The Instructor’s Manual accompanies the DVD Confronting Death and Other Existential Issues in Psychotherapy, with Irvin Yalom, MD (Institutional/Instructor’s Version). Video available at www.psychotherapy.net.

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Instructor’s Manual for Confronting Death and Other Existential Issues in Psychotherapy, with Irvin Yalom, MD

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Instructor’s Manual for

CONFRONTING DEATH AND OTHER
EXISTENTIAL ISSUES
IN PSYCHOTHERAPY WITH
IRVIN YALOM, MD

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS
Encourage viewers to voice their opinions about what is presented in the lecture.

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Related Websites, Videos and Further Reading prior to or after viewing.

5. ASSIGN A REACTION PAPER
See suggestions in the Reaction Paper section.

6. CONDUCT A ROLE-PLAY
The Role-Plays section guides you through exercises you can assign to your students in the classroom or training session.
Reaction Paper for Classes and Training
Video: Confronting Death and Other Existential Issues in Psychotherapy with Irvin Yalom, MD

• **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.

• **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about Yalom’s approach to working with death anxiety and other existential issues in psychotherapy? What stands out to you about how Yalom works in the here-and-now of the therapy relationship?

2. **What I found most helpful:** As a therapist, what was most beneficial to you about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own perspective or style of working?

4. **How I would do it differently:** What might you have done differently from Yalom in the cases he presented in the video? Be specific about what different approaches, interventions and techniques you might have applied.

5. **Other questions/reactions:** What questions or reactions did you have as you viewed the lecture with Yalom? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

WEB RESOURCES
Irvin Yalom’s webpage
www.yalom.com
Louis Hoffman’s Existential Therapy Website
http://existential-therapy.com

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET
Irvin Yalom: Live Case Consultation with Irvin Yalom
The Gift of Therapy: A Conversation with Irvin Yalom
Understanding Group Psychotherapy – 3 Volume Set with Irvin Yalom
Rollo May on Existential Therapy
Existential-Humanistic Psychotherapy with James Bugental
Existential-Humanistic Psychotherapy in Action with James Bugental
James Bugental: Live Case Consultation
Death, Dying and Grief in Psychotherapy – 2 DVD Set with Milton Vieder-
man
The Legacy of Unresolved Loss: a Family Systems Approach with Monica
McGoldrick, LCSW

RECOMMENDED READINGS
Work Series. Lanham, MD: Jason Aronson (first published
1958).
Basic Books.


Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

EXISTENTIAL SPECTACLES

1. **Your experiences:** Yalom made the comment that, if asked, most therapists today would say that patients rarely express concerns about death in the therapy hour. Is this true for you? In your work so far with clients, has anyone come to you with terror about death? Has the issue of death anxiety come up at all, even covertly? If so, what were the circumstances? How did you work with it?

2. **Death terror:** Yalom makes the distinction between death anxiety and death terror. What did you think of this distinction? Do you agree with him that we can’t relieve death anxiety, only excessive degrees of death anxiety? Have you ever experienced death anxiety or terror about death? If so, how have you dealt with it? If you dealt with it in your own personal therapy and feel comfortable sharing about it, how did your therapist help you with your death anxiety?

3. **Staring at death:** Did any of your views about death change from watching this video? If so, how? Do you agree with Yalom that there is some benefit from staring directly at death? What do you think the benefits are?

4. **Meaninglessness:** Yalom shared his belief that we live in a world that is devoid of meaning and that we have to invent meaning. Do you agree with his position? Why or why not? Has the issue of meaninglessness been prominent with any clients you have worked with? If so, have you been able to help them grapple with this and find more meaning in their lives? How?

5. **Isolation:** Yalom talked about a certain kind of isolation that stems from our knowledge that we are “thrown alone into the world and we have to leave the world alone.” Is this something you have thought about before? What comes up for you when you reflect on this idea?
6. **Freedom:** The fourth ultimate concern that Yalom spoke about is “the freedom which suggests that each of us is the author of our own life and that we have to create our own life design.” What are your reactions when you reflect on this concept? Do you have any clients who are coming to terms with this concern? How are you helping them with this?

7. **Existential view:** What do you think of the existential point of view that Yalom described? Do you also believe that we are all here through random events? Do you agree or disagree that there is no afterlife? How about the idea that there is no pattern, no inherent meaning in life? If you disagree, how do you see it differently?

8. **Not a school of therapy:** What do you think of Yalom’s belief that all therapists should have a broad knowledge of all the various schools of therapy, and, in addition, should have a sensibility and a willingness to engage existential issues? Do you consider yourself to have an interest and willingness to engage existential issues? Have you explored existential issues in your own personal therapy? Did it surprise you to hear that Yalom never meant that existential psychotherapy was a free standing ideological school of therapy, even though he wrote a book by that title?

9. **The wound of mortality:** Yalom talks about how we all have different ways of softening the knowledge of our mortality—through having children; by becoming rich and famous; through merger with a loved one or a cause, etc. If you look at your life through this lens, how do you think you might be “softening the knowledge of your own mortality”? In thinking about some of your clients, how might they be doing so?

10. **Religion:** Yalom said, “I think death anxiety is the mother of all religions.” How did you react when he said this? What do you think about his perspective on religion? What came up for you as he expressed his views on God? Have religious or spiritual issues been something that your clients have struggled with in therapy?

**DON’T SCRATCH WHERE IT DOESN’T ITCH**

11. **Always there:** What do you think of Adolf Meyer’s view
to “Don’t scratch where it doesn’t itch,” and Yalom’s point that death itches all the time? Do you agree with Yalom that death is always there, just under the membrane of consciousness? After watching this video, is it any itchier?

12. **Comfort level:** Yalom disclosed that in his own psychoanalysis the topic of death never once emerged. Is the topic of death and your own mortality something you have addressed in your own therapy? How did your therapist help facilitate this? Is this a topic you have helped your patients explore? What would you say about your own readiness and comfort level with regards to talking about death? Reflecting on your patients now, do you think any of them may have expressed concerns about death (overtly or covertly) that you did not pick up on at the time?

13. **The idea of death:** What was your reaction to Yalom’s comment that “though the physicality of death destroys us, the idea of death can save us”? Do you agree with him that thinking about death can help us live more authentically? Does thinking about your own death inspire you to live any differently? Have you worked with clients who have experienced growth through their confrontations with death?

**WE’RE ALL IN THE SAME BOAT**

14. **The healing relationship:** How did you react to Yalom’s description of the healing relationship and how he doesn’t wear any kind of therapist’s uniforms or hide behind a wall of diplomas? How comfortable do you feel being yourself with your patients? Do you also strive for openness and honesty with your patients? Why or why not?

15. **Alleviating terror of death:** What do you think of Epicurus’s ideas for alleviating the terror of death: mortality of the soul; the nothingness of death; and the symmetry argument? Do you agree with the idea that the soul dies with the body, so therefore we have nothing to fear in the afterlife? How about the idea that we can never encounter death because once the body dies, the mind ceases to exist? Do you agree with the idea that the state of nonbeing that we’ll be in after death is the identical twin of the state that we were
in before birth? Do any of these ideas alleviate any of your own death anxiety? Have you come across any other ideas that bring you or your patients comfort around the topic of death? Can you see yourself offering any of these ideas to any of your patients?

**JOAN: “LIVING A LIFE OF ABSURDITY”**

16. **A simplistic question:** What do you think of the “silly” and “simplistic” question that Yalom asked his patient, Joan: Will you please tell me what precisely is it about death that so frightens you? How do you think you might answer this question? Can you see yourself asking any of your patients this question?

17. **Regret:** What do you think of the idea that the more regret you have about the way you lived your life, the more anxiety you will have when it comes to facing death? What, if any, areas of unfulfilled potential within yourself do you want to experience before you die? Does this concept make sense for any of your clients in particular? If so, talk about one of those cases.

18. **Rippling:** One idea that Yalom uses to alleviate excessive death anxiety is what he calls rippling—that even though we die, our acts can persist and be passed on for generations. What do you think of this idea? Do you think it would be an effective way to help relieve someone of their death terror? Why or why not? Can you imagine offering this idea to any of your clients who are experiencing death anxiety?

**MARK: WE ALL OWE NATURE A DEATH**

19. **Process:** What reactions did you have when Yalom stated that the most potent weapon for increasing a sense of authentic connection with patients is to focus on the therapeutic relationship? Do you tend to draw your patients’ attention to what is happening in there here-and-now, to the relationship between you and them? If so, what results have you seen? Do any experiences of this stand out to you in your work with patients?

**AMELIA: “I WANT A HUG”**

20. **Amelia:** How did you react when Yalom talked about how
he persisted in asking Amelia whether he was helping her stay off drugs? Did you like this series of interventions? Why or why not? Do you tend to be as persistent as Yalom was with Amelia? Can you imagine yourself having an exchange similar to this with any of your patients? Why or why not?

21. **Therapist transparency:** What came up for you when Yalom spoke about how he told Amelia some of the things he liked about his own therapist? Do you think that was an effective intervention? Why or why not? What are your thoughts about the idea of disclosing to your patients some of the feelings you have in relation to them? Is this form of transparency something you incorporate into your work? Why or why not? How do you think you would have responded if a patient asked you what Amelia asked Yalom: “Would you welcome me as a member of your family?” Have you ever had a patient ask you a question like that? How did you handle it?

22. **Interaction and reflection:** Yalom stated that therapy gets deeper and deeper through an alternating sequence of interaction and then reflecting back on that interaction. Does this view match your understanding of how to deepen the therapy? Why or why not? How else do you deepen the therapy with your patients?

23. **Personal Reaction:** How do you think you would feel about having Yalom as your therapist? Do you think he could build a solid therapeutic alliance with you and help you if you were dealing with existential issues? Why or why not?
Role-Plays

1. EXPLORING EXISTENTIAL ISSUES

After watching the video, break participants into groups of two and have them role-play a therapy session focusing on death anxiety or other existential issues. One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. This is an opportunity for students to get more familiar talking about death and other existential issues in the therapeutic relationship.

Instructions for clients

Select from one of the following three options:

1) Choose an existential issue that either you or a client of yours is grappling with and talk about it explicitly with the therapist.

2) Role-play a client who is turning 50 and is questioning the meaning of life. As anxiety about death is not something of which you are consciously aware, wait for the therapist to help bring this out.

3) Role-play a client who is explicitly dealing with the terror of death in the face of a recent cancer diagnosis.

Instructions for therapists

Keeping in mind that Yalom said “effective therapy is a synergy of powerful ideas and a powerful, intimate connection,” focus your attention on both the existential content and the therapeutic relationship. This is an opportunity to practice engaging the client in an explicit conversation about life and death, and to try out some of the ideas Yalom discussed in the video for alleviating the terror of death. Feel free to try other ideas as well.

Some suggestions for therapists:

1) Ask the client, “Will you please tell me what precisely is it about death that so frightens you?”
2) Elicit the client’s thoughts and feelings about existential issues such as the finitude of life, meaninglessness, isolation, and freedom.

3) Encourage clients to talk about what kind of ripple effect they want to have on the world. Direct their attention to how they want to live while they are still here.

After the role-plays, have the pairs come together to discuss their experiences. First, have the client talk about what it was like to role-play someone confronting death and how they felt about the therapist’s interventions. What was helpful and unhelpful in alleviating their anxiety? Then, have the therapists talk about their experiences; how did it feel to conduct a therapeutic session around these existential issues? How comfortable did they feel talking about death? What was it like to offer ideas for alleviating the terror of death? Finally, open up a general discussion of the strengths and the challenges in applying Yalom’s approach to confronting death anxiety and other existential issues.

2. WORKING IN THE HERE-AND-NOW OF THE THERAPY RELATIONSHIP

Yalom advocates using the therapeutic relationship as a vehicle for exploring the client’s interpersonal world. He is not just acknowledging that the therapeutic alliance is a powerful ingredient in the change process—which of course it is—but rather, he is describing ways to create an authentic connection by exploring the relationship in the here-and-now. This is an advanced skill that is difficult for therapists to master, but the following role-play will be a way to practice.

After watching the video, break participants into groups of two and have them role-play a therapy session. One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles.

Instructions for Clients

Role-play a client who presents one of the following dynamics:
A. Excessively worried about how others think about him. For example, he may express concerns about whether he has done something wrong to upset his partner or boss. At the same time, he seems very worried about disappointing the therapist, apologizing profusely if he is two minutes late, or hasn’t practiced his relaxation techniques, etc.

B. Has a pattern of conflicts with others, which has resulted in lost jobs and explosive relationships. She tends to challenge or ignore therapist’s feedback, and just keeps complaining about the annoying things that her coworkers are doing. She tends to come late, and complains that therapy isn’t helping.

**Instructions for Therapists**

First pay attention to your own feelings that are elicited by the client. For example, with client A you may find yourself initially wanting to reassure him that he isn’t disappointing you, but as he persists you may find yourself wanting to take care of him, or, conversely, you may feel tired and frustrated that your reassurances have no effect. For client B you might find yourself getting annoyed or even resentful.

Then find a way to explore your experience with the client, trying to do it in a way that ties this to the issues they are working on in therapy. For example, with client A you might say, “I’m aware that you seem so worried about disappointing me. How does that impact how it is to be in the room with me?” Or you might share how it affects you by saying, “I feel like I need to be extra careful with you, as you are so prone to interpret anything I say as judgmental.” Or for client B you might say, “It seems like you either immediately disagree with anything I say, or you just ignore it. It makes me feel that you don’t value what I have to offer.” For either scenario, after spending several minutes examining how their dynamics play out in the here-and-now of the therapy relationship, try to make links to their relationships in their lives, by suggesting things like, “Does what we’re talking about here seem similar to your relationship with (your partner, your co-worker, your boss)?”

Try not to make definitive interpretations from the “expert” stance,
but rather as another concerned human who is sharing their experiences as useful data. Although you have useful expertise as a trained participant-observer, the client’s experience is equally important, so consider this a two-way dialogue that you can learn from as well.

After the role-plays, have the pairs come together to discuss their experiences. First, have the clients talk about what it was like to role-play their character and how they felt about the therapist’s interventions. How did it feel to have the therapist bring their attention to the here-and-now of the therapeutic relationship? Then, have the therapists talk about their experiences: How was it to tie their experiences of the client to the client’s issues? How comfortable did they feel focusing on the therapeutic relationship? Finally, open up a general discussion of the strengths and the challenges in working in the here-and-now of the therapy relationship.

**Alternative Role-Play Format**

An alternative is to do either role-play in front of the whole group with one therapist and one patient; the entire group can observe, acting as the advising team to the therapist. Before the end of the session, have the therapist take a break, get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Yalom’s approach.
Complete Transcript of Confronting Death and Other Existential Issues in Psychotherapy with Irvin Yalom, MD

INTRODUCTION BY DAVID SPIEGEL, MD

David Spiegel: Thank you. It’s an honor to help introduce my friend and colleague, Irv Yalom. Dr. Yalom sheds light on the dark places of the soul, and I know he has changed the way we think about psychotherapy, really, around the world. And he’s certainly done that for me.

He helped to recruit me to Stanford in 1975. I’d been there for half a year. And he called me up and he said, “David, I’m running this group of women with metastatic breast cancer. Would you like to co-lead it with me?” When you’re just starting your career and the world’s authority on group therapy asks you to co-lead a group, you think for about a second and a half and say yes.

And that really started my career of research on breast cancer support groups. I learned a tremendous amount. He’s one of the teachers who can not only write about it, but can do it. They say, “Those who can’t do, teach.” Well, Irv can do it and teach. I learned a tremendous amount from watching him do this work.

His influence on the way we focus on the future more than the past, on the way we use confrontations with death to invigorate life, has been an inspiration for me and for a generation of psychiatrists and psychotherapists. If you think it’s crowded here, he just gave a series of lectures in Athens. There were 2,500 people in the hall and 2,000 people in the line outside waiting to get in. The real mark of fame is that waiters were bringing over copies of his book for autographs in the restaurants there.

I owe a great deal personally to Irv Yalom and I’m sure you will tremendously enjoy his talk about Staring at the Sun and how we face,
and grow from, confronting our own death.

Irv Yalom.

EXISTENTIAL SPECTACLES

Irvin Yalom: Thank you very much for that introduction and for those remarks, David. It’s a great honor to be here. Very sorry about the people who could not get in the room today. It’s an enormous audience here and I’m very honored by your presence.

Lately as I’ve been talking over the last few years and gotten older and older, the crowds are getting larger and larger. Of course, that’s very self-affirming, but if I don my existential spectacles here—and I’m going to be wearing them the whole morning today—there’s a dark side to these increasingly large crowds. The dark side is, what’s all the rush about seeing me now, all of a sudden?

That leads right into the topic of my talk. I’m going to be talking about the presence and the role of death anxiety and psychotherapy. I often say death anxiety, but I really mean death terror. I’m not talking about alleviating death anxiety. We can’t do that. It’s inbuilt, hardwired into us all—into all living creatures, I believe. So I’m talking about excessive degrees of death anxiety. So please keep that in mind.

00:05:14

I want to say most of the material I talk about today is from my last book. Incidentally, last has two meanings, of course. It means most recent and final. I’m talking about most recent book, I hope. So much of the material I’ll be speaking about today is found in that book. The title of the book, Staring at the Sun, is taken from an aphorism by the 18th century French writer La Rochefoucauld, who said, “There are two things at which we cannot stare directly: at the sun and at death.”

Now I’m not suggesting, of course, that we stare at the sun, but I am suggesting there is some benefit from staring directly at death, some benefit from illuminating life for us and allowing us to live it more richly and more fully.

This is not a common topic to talk about in our field. You can look through the program that you have of the convention. You’ll not see
any topic that’s even similar to this. I think I want to talk about why it is that I am writing such a book as this. Many of you might suggest—and I think you’d be accurate to some degree—that while it has something to do with my being 77 years old and I’m thinking about the end of life too—I think that is true to some extent, but that’s not the whole story, because I’ve been writing about this topic for a very long time.

If I try to think about what the autobiography of this book would say if it could speak, I think it maybe really began when I was a psychiatric resident. I was about finishing my first year of residency at Johns Hopkins. In those days, we were presented with two major ideological frames of reference—the orthodox psychoanalytic field and the biological psychiatry, which of course had much less to offer in those days than now. Neither of them seemed to address to me some of the things that made us basically human. I felt there was a lot left out.

It was about that time that a book by Rollo May came out called Existence. It’s still around. The book was an eye-opener to me. It talked about the issues, the anxiety inherent in simply being in existence. He wrote some very good essays in that book, and it showed me that perhaps there was a third way of looking at the sources of the things that bedevil us.

At that point, I started taking undergraduate courses at Hopkins in philosophy and have been an autodidact in philosophy ever since then. I felt though in the beginning—as Dave just alluded to in the introduction—that the psychoanalytic position then focused much too much, it seemed to me, on the distant past, on the early years of life, and much too little on the future, much too little on each of our notion of what will become of us in the future—what will be our fate.

When I was a student in psychiatry and we were given lectures on the history of our field, they often talked about the beginnings of this occurring in the late 18th and 19th century. We heard talk about figures such as Pinel and Esquirol and Rorschach and Jung and Freud and Skinner, as though these were the beginnings of the field.

I feel now that that’s an error. Our field really began a couple thousand years ago with the writings and the thoughts of the great philosophers...
and writers and thinkers who have spent their lives thinking about how and why we should live as we do.

When I came to Stanford, I spent the first 10 years there emerging myself in group therapy, doing research of that and finally writing a textbook on group therapy. But all the while, another book was percolating in my mind. I wanted to write something to see what I could contribute to this field of existential thought as it applied to psychotherapy.

00:10:26

I spent several years after that writing a textbook of existential psychotherapy. I’ve always thought that was my best work. It’s the mother book, the source of all the books I’ve written since then. The novels and the stories are all explications, expanding some of the ideas and thoughts that I had in that book. It’s also the sourcebook of this current book, Staring at the Sun.

I decided to bring it up to date. I wrote that textbook 25 years ago and as I began to think about the clinical work that I’m doing, many of the patients that I see come to me with terror about death. So I began to just focus on the topic of death. But this textbook lies at the foundation of my remarks today and my writings now. So I thought I’ll spend about three or four minutes summarizing this 500-page textbook.

The textbook really assumes—it’s a thought experiment. It begins with a thought experiment. It asks you all to take a few minutes to meditate upon your own existence, to bracket out all the other things that clutter our mind—all the other forms of busyness, all of your schedules and your cell phones, which I hope are turned off now, all the various budgetary concerns, everything else. You just put them out of your mind and think of you as a solitary being in existence and what that means.

I’m suggesting that if we get to the deep ground of existence, we reach a realm of something—I like to use the term “ultimate concerns.” It’s a term taken from Paul Tillich, the theologian. As I thought about it, it seemed to me that I selected—there are many that you can think of—
but I selected four that I thought had particular salience to the field of psychotherapy. And they form the spine of that book.

The four concerns that I write about then and still do are the concerns, obviously, of death—the fact that we are aware of the fact we’re finite. Like all living creates, we wish to preserve in our own being, yet we are aware of inevitable death, and that causes a great deal of inner, hidden turmoil.

Another ultimate concern would be the concern of meaning in life. It seems to me that we’re meaning-seeking creatures who are unfortunate enough to be hurled into a universe, into a world that’s devoid of meaning. So we have to invent a meaning that’s sturdy enough to support our lives. And maybe then we also have to perform the acrobatic feat of pretending that we haven’t invented, but that we discovered this meaning—it’s been out there all the time.

A third one might be the idea of isolation. I’m not talking about interpersonal isolation, about loneliness, nor am I talking about isolation as it’s used analytically, intrapsychic isolation—the idea of splitting off affect from ideation and experience. I’m talking about isolation that stems from our knowledge that we are thrown alone into the world and we have to leave the world alone. It’s a kind of isolation that is often not thought about and not considered, until perhaps you contract a fatal illness. And I think it’s a very powerful experience.

The fourth one might be the ultimate concern of freedom. I’m not speaking, of course, of political freedom, toward which we all yearn, but I’m talking about the freedom which suggests that each of us are author of our own life and that we have to create our own life design. We look for certain guidelines. No one has written about this more beautifully, I think, than Erich Fromm in his work Escape from Freedom. He talks about our need for structure. Though we are granted freedom inherently, nonetheless we have a lust for submission.

Let me just give you one definition of this word “existential” that I will use a lot in my talk today. What I mean by it is I think it represents a view of the human condition, that each of us are here through random events. We could just as easily have not been here. We’re facing sheer contingency. We’re finite. We will inevitably perish. There’s no afterlife
CONFRONTING DEATH AND OTHER EXISTENTIAL ISSUES IN PSYCHOTHERAPY WITH IRVIN YALOM, MD

facing us. We’re thrown into the world alone, as I’ve mentioned, have to leave it alone. There is no pattern, no meaning in our life.

00:16:03

Maybe this is a very harsh view of life, but I do believe it’s a realistic view of life. This is the foundation of this particular view. The term that I use, “existential psychotherapy”—I could just as easily say “existence psychotherapy.” I only say “existential,” using the adjectival form, because it’s a sleeker term. “Existential therapy” sounds better than “existence therapy,” but I never meant that existential psychotherapy was a free-standing ideological school of therapy. I never meant that to be, even though I wrote a book by that title.

What I’ve always meant is that all of us therapists should be trained in all the major schools of therapy and be able to select which is more useful to the particular patient that we encounter. I think we need to have a broad knowledge of all the various schools of therapy. But in addition to that, we should also have a sensibility and a willingness to engage existential issues that plague some of our patients.

Perhaps just another way of saying this would be to consider the idea of where anxiety comes from. I think we can say that the existential approach posits that the inner conflict that’s bedeviling us issues not only from our biological genetic substrate. Anxiety emanates not only from repressed, instinctual strivings, as an orthodox Freudian approach might suggest, and not only from introjected significant adults in our lives who happened to be uncaring or unloving or neurotic, which would be an object relations approach. And not only from disordered forms of thinking—the CBT approach. And not only from shards of half-forgotten traumatic memories. Not only from these, but also from the confrontation with the givens of existence. That’s the position that I’m taking in this talk.

So let’s turn down to the topic of the talk and turn to death. I’ll read a few lines from the opening of my book. These are just reminders to you—nothing that you don’t already know, of course.

“Every human being has a mortal wound, a wound deep in the heart. When did it happen? It’s an ancient wound, inflicted during
the forging of the self. The moment the separate I appears, so did awareness of our destiny – youth, blossoming, diminishment, and inevitable death. So self-awareness is a supreme gift. It’s as precious as life. It made us human, but we paid a costly price for it. The price, of course, is the wound of mortality.”

Now mortality has haunted us, I think, since the beginning of time. Writers beyond count have written on it, yet we can’t remain frozen in fear about this and hence, throughout the millennia, we generated a number of ways to soften this knowledge. Many of us, for example, assuage the mortal wound by projecting ourselves into the future through our children. In a sense, you could say that children are, for many of us, our symbolic immortality project.

Some of us attempt to chisel our names into tablets of eternity by becoming wealthy and rich and famous, powerful. Some us construct death-defying defenses in deeper, unconscious layers of our personality through certain ideas about grandiosity and invulnerability. Some of us seek to assuage this by seeking personal transcendence through personal creativeness or through avoiding their once painful isolation through merger—merger with a loved one, merger with a cause or community, merger with a divine being.

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I think death anxiety is the mother of all religions. I think all religions in one way or another attempt to assuage the pain of finitude. The religions come in a rainbow of hues throughout the millennia. They all have certain common features to them. They all offer a similar commodity, and that is an antidote to our pain about mortality. I think God, as described in every religion, not only softens the pain of finitude by offering some vision—it varies, of course, the type of vision—but some vision of everlasting life. Also, God palliates certain other of the existential dimensions: We’re not alone. We have an observer. We have a personal presence who’s aware of our existence. We have an ordained set of rules that offer structure and a sense of meaning in life.

But I think, despite all these efforts, the anxiety about death is never, never subdued. It’s always there. It’s lurking in the hidden ravines of
our minds. Perhaps as Plato says, “You cannot lie to the deepest parts of yourself.”

DON’T SCRATCH WHERE IT DOESN’T ITCH

Let me say some things about death now and contemporary therapy. Contemporary times, many people who have begun to shuck some of the culture and religious beliefs of the past turn towards therapists for help with this. But are we therapists prepared to deal with this? Are we trained to recognize the presence of death anxiety? Are we equipped to offer something to alleviate it?

I think when death enters the scene in contemporary therapy, many of us psychiatrists sort of heed, implicitly, of course, the dictum of one of the founders of American psychiatry, Adolf Meyer, who was chairman of psychiatry at Hopkins for so many decades. Adolf Meyer once said, “Don’t scratch where it doesn’t itch.” Don’t get into things you’re not going to be able to offer any solution for. And I think in a sense we avoid that. The problem, of course, is that death itches all the time. It’s always there. It’s knocking at some interior door. It’s whirring softly, barely audibly, just under the membrane of consciousness.

Many patients may not complain overtly of death anxiety. It may be suppressed or camouflaged in ways that I’ll talk about as we go on. If you ask contemporary therapists, “Does death anxiety overtly enter into the therapeutic dialogue?” they’ll say, “No, it doesn’t.” Patients rarely express concerns about death in the therapy hour.

I’ll give you a personal example of that. After I was at Stanford for about 10 years, as David mentioned, I started to do groups of cancer patients. Later on, David joined me and really performed some wonderful, meticulous research on these groups. But as I started to work with patients, I began feeling tremendously anxious, having nightmares. I wanted to be present—I wanted to be able to have patients talk to me very deeply about what they were going through. I did that, incidentally, because I was writing about existential therapy and I wanted patients to talk with me about it, and they never talked about it.

I didn’t know how to ask them and how to talk about it. I’ve learned
how to do that now, but I didn’t then. So I thought, “I will work with a client population that has to talk about it—people that have metastatic cancer.” For the most part, I was working with metastatic breast cancer patients. So I was aware, as I began to encounter a lot of anxiety, I thought back on the fact that during my residency, I had a rather orthodox psychoanalysis, four times a week on the couch, 700 hours over three years and never once had the topic emerged. So I had to get myself back into therapy. That’s when I began seeing Rollo May as a patient, to be able to deal more openly with these issues.

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The other thing is that I think it’s got to do with the therapist’s readiness to deal with the topic. That will determine what the patient brings to the therapy hour. Patients don’t voice concerns about death if they sense the therapist’s discomfort. What’s more, therapists don’t hear it if they do not wish to hear it. Maybe they fear igniting some of their own subterranean anxiety about this. I think part of our preparation as therapists in dealing with this is to deal with our own thoughts of death anxiety, and deal with it perhaps in our own therapy as well as our own inner meditation.

But I think that if you’re able to deal with this and if you’re able to develop some techniques—which I’m going to try to suggest to you in a few minutes—that I think that we have the ability to go with patients into these realms, and I think we have the ability to assuage, to a great degree, the terror of death that patients bring to us.

But that’s not all we can do. We can do much more than that—much more than simply assuaging anxiety. I think there’s a long philosophical tradition—which you’re familiar with, I know—the idea that life and death are interdependent. Socrates, for example, talked about the fact that preparing for death is a way of preparing for life. So a concept that I’ve used throughout my writing, throughout this book, is the idea that though the physicality of death destroys us, the idea of death can save us. That’s a strange comment. The physicality of death destroys us; the idea of death can save us. Save us from what? How save us? What I mean by that, of course, is that it can change the way that we live, that we can live more authentically.
This was brought home to me in a stunning way in the group that David and I were leading. We began to notice that patients we had in our group did not all slump into a kind of numbing despair. There was a certain percentage of patients—I think a substantial percentage—perhaps a third of the patients seemed to change in the way that they lived in the world, and they talked about living differently and feeling differently. They described things like they’re reprioritizing their priorities. They’ve stopped doing things that they don’t want to do. They begin to say no to things that they didn’t want to do. They began to want to spend time with the things that they really loved doing and the people they loved being with. They were more in touch with the changing seasons and the beauty of nature. Furthermore, things that used to bother them didn’t bother them. They weren’t so concerned about not being invited to a certain party any longer.

One of my patients rather drolly put it to me, “You know, Dr. Yalom, cancer cures psychoneurosis.” Another one said to me at one point—and this is something I’ve never forgotten because it’s been the foundation of what I was to do for many years—another one said, “What a pity it was that we had to wait until now, now that our bodies are riddled with cancer, to learn how to live.” So I began to feel there’s so much truth in that. How do we make people aware of this earlier in life, at a time when you’re not actually facing death?

So facing death for some was an experience that changed them. I’m using the term “awakening experience.” There’s an old term in the literature that meant more or less the same thing, called “boundary experience”—in the older psychiatric literature, you’ll find that. That’s a poor term nowadays because we have other ideas and feelings about boundaries and use of boundaries. So I think “awakening experience” is a better term for that.

I think you’re all aware of awakening experiences. They’re very prevalent in great literature, by the way. San Franciscans, all of you are very aware of the Christmas Carol. The American Conservatory Theater runs a play of the Christmas Carol every year for three weeks or so before Christmas. It’s, of course, not a play. Dickens wrote it. It’s one of his Christmas tales. And it’s a classic story of
a great transformation. Old Ebenezer Scrooge started the story as an avaricious, mean-spirited, greedy, cruel old man who everyone disliked, and then underwent a transformation and ended the story in quite a different fashion—loved, charitable, generous, loving.

Unfortunately in the time of Dickens, psychotherapy had yet to be born, so we can’t claim any credit for that, but Dickens was a superb master psychologist and Dickens used a very potent form of existential shock therapy for Scrooge. You may remember that he sent him the angel of the Christmas yet to come, who escorted him into the future, who allowed Scrooge to see his final days, and to see his own death, and to see strangers fighting over his bedclothes and to see his own funeral almost entirely unattended and hear townspeople dismiss his death very lightly. Then finally, in the last scene, he was in the graveyard fingering the letters of his name on his tombstone. In the next scene, Scrooge is transformed. That seems to be the critical event for his transformation. There are many other great tales of transformation, awakening experiences. It’s also a core issue in War and Peace.

So these are awakening experiences. But where are the awakening experiences in our everyday therapy, when patients aren’t necessarily facing death with a fatal illness? When you’re not facing a firing squad or you’re not being escorted into the future. I think there are plenty of awakening experiences available to us if we only take use of them. Many of them may be—what shall we say—nano-experiences, but we magnify them and use them in therapy.

One of them is grief. We work very well with grief, with the idea of loss and how we help patients deal with loss and how we gradually—we’ve known this since the days of Freud and Abraham. We gradually help them detach themselves from the person who has died, detach their energies and begin to attach it onto life once again.

So loss is an important part of it, but an often overlooked aspect of grief is the confrontation with our personal death. If our peers, our friends can die, then so can we, so will we. If our children die—the worst loss of all, I do believe—then in a sense our own symbolic
immortality project has collapsed. If our parents die, then who is it that stands between us and the grave? So it has implications for death, and I try to work in that with my grieving patients.

Other kinds of experiences, all the major life eras—children leaving home, and of course, the midlife crisis. Once the midlife crisis hits, then the ideas and thoughts about death are never far out of consciousness. The idea of life era markers, people coming in with big birthdays—they’re 40 or 50 or 60. We celebrate birthdays and there’s always great parties. But if you really think about it through these existential spectacles, what’s the celebration all about? It’s really a confrontation with the inexorable, irreversible rush of time. If we can get below that and help patients talk about what it means for them to be on schedule—

And of course, nightmares. Nightmares are always dreams of death anxiety, death terror which has escaped the corral which we keep it in during our waking life.

The life cycle of death awareness, too, is something to be kept in mind. It changes as we go through life. Children much younger than some of us think—at the age of three and four and five—they’re doing a lot of silent research about that. They’re thinking about it. They sometimes pose uncomfortable questions for their parents, but they notice that insects die and leaves die and pets die and grandparents die. Then it seems to go underground—maybe during the same years that Freud talked about a sexual latency.

I think there’s a death awareness latency and it emerges again with force during adolescence, who are often pervasively concerned about death and death anxiety. They will deal with it in a number of ways, many of them counterphobic—many of them moving into a kind of daredevilry, or taking risks, or taunting death, or, of course, attending in a counterphobic way horror films by the tens of millions. These are the people who go to see them.

WE’RE ALL IN THE SAME BOAT

00:37:12

So I think I’m going to begin to talk about, how do we deal with these
things in psychotherapy? I think that in dealing with death anxiety, we use a combination of factors that we use in all forms of doing deep psychotherapy. We offer patients two major factors. We offer a synergy of powerful ideas and a powerful human connection. Those are the two things that we have to offer patients, and it’s certainly true for this form of psychotherapy, too. I’ll talk about each of them and then I’m going to end this talk by giving you a couple of long descriptions of two sessions that I’ve had with patients which will illustrate them for you.

So I’m going to just say something about the healing relationship, the connection. How does the existential factors that I’ve been talking about—how does that change the way we relate to patients? It’s changed the way I relate to patients in a very profound way. Again, I am not talking about patients with very severe psychotic mental illness. I’m talking about the everyday patients I see in longer-term psychotherapy. Do keep that in mind.

It does change it in that, for me, it dismisses the last vestiges of a kind of model I used a long time ago with patients where I am the healer, dealing with these afflicted patients with just some strange or odd disease that they have. Now I change a whole lot towards them. I begin to eliminate the boundaries between them and me. I begin to feel that we’re all in this together, that I suffer from some of the same issues that they are dealing with.

It’s no longer them, the afflicted, and me, the healer. I realized after all, we’re all in the same boat. We all face the sense of our infinite smallness—insignificance measured with the infinite largeness of the universe. I feel that I have a different kind of connection and a different kind of compassion for the people I work with. So I try to help them, and I demonstrate, too, facing as much truth as they can bear. I strive personally in my work for openness and honesty with patients. I don’t wear any kind of therapist’s uniforms. I don’t deny that any of these dilemmas strike home for me. I don’t refuse to answer questions if I feel that I can. I don’t pretend I know things I don’t know. I don’t hide behind a wall of diplomas.

So I said a little while ago, I’m going to demonstrate this with the
vignettes that I’m going to mention. Let me turn to the other aspect of this synergy of connection and ideas. Let me talk about some of the ideas that we can use in therapy.

If we talk about powerful ideas of therapy, some of them have been around for millennia. I’m very interested in some of the ideas—and I use them in therapy—of an ancient Greek philosopher named Epicurus. We know Epicurus often by this term, “epicurean” food or drink or something. That’s bizarre because he was quite ascetic in a way. But he was this interesting philosopher. I do think he’s a very significant but often ignored ancestor of all of us. He called himself a medical philosopher. He said the goal of philosophy was to deal with the misery and anguish of human beings. Just as the medical physician dealt with the problems of the human body, his goal was to administer to the human mind, the human spirit.

What was it that was behind our misery? He felt that it was always the omnipresent fear of death. He felt that it controlled so much of the way that we lived. He was born, by the way—let me just place him in time—he was born in about 340 BC, not too long after the death of Plato. He was one of the important Greek philosophers—had his own following. They often speak of the Garden of Epicurus. That’s the name that my book has, by the way, in Greece and also in France. It was almost a kind of a cult where students lived with him rather than came to study with him during the day.

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He felt that the anxiety about death was with us all the time, but not necessarily consciously. So I think in that way, he was one of the ancestors of Freud’s view of the unconscious. He said we could guess at its existence through its disguised form—through, for example, exaggerated religiosity, through restlessness, moving from one place to the other, through a consistent accumulation of great wealth or blind groping for power. All of these, he felt, offered counterfeit visions of immortality.

He constructed a number of, I think, well put together ideas that his students learned almost as a catechism for dismissing or alleviating the terror of death. I’ll just tell you about three of them today. These
three, I think, are things that are useful to me in my own thinking about death, and I’ve often talked about them with my patients.

First one has to do with the mortality of the soul. He insisted that the soul dies with the body, the mind dies with the body. This was a controversial view at that time. Remember, one generation before, Socrates—and it’s well illustrated in the Phaedo and one of the Platonic dialogues—Socrates very much believed that after death he would pass on to another kind of life, a much better life once he’s freed of the shackles of the body, where he’d be in endless discourse with like-minded philosophers. And Plato’s view of this afterlife had a great rebirth in the neo-Platonic literature when it became one of the foundations of the Christian views of the afterlife.

Epicurus was taking a very materialistic view of existence. He says that if we’re mortal, the soul does not survive. Therefore, we have nothing to fear in the afterlife, and the gods cannot hurt us there.

I sense that was very much relevant to the kind of religious leaders that were present at the time of Epicurus’ life that were frightening the population that if they didn’t live in a certain way and perhaps didn’t give the proper type of gifts to the religious leaders, that they were going to suffer in the afterlife. So he was trying to alleviate that form of fear of the afterlife. And that kind of fear has been very relevant throughout many of our historical epochs—certainly during the middle ages.

Now, Epicurus did not deny the existence of gods. I mean, he didn’t dare do that. Socrates had been executed only a generation before that, but he did say the gods were there. They were there on Mt. Olympus, but they were totally oblivious of us. But they were important because they could serve as models for us, models of bliss and tranquility, and we should strive to emulate them. We should strive to achieve their type of ataraxia—blessed tranquility.

When I was a resident, one of the first drugs that came out was called Atarax. It comes from the Greek word for ataraxia. I think Atarax is still around, as a matter of fact.

The second Epicurean argument had to do with what he called the
nothingness of death. He said, once the body dies, the mind ceases
to exist. That means our senses are dispersed. And that means we
can never encounter death. So what do we have to fear? His famous
aphorism that his students all memorized was, “Where I am, death
is not. Where death is, I am not.” It’s the ultimate answer to Woody
Allen’s quip about death, which is, “I’m not afraid of Death. I just
don’t want to be around when he comes.”

A third argument that I’ll tell you about, which I personally—this has
been debated endlessly in philosophical literature since than. Many
people take strong stance against it, but I think it’s still got a lot of
value. He called it the symmetry argument. He’s saying in effect that
the state—if you will call it this—the state of nonbeing that we’ll be
in after death is the identical twin of the state that we were in before
birth. We have so much concern about the second one and so little
concern about the first. I find that personally quite useful and I’ve
offered that to many of my patients. It’s an argument that has been
discussed by many people.

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Nabokov, the great Russian novelist, starts his wonderful
autobiography called Speak Memory, which is—have you ever
imagined a better title than that for an autobiography? Speak,
Memory—but he starts it off by saying, “Life is a brief crack of light
between two eternities of darkness—the darkness before we were born
and the darkness after death.” Right out of Epicurus.

JOAN: “LIVING A LIFE OF ABSURDITY”

Let me go on. So those are three arguments. Let me describe another
idea. I’ll do it by telling you about a patient that I saw. A patient
came to see me years ago, came from another country, wanted
to work with me for about a week. She was a psychotherapist in
midlife. She had been suffering from a number of symptoms—great
hypochondriasis—any type of ailment that she’s had, she’s rushed to
seeing a doctor. She’s afraid it’s a fatal illness—and furthermore, she
had a whole series of fears. She was extremely risk-averse. She used to
be a good ice skater and gave that up, and had to give up skiing, and
was afraid to drive. She had to take a whole handful of Valium to get on the airplane to come to this country.

It all began two years ago, quite precipitously. It began after the death of her mentor and very close friend. So we talked about this, went into it in great detail. I began to feel that these symptoms were gossamer-thin manifestations of all death anxiety—the hypochondriasis, the risk-averse behavior beginning suddenly after the death of a close friend. In pursuing her awareness of death and a history of this, I asked her a question which I ask all my patients who are dealing with this issue. It seems like a silly question, a simplistic question—in fact, so much so that I often will introduce it saying, “I’m going to ask you a very simplistic question, but just humor me on this one and answer it anyway.” The question I asked her is, “Will you, Joan”—I’ll call her Joan—“Joan, will you please tell me what precisely is it about death that so frightens you?”

As I say, it seems like a silly question, but the answers are quite varied and I think quite informative. Her answer immediately was, “All the things I would not have done.” “How so?” And then she went on to tell me a long story about the fact that she was a very gifted artist. She was a prodigy, won a lot of prizes when she was quite young, but when she started a career of psychotherapy to earn a living, she gave it all up. “No, no. That’s not quite true,” she said. “I haven’t given it all up. The truth is, I start a lot of things. I start a lot of paintings, but I never finish them. I stuff them in my desk. I don’t finish anything. I’ve got a whole closet full of them.”

So I said, “Why is that so? You’re so gifted and you start all these things. Why do you not finish them?” She said, “Well, it’s money. I have to earn a living. I see 40 hours a week.” I said, “How much money do you earn? How much do you need?” She said, “Expenses—three children in private school.” In Britain, they call those public schools just to confuse us. Then I said, “And your husband—you said he was a psychotherapist too? Does he work also as much?” She says, “Yes. He works as many hours as I do. In fact, he does a lot of neuropsych testing. So he earns even more money at times because he charges more.”
So I said, “Then it sounds like you’re making more money than you need. So what’s the explanation for your not exercising and fulfilling your urges to create?” She said, “Well, it’s not really money. There’s another issue involved. The issue is that there is a kind of implicit competitiveness between the two of us—me and my husband—to see who earns the most money. It’s not explicit, but it’s implicit.” So I say then, “Let me ask you a question. You may think this is a very unfair kind of question to ask a therapist who’s in therapy. I see therapists in therapy all the time. They should have a place of comfort and be taken care of and not asked to do their own work, but I don’t ever hesitate to do this.

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So I’ll say to you, okay then Joan, let me ask you a question. Imagine a patient enters your office and says this to you, tells you that she was greatly talented and ached to express herself creatively, but couldn’t do so because she was in a covert competition with her husband to earn money which she didn’t need. If a patient were to tell you that, what would you say?” I can remember her clipped British accent saying this immediately. “Well, I’d say you’re living a life of absurdity.” So we went on talking about how come she was living a life of absurdity, and did a lot of other things—did some marital therapy too. As I say, you don’t only work with existential issues, of course.

This notion of the idea of “all the things I would not have done”—I think that’s another foothold that we have into working with patients. There is a correlation which I feel is true—I even have some doctoral dissertations that have worked on this too—and it goes roughly that the greater the sense of unlived life, the greater the panic about death. The more you sense you haven’t lived your life, the more you sense that there are unfilled potentials and areas of life that you’ve never experienced, the more regret you have about the way you lived your life, the greater the anxiety you will have when it comes to facing death.

That’s why her comment about “all the things I would not have done” was so important. I think this is the meaning of some of Nietzsche’s odd dictums, which would be, “Die at the right time. Consummate
your life.” And I think it’s exactly what Kazantzakis meant when he had one of his great characters in Zorba the Greek—he had Zorba say, “Leave death nothing but a burned-out castle.”

I think this gives us another foothold into psychotherapy. There’s another, I think, powerful idea that we could use in therapy. These are all ideas that I use in therapy. I use them in my own life. That’s the idea—I call it rippling. Just as we throw a pebble into a pond and the ripples kind of go on and on and on into nanolevels that we can’t see, but are still going on molecularly. And I think it’s true that, although our personal identity does not continue and in a couple of generations, there won’t be anybody alive who’s ever known you or seen you, our acts can persist and be passed on and on and on.

Acts of wisdom, acts of charity, acts of great virtue—things that we pass on to others, the teaching that we pass on to others continues to exist far after our own personal deaths. I think this is an important issue for psychotherapists. We all know that when we treat this patient in our office, we’re not just treating that patient. We’re treating other people who that person comes into contact with. We’re treating the children. If we’re treating a teacher, we’re treating all the students of that teacher too. The same thing is true of people in all health fields. It’s all true of all teachers. It’s true that we’re passing ourselves on through our acts into other people. Certainly I think this is one of the things that keeps me pecking away at my keyboard long after retirement age has come and gone.

**MARK: WE ALL OWE NATURE A DEATH**

So now I think I’d like to spend the rest of the time talking about a couple of therapy hours that I’ve had that will back up some of these things. I’ll tell you a couple of clinical tales.

One of them involved a patient that I’ll call Mark. Mark was a 40-year-old psychotherapist. I had seen him in supervision for a couple of years—supervised his therapy groups, his individual work. He came back to me as a patient. And Mark had had a great deal of anxiety about death. He was obsessed with it—the idea of transience. He’s also had a lot of unresolved grief that he could not get past about his sister,
an older sibling who had died.

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So we worked on this for quite some period of time. Gradually, the anxiety about death and even the grief began to resolve—or we might say it came to be transformed into something else. He developed an intense sexual love obsession with one of his clients. I’ll call her Mary. He thought about Mary all the time. We talked and talked and talked about Mary. Never crossed any physical boundaries with her, but he would do a couple of things that were getting close to it. He’d call her up when he knew she wasn’t there just to hear her voice on the voicemail—this type of thing.

I started this particular session by announcing to him that I had just seen a patient that morning who I referred to him as a patient for his therapy group. I know you’re all going to have some questions about this kind of act—this dual relationship, but I will talk about that, I promise, in a few minutes. So I referred a patient to him. He told me, “Thanks.” He went on then to talk about—he said, “As usual, on the way to see you today I’m preoccupied about death, and also preoccupied about Mary.” He switched and talked some more about Mary.

He had gone out with some college roommates. They had a reunion the night before and they all did a lot of talking about former girlfriends and dates, and he just got lost in his feelings about Mary. So I asked him, “Tell me about those feelings about Mary. Just meditate for awhile.” I’m asking him to do some free association for a couple of minutes. He started talking about it: “Well, it’s that starry-eyed feeling.” “Meditate on that starry-eyed feeling. What comes to mind?” And what came to mind after a few seconds was he was sitting on his mother’s lap. He was about nine years old. At ten years old, his mother developed breast cancer, and she died slowly over a period of six years. So his whole adolescence was preoccupied with a mother who was dying all the time. So he was sitting in a time before that, sitting in this time of bliss.

So we talked about this idea, and I offered him some ideas about that. I talked to him about how often it occurs that sex and love both can
help to banish and assuage fears about death—and how powerful, too, is the efficacy of the sense of merger to eliminate death feelings—this idea of merging with his mother, the starry-eyed feeling he had about Mary and about his mother as well. It’s the idea that the lonely I dissolves into the we. So you’ve lost some of your isolation and some of your fear when you’ve dissolved into another person, into a couple.

He then went on to say that “death has been intruding a lot this week. It’s been intruding upon what’s really a very good week. Clinical practice is going fine. A couple of days ago on Sunday, I took my daughter on a motorcycle ride. We went down to—those of you who are native San Franciscans know it—we went down to La Honda, a town not too far from here—and then a lovely ride down to the ocean. It was a beautiful afternoon with her, but the idea of transiency began to plague me. How long will this go on? Will she remember this? It’s all going to turn to dust sooner or later.” He’s had a lot of nightmares. He wakes up often feeling terrified.

So I began to try to probe deeper, and I asked him the same question I asked Joan. “Tell me, Mark, what parts of death are so terribly frightening to you?” His answer was very different from Joan. He said, “I worry about how my daughter will cope with my death.” So again, I tried to give him some ideas about that. I told him the obvious thing: “Perhaps you’re projecting some of your own thoughts about death onto your daughter. You and your daughter have had very different lives and very different parents. You had a mother that was dying all through your adolescence and a father who deserted the family, whereas your daughter had two parents who love her very much. Your daughter has a father who takes her on beautiful motorcycle rides on Sunday down to La Honda.”

01:04:06

Then he turned to me—this was a little unusual for him—and then he asked me, “What about your death awareness? What about your death anxiety, Irv? How do you experience it?” So that was unusual. I talked to him about how it affected me at my age. I told him how the idea of death had the sense of making life more poignant and more precious to me. It made me kind of appreciate every moment and how
I was living life and doing the things that I really wanted to do and cherished doing. I still had my 3 AM bouts of anxiety about death, but on the whole, it augments this.

When this happened three or four years ago, I’d been reading a biography of Freud—I’ve forgotten which one—I think Peter Gay’s book. There’s an episode in there where Freud had mentioned that his mother once talked to him and rubbed her hands like this, like that, and then showed the dead skin. She said, “See, death is with us all the time. We all owe nature a death. It’s part of life.”

I just mentioned that to him, free associating about that. He asked me then—he continued, do I worry about my children’s response to my death? I said that I didn’t. I thought that my children were quite autonomous beings at this point. I think the job of good parents is to create children who are autonomous, who can grow away from their parents and can cope with the loss of their parents. And I felt very good about my children being able to do that.

He then said, “I’ve been thinking during the last week that maybe I can offer something to my daughter by modeling how I face death—by facing death in a way that’ll be interesting and useful for her.” Now, I applauded that tremendously.

Once in the cancer group that David and I were leading, a patient announced during the meeting that she had come upon a tremendous discovery during the last week—that she came upon the same discovery that Mark did. She’s decided that she could model how to face death graciously and gracefully and with dignity to the people around her, to her children and to her spouse. It was very important for her, and it woke up the whole group. It was important to her because it meant that she could imbue the very end of life with a different kind of meaning for her. It gives meaning even to the waning, last days of her life. So I applauded Mark’s doing that.

So that’s the content of the session. Now when we think about a psychotherapy session, I think we should be thinking about it in two modes. One is the content and one’s the process—and by process, I mean, of course, the nature of the relationship between the patient and the therapist.
So if we take a look at what the process of this is—I began to then focus on—with Mark—taking a look at whatever things I have been storing up in my mind about what had been happening between the two of us. The first thing I mentioned to him: “As you know, Mark, this session’s a little unusual. You’re asking me questions. You asked me how I felt about my children, how I felt about death. How do you feel about that? How do you feel about asking me these questions, and how do you feel about my answers to them?” His answer was unequivocally positive. He says it makes him trust me more. He feels closer to me and he realizes he’s got to do more of that with his own patients.

I referred then to another aspect of our interaction—because he said to me right at the beginning that he had had, as usual, this surge of anxiety about death and thinking about Mary on his way to see me. So what is there about “on his way to see me”—what does this have to do with me? I wondered, “Is it possible that you plunge into something more comforting to you knowing that you have this ordeal of working with me because we’re dealing with such painful material?”

He says, “No. That’s not what it is. I’ll tell you what it is. What it is is my shame in front of you.” Then he screwed up his courage and he asked me how I judge him for his whole episode with Mary. So I tried to be upfront with him. I tried to empathize with him.

Whenever I teach my students about empathy, one of my favorite mantras is I go back to an old saying by Seneca, the Roman playwright who once said, “I am human, and nothing human is alien to me.” You hear patients say dark things to you. I think the way you can most easily reach a level of compassion and empathy is to search for those dark parts in yourself. That’s what I did. And I said to Mark, “You know, Mark, there have been times that I’ve been sexually aroused by patients, and I think that’s true for every therapist I know. Yes, you did get too consumed—and yet, sex has a way of defeating reason. Besides,” I said, “I wonder whether or not you went so far with this because you had me here as a safety net. You knew you were going to have to come here and talk about it with me.” Then he said, “Well, still, I think you judge me as incompetent.” I said, “What do you make of the fact that I referred a patient to you this morning?”
I’ll go back to the dual relationships. I think in this instance it was a positive thing. I knew he was a good therapist. I’d supervised him for years. I wrote about it in a book called the Gift of Therapy—the idea of the therapeutic act versus the therapeutic word. This is a good example of that dictum—the idea that I was able to extend outside of the formal relationship and refer this patient to him meant a great deal to him.

He says, “I still can’t get out of my mind that you think I’m a shit.” “No, no, I don’t,” I said. “I think it’s time to press the delete button on that idea. You’re working hard on this. I care for you. I respect you a great deal. I also think, Mark, you’re learning a great deal from this. I think it’s going to make you a better therapist.” I gave him one of my Nietzsche quotes which I love, because I think it’s very pertinent here. I said, Nietzsche once said that “To grow wise, you have to listen to the wild dogs barking in your cellar. In a sense, you’re doing that right now.” He wept with grief at the end of that because he thought that I had lost all regard for him.

I don’t have time to discuss that in detail, but you see how I changed the tenor of this session by moving into the here-and-now. That’s what I think is our most potent weapon for increasing this sense of authentic connection with patients. Focus on what’s happening between the two of you.

**AMELIA: “I WANT A HUG”**

I’ll give another example of this. This example involves therapist self-disclosure. This is an example of being pushed to your limits about that. This is about a patient named Amelia, I’m calling her. She’s a 50-year-old black, handsome, heavy-set, highly intelligent public health nurse.

35 years before I saw her, she had been for over two years a homeless heroin addict—and of course, to support her habit, a prostitute. I think anyone seeing her then, spotting her on the streets of Harlem, a ragged, emaciated, demoralized soldier in a vast army of heroin-addicted prostitutes would have laid good odds that she was doomed.
for a short and brutish life.

Yet, remarkably enough, with the help of a forced detox period, and prison when she was sentenced for six months, and hundreds of Narcotics Anonymous meetings, and extraordinary courage, ferocity to live, she really pulled herself out of that. She moved to the West Coast. She became a club singer—she had a wonderful voice. Put herself through the rest of high school, through nursing school, and for all these years now, 20 years, had devoted herself to being a public nurse to the poor.

She had severe insomnia, severe nightmares. Frequently she’d be awakened by nightmares. I won’t describe them in detail because I’m not going to have time, but things like light, which really was a kind of music, seeping through the blinds of her window, and the music was a Roberta Flack that she used to sing a lot called “Killing Me Softly.” She simply came to me when she was so insomnic she needed some help, and she read a story I’d written called In “Search of the Dreamer”—it’s in Love’s Executioner.

So let me tell you about this session. She came, plopped herself down in the chair, said, “I’m not sure I can stay awake. I was up all night with a nightmare,” and told me the nightmare. She not only had these feelings about depression and fear of death, nightmares, but she also had another major problem—and that’s what I’m going to focus on mainly on this session—A lot of problems with intimacy, as you might imagine, especially intimacy with men, but also with women.

So we were working hard on that. I was working on that in the same way I just mentioned to you—working on our relationship. She started the session with a phone call she got on her cell phone. Used to be a big problem in therapy was therapists taking calls. Now it’s patients taking calls during therapy.

She got a phone call, and she handled it in a perfunctory manner in a couple of minutes, making an arrangement for meeting later that day. I thought she was talking to her boss. At the end of the phone call, I asked her was she talking to her boss? She said, no, no. She was talking to her new boyfriend that she’s been going out with for the last three months. I said, “That sounded like you were talking to your boss.
What about some terms of endearment, Amelia? How about calling him honey or darling or sweetheart or sugar?” She looked at me as though I’d dropped out from a parallel universe at that point.

She changed the topic. And she was telling me about yesterday she’d gone to a Narcotics Anonymous meeting. She had been sober and off for heroin for 30 years, but still went to NA meetings about weekly, or AA meetings. The meeting she went to was in the Tenderloin, one of the seedy areas of San Francisco, about six or seven blocks from here. If you walk straight out that-a-way, you’ll see that area.

**01:16:35**

She said that as usual, when she goes through those neighborhoods, a strange wave of feelings comes over her. It’s something like nostalgia. She begins searching for where she might be able to spend the night, in an alleyway or a doorway, as of course she did when she was 15 and 16. “It’s not that I want to be back there, Dr. Yalom,” she said. “You know,” I said, “you still call me Dr. Yalom and I call you Amelia. Doesn’t seem quite balanced to me.” “Like I said, give me time—got to know you better. But as I was saying”—she went back again to these experiences.

And the experiences are not entirely negative. There’s almost like a little homesickness. I said, “What do you make of homesickness?” She said, “I tell you what. I walk through these neighborhoods. I hear a voice in my mind and I’m saying, ‘I did it. I did it.’” I said, “It sounds like you must be saying to yourself, ‘I went through hell and back and I survived.’” “Yeah, it’s something like that, but also life was so much simpler for me then. I didn’t have to worry about budgets, and what I was allowed to do for patients and what I wasn’t, and tax deductions. All I worried about was one thing—next sack of dope, and, of course, the next john to help pay for that sack of dope.”

Of course, I say, “A little selective memory here, Amelia. What about the broken bottles and the freezing on the streets at night and death everywhere and the dead bodies and you almost getting murdered?” “Yeah, yeah. I know. You’re right. I forget about these. I got almost killed by some freak and next minute, I’m back again out on the streets.” “So heroin puts,” I said, “all other thoughts out of your mind—even death.” I said, “You’ve got to feel proud about climbing
out of there. You’ve got to feel good about yourself.” “Yeah, I feel some of that. I feel good about it. My mind is loaded with other things, but it’s true. Right now though, really what I’m most interested in doing is staying alive and staying off drugs.”

Then I said to her, “Well, does coming here, does seeing me, help you stay off drugs, Amelia?” Her answer: “My whole life, my work in groups, Narcotics Anonymous, my therapy—yeah. That helps.” I said, “That wasn’t my question, Amelia.” I said, “Do I help you stay off drugs?” “Like I said, everything helps.” I said, “That phrase ‘everything helps’—do you see how that dilutes things? Keeps me distant? You avoid me. Could you try to talk more about the feelings you have to me in this session? Or perhaps last week or what you’ve been thinking about me during the week?”

She says, “No man, you’re not off on that again.” I said, “Trust me.” This is the 20th time. Trust me. This is important, Amelia.” “Well, you tell me that all patients think about their therapists?” I said, “That’s my experience. I tell you, I thought a lot about my therapist when I was in therapy with him.” She’s been slumping on her chair, making herself small whenever we got around to talking about our relationship. For that moment, though, she straightened up. I’d really caught her attention.

She says, “Your therapy? When? What thoughts?” I told her about some of the things I liked about my therapist, Rollo May. “I liked his gentleness. I liked his attentiveness to everything I said. I liked the way he dressed with turtlenecks and had this nice turquoise necklace around his neck. I liked his way of saying he and I had a special relationship because we had similar interests. I liked his reading the draft of something I had written and complimenting me on it.” Silence. Amelia was looking out the window.

I said to her, “Your turn, Amelia.” “Well, I guess I like your gentleness too.” She squirmed, looked away from me. “Keep going. Say more.” “It’s embarrassing.” “I know. I know, Amelia, but embarrassment is our quarry. Embarrassment’s our target. We’ve got to plunge right through it. I’m going to get right into the middle of your embarrassment. Try to keep going.”
“Well, I like the way one day you helped me on with my coat. I liked your chuckling those times when I fixed the turned up corner of your rug. I mean, I don’t know why that don’t bother you, too. You got to do some fixing in your office here. That desk of yours is a mess. Okay, okay. I’ll stay on track,” she said.

01:21:58

Then she talked about the time she’d come into my office with a bottle of Vicodin in her hand that a dentist had given her and how hard I’d tried to get it out of her hand. She says, “I mean, the dentist dumps it in my lap. You think I’m going to just give it away? I remember at the end of that session when you wouldn’t let go of my hand when I tried to leave the office. I’ll tell you one thing. I’m grateful you didn’t put therapy on the line. You didn’t give me an ultimatum that it was that bottle of Vicodin or you’d stop therapy. Other therapists would’ve done that and I would’ve left them.”

“I like you saying that, Amelia. I’m touched by it. Tell me, what’s the last five minutes been like for you?” Remember, therapy is an alternating sequence. Interaction and then reflecting back on that interaction—that keeps getting it deeper and deeper. “What have the last five minutes been like for you?” “Embarrassment, that’s all,” she said. “Why?” “Well, because now I’m open to being mocked.” And then she went on and talked of one of these times—there were a lot of experiences when she was younger, a lot of them having to do with sex, too, where she was mocked by other people.

I raised the possibility that maybe some of the mocking, too, some of the embarrassment, has to do with her two years on the street and the shame there must be about that. She said maybe that was so, but she disagreed, really, because the embarrassment was there even before those two years on the street.

Then suddenly she turns to me and she says, “I have a question for you.” That’s a new one. She never did that before. That caught my attention. I didn’t know what to suspect and I just waited eagerly. I really like such moments in therapy like that. She says, “I’m not sure you’ll be willing to handle it, but here it is. You ready?” I nodded. She says, “Would you welcome me as a member of your family? You know
what I mean—theoretically. Would you welcome me as a member of your family?"

Well, I took a breath. I thought some time on that. I really wanted to be honest, wanted to be genuine. I looked at her—head held high, large eyes were fixed on me. She was not avoiding me as she usually did. I looked carefully and I said, “Yes. The answer is yes, Amelia. I consider you a courageous person, a lovely person. I’m full of admiration for what you’ve done with your life—the moral kind of life you’ve led. So yes, I’d welcome you.”

Her eyes filled with tears—first time I saw a tear from her in the year and a half I’d been seeing her. After a few minutes she said, “You have to say that, of course. It’s your job.” So of course I said, “You see? You’re doing it again, Amelia. Right now you’re pushing me away. We got too close for comfort, eh?” Time was up. It was raining outside. She headed towards the chair where she—it’s one of the six days of rain we have here in California. She went for the chair where she left her raincoat. I reached for it and I held it up for her to put it on. She cringed. She looked uncomfortable. “You see? You see? That’s just what I mean. You’re mocking me.” “Nothing further from my mind, Amelia. It’s good you said it though. It’s good to express everything. I like your honesty now.”

As she turned to the door—she reached the door, she turned back to me and she said something that was totally unbelievable to me. She said, “I want a hug.” That was really unusual. I liked her saying it. I hugged her, felt her warmth, her bulk—and then she walked down a few steps from my office. I have an office a couple hundred feet from my home, a long gravel path. She walked down the path and I said to her as she walked away, “You did good work today, Amelia.” I could hear her steps on the gravel. And then, without turning around, she called back over her shoulder, “You did good work, too.”

So that’s that session. That was both those sessions. I think the major point, as I say, I’m trying to make to you, is the idea of working in the here-and-now—of trying to examine the relationship between the two of you and being honest in that relationship. I write a lot about that in a lot of works I’ve done. You see long discussions of it in The Gift
of Therapy, and also in this current book, as well. And, of course, it’s closely related to the idea of therapist transparency—a topic that is a difficult one with a great deal of debate about that.

01:27:22

I personally like to talk about the idea of therapist transparency—and there are different forms of therapist transparency, too. There’s the idea of how transparent we are about, let’s say, the mechanisms of therapy—how therapy works. I really believe that we can be entirely transparent about that. I think psychotherapy is a very, very robust, hardy organism, and we don’t need any magic. We don’t need anything hidden.

When I introduce my patients into group therapy and in individual therapy both, I tell them what to expect. I tell them how therapy works. I tell them what you could do that you make the most use of it, and what I’m going to be trying to do. There’s a good deal of a very persuasive body of research that indicates the efficacy of this kind of approach. So that’s one form of transparency.

Another form of transparency has to do with transparency in the here-and-now, of using your feelings towards the other person, and being able to express it in a way that invokes responsibility to the patient—expressing feelings and thoughts that will be useful to the patient and in ways that they can use them. So any kind of strong feeling that you have about the patient, you have to find a way to make therapeutic use of that.

Let’s just take one extreme example. If the patient is very boring to you, obviously you don’t tell the patient you’re bored, but you find ways to use that. You say, “I’ve been aware in the last 10 minutes that I’m feeling quite distant from you.” That, of course, has the implication that you want to be closer. “Are you feeling that too, John? Let’s see when that started. It’s so different from, say, the beginning of our session, those 10 minutes, when we felt so much closer. Let’s take a look.”

Because, remember, the kind of feelings you have about patients are a microcosm of how other people will feel about them in their life. So these little nanofeelings that you’re having are important to work on.
Unfortunately, we’re reaching the end of the time that we have. Let me just summarize for a couple of minutes what I’ve said. I know this has been a little unusual talk for you, without any PowerPoint, but I’m a storyteller and I never use it.

What I’ve tried to do today is to emphasize the importance and ubiquity of anxiety about death during psychotherapy. It plays a far greater role in our internal life than we often think, both overtly and covertly, and I think it should be addressed in therapy. I think if therapists are trained to recognize this, have dealt with it in their own personal therapy, they can do a great deal to help patients with this. We can’t assuage this kind of anxiety, but we can do more than that. We can enhance the way that people live.

I think effective therapy in this, in all other parts of therapy, is a synergy of powerful ideas and a powerful, intimate connection. I’ve tried to describe some of the powerful ideas, some of the ideas of Epicurus, about the idea of unlived life and its relation to the fear of death, and also the idea of rippling. I’ve tried to emphasize and describe some methods of enhancing this sense of connection in psychotherapy through the use of the here-and-now.

I’ll stop now. Thank you very much.
Video Credits

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...and more

**Therapeutic Issues**

- Addiction
- Anger Management
- Alcoholism
- ADD/ADHD
- Anxiety
- Beginning Therapists
- Child Abuse
- Culture & Diversity
- Death & Dying
- Depression
- Dissociation
- Divorce
- Domestic Violence
- Grief/Loss
- Happiness
- Infertility
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- Medical Illness
- Parenting
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**Population**

- Adolescents
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- Inpatient Clients
- Men
- Military/Veterans
- Parents
- Prisoners
- Step Families
- Therapeutic Communities
- Women