can make another connection. There is another way in which I take after Sam. He had a habit of picking his teeth with the folded cover of his matchbook and that's exactly what I do."
At this point the patient said, "But this has nothing to do with what we have been talking about the past few sessions. We seem to be getting nowhere."

My response was to point out that the opposite was true. In fact the subject of wanting the father's love by way of identification with Sam continued the theme we had been discussing for weeks, namely the patient's wish to be loved by his brother, his brother's friends, etc. I added that if he felt that at this point we were getting nowhere, we must be approaching something that threatens to make him uncomfortable so that he wishes to discontinue investigating the theme under discussion.

The patient reflected on this for a while and agreed that it seemed reasonable. He then went on to discuss another way in which he resembled his Uncle Sam. Sam was always complaining about various aches and pains. When the patient was a child he complained of the same aches and pains. The patient then reverted to the theme of how he was able to win the affection and regard of older male figures. In this context he recalled an incident in which his dog was injured by an automobile while the patient was away for a weekend. Before the patient returned the dog died and the patient felt that had he been present, the dog might have been saved.

The patient began the next session in a very benign mood saying, "I have nothing to talk about." After a pause, "Nothing seems to come to my mind." After another pause, "I had no dreams." He then launched into a detailed description of current events, reports of telephone calls from his children, and a long account of how well they were doing in their various activities. In this mellow mood the patient continued for quite a while, while I found myself getting increasingly perplexed and beginning to feel bored. It was hard for me to maintain an interest in what the patient was saying, so I stopped him and wondered
aloud why he was detailing this report of current events at such great length. Perhaps there was something he was trying to avoid. The patient agreed that this might be possible and he wondered what it could be. However, he had nothing further to add. At this point I asked him if he recalled what our previous session was about. A blank expression came over his face. He could recall nothing. This amazed him. He could not believe it possible. Slowly he tried to recall the details of the previous session. Gradually he thought of the various people who had come up in the course of the material. Each time he would stop and say, "Was that it?" It was striking that among the people whom he mentioned he did not include his Uncle Sam who had been the main focus of the previous session, so when he stopped to ask me if that was it I would respond, "Wasn't there someone else?" Finally I pointed out to him that the person that he did not mention was his Uncle Sam. He was truly amazed by this and deeply impressed. He wondered how such a thing could happen.

The patient then began to reminisce about Uncle Sam's stationery shop. Next door was a store where pinball machines were repaired. The atmosphere of the place was very exciting. Once again, the men in the store were very fond of him and treated him as 'special'. They were all very masculine. There were two strong black laborers who worked there. The patient loved to hear their talk and to watch how they repaired the machine. Sometimes if the space was too narrow for an adult hand to get into, they would ask the patient to do some bit of the work. Once he noted that one of the workers was stealing money from the machine. When he called it to the proprietor's attention, the proprietor said, "I know. It's perfectly all right. He steals. He gets his share and I get my share. That's good business." The patient was convinced. The laborers were rough men,
often involved with the police. Every once and a while they served short jail sentences for assault.

(Listening to how the patient admired these powerful men in the context of the little hand that could get into the machinery from which something could be stolen, I began to think of the patient's image of himself as a mascot-apprentice, superficially subservient, but quietly motivated by an impulse to steal the power of the more powerful mentor. In turn this brought to my mind the material about feeding the snakes. By being passive and subservient it may be possible to grasp the omnipotent phallus, steal it and eat it. None of this was expressed aloud.)

The patient then proceeded to describe the lively activities in the other stores on the block. In each instance there was some male figure whom the patient admired, felt attached to and from whom he wished to learn. I brought him back to the theme of the dishonesty involved in connection with stealing from the pinball machines. It turned out that the shop was a front for the distribution of illegal slot machines as well as a "drop" for the numbers game. Most of the stores on the block, including his uncle's, participated in the latter. Now the patient could say with certainty that the father really was the owner of the stationery store which also served as a drop for bookmaking.

During the rest of the session the image of the father was the central theme of the patient's thoughts. It was a heroic and fearful image of the father that he drew. Two sets of incidents stood out. In one, the father was able to stand up bravely and defiantly against some of the local mobsters. The second was even more dramatic. It was a story that the patient loved to hear his father tell, again and again, when he was a child. The story related to the father's childhood. There was an older boy who terrorized the younger
children on the block, frequently beating them severely. One day this young hoodlum began to pursue the patient's father who was much smaller and younger. (Incidentally, the patient was very short and slight for his age.) The father ran away but the bully continued to chase him. As the bully was about to catch up with him, the father ran alongside an ice wagon, seized the ice pick and turned upon the bully, plunging the pick into his chest. Fortunately there were no serious injuries, but the father was never molested again. This was the story the patient wanted to hear again and again during his childhood.

(This material demonstrates the cognitive confirmation of an intuitive insight through the various criteria mentioned above. A repetitive theme emerges which is elaborated through many variations. The repetitions and similarities of the theme take on affective significance in specific contexts, culminating in a coherent concept, namely the psychology of the mascot-apprentice — the youngster who feels weak and defenseless, who attaches himself to older, powerful figures, through admiration, ingratiation and subservience, in order to learn from them, i.e. to acquire their strength and daring. This consciously elaborated pattern constitutes a derivative representation of an unconscious fantasy, early apprehended intuitively by the therapist, a fantasy embodying the wish to grasp, steal and incorporate the all powerful phallus during an act of sexual submission. This trend in the material culminated a few weeks later in the development of the therapy in a nightmarish experience in which the patient dreamt that he was seized and tied by several men and suspended upside down in a dark chamber while a man, who resembled an oriental priest, raised aloft over his outstretched neck a long, thin, pointed instrument which he plunged into the base of the patient's throat. At the last moment the piercing instrument was deflected and the patient awoke in great fear. Only a few of the
associations will be noted at this time. They concern the Mayan and Aztec custom of sacrificing beautiful young women to the gods, fear of Orientals, especially of the Fu Manchu characters of his childhood radio programs and the last minute rescue of Isaac as he was about to be sacrificed by Abraham. The most telling association, of course, was the connection between the sacrificial instrument and the ice pick of the father's childhood heroism.)

Until now we have been discussing how insight develops in the therapist. Having achieved such insight his next responsibility is to transmit his understanding to the patient. In psychoanalytic psychotherapy we regard insight as the effective instrument. The bridge between the insight of the therapist and insight in the patient is, of course, effected by means of interpretation. The art of interpretation is a difficult one. Its ultimate goal is to bring about insight in the patient, effectively altering the balance between the dynamic thrust of the impulse and the countervailing opposition of the defense (Loewenstein 1951). Through insight, the patient learns either to disregard what he thought were the dangers connected with the gratification of certain primitive impulses, or to dismiss these impulses as being childish and no longer relevant (A. Freud 1956). In this way change, improvement or cure can be brought about. These aspects and the problem fall within the scope of other presentations. There are, however, a number of observations that I would like to make on the way.

First the question may be raised: in our therapeutic efforts we endeavor to give the patient insight. Insight into what? At the present time there are many answers to this question. The answer usually given depends upon how the author and/or therapist conceptualizes the process of pathogenesis. Therapeutic technique logically derives from
one's understanding of how illness developed in the first place. Of necessity, imparting insight will play a lesser role in the therapeutic techniques of those who regard illness as the consequence of derailed early development and who consider treatment in terms of completing the maturational developmental line. Similarly it would not be difficult to speculate where the emphasis would fall with the therapist whose special interest lies in the vicissitudes of narcissism or object relations (Arlow 1981). Both the tactical and strategic goals of psychoanalytic technique as Loewenstein (1957) described them and the nature of the insight we hope to establish in the patient change as concepts of pathogenesis change. There was a time when insight in the patient was considered securely founded when he was able to recall forgotten memories. At another time, insight consisted of making the patient aware of how he was repressing his libidinal urges. In our current state of knowledge, in my view, if we adhere as closely as possible to the vicissitudes of the dynamic interplay of impulse and defense as we observe them in the treatment situation, we impart to our patients the most reliable kind of insight, insight into how his mind works in the context of inevitable and inexorable conflict which is the hallmark of the human condition (Arlow 1981a).

It could be said that this view of how insight develops in the course of psychoanalysis or psychoanalytic psychotherapy suggests that these procedures are educational ones. If we amend the statement to read that they are special kinds of educational procedures, then we could say that this statement is true; it does not constitute education in the pedagogical sense where information is imparted and the individual is directed along certain lines with preconceived goals. It is educational in the sense that the individual attains insights into how his mind works not only by the
information that is imparted to him but by the unique opportunity to test the interpretations or hypotheses repeatedly on himself through his own words and behavior within the context of the treatment situation and from his own experience.

Sometimes interpretations do not seem to help, insight, does not seem to work. Under such circumstances we often hear it said that the individual has intellectual but not emotional insight. Such a statement is in the nature of a tautology. Nevertheless, it has often been stated that insight is useful only if it is experienced emotionally. This viewpoint seems to reverberate the cathartic model of therapy. Brenner (1974) has pointed out that to be effective each new bit of insight in the course of treatment does not have to be accompanied by an outburst of affect, either immediately or after some time. This may and often does happen but it need not necessarily happen for insight to be genuine and effective. There are, of course, cases in which insight does not effect change. The insight may be incomplete in the sense that some aspects of the transference or the nature of defense is not completely understood. Often we do not know. Our only recourse is to the examination of the data in the context of the dynamics of the treatment situation.

Some patients seem to get nowhere from their analytic work, whether they seem to accept or reject the therapists' interpretations. They exhibit a resistance against an aspect of the method which is not contained in the wording of the basic rule, namely, the requirement of the patient to cooperate by reflecting on his own productions on the basis of hitherto warded off information that has now been brought to his attention. Such self-reflection is a necessary step in achieving dynamic insight (Loewenstein 1963).

Interpretations do not represent the sum total of the therapist's interventions. Some interventions make it possible for interpretations to have the desired dynamic
effect. Some represent the preparatory work that leads from intervention to interpretation, from interpretation to insight. This preparatory work may take many forms. They may serve to facilitate the patient's ability to communicate. Others lay the basis for provisional hunches that may be corroborated later or discarded in keeping with how the material unfolds. Some of the work represents organizing the patient's productions in such a way as to elicit additional material by bringing out similarities of themes, similarities of mechanisms, for dealing with situations, people or impulses. Finally, the work of preparation may involve confrontation, clarification and, of course, interpretation proper.

Thus it follows that the process of interpretation leading to insight is a continuing one, a layering or a hierarchy of interventions or explanations that one communicates to the patient in order to increase his knowledge of himself. Accordingly, the therapist must work from the surface to the depth — the surface meaning not only what is conscious but also what is present and real and significant.

The most important thing, technically, is to observe the dynamic transformations that interpretations induce in the functioning of the ego. These recapitulate the stages of the original conflict which eventuated in the structure of the neurosis.

The obtaining of insight is a continuing process. There are insights at various levels. Effective insight is one that has a dynamic quality. By this I mean that the patient, as it were, learns to speak the language of understanding, to apply it in an effective way to his own thought processes and behavior. At one level, interpretations given by the therapist do not yet constitute insight. To the patient they are only information. To be able to utilize the information, to understand what is not immediately apparent constitutes insight. It is analogous to the difference between learning the vocabulary of a foreign
language as opposed to learning how to communicate in that language. For this reason it is just as important for the patient to become thoroughly knowledgeable concerning the nature of his defenses as it is for him to become aware of the primitive character and the imperious intensity of his instinctual drives.
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