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Instructor’s Manual Death, Dying, and Grief in Psychotherapy, Volume 1: A Brief Psychodynamic Treatment with Milton Viederman, MD

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Instructor’s Manual for

**DEATH, DYING AND GRIEF IN PSYCHOTHERAPY, VOLUME 1: A BRIEF PSYCHODYNAMIC TREATMENT WITH MILTON VIEDERMAN, 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 provide ideas about key points that can stimulate rich discussions and learning.

3. LET IT FLOW
   Consider playing the sessions all the way through at once, rather than hitting the pause button frequently, so viewers can appreciate the way they flow together. It is best to watch the video in its entirety since issues untouched in earlier parts often play out later. Encourage viewers to voice their opinions; no therapy is perfect! What are viewers’ impressions of what works and does not work in the sessions? We learn as much from our mistakes as our successes; it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
   Assign readings from Suggestions for Further Readings and Websites prior to viewing. You can also schedule the video to coincide with other course or training materials on related topics.

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

6. CONDUCT ROLE PLAYS
   After watching the video and reviewing Viederman’s Approach to Death, Dying and Grief in Psychotherapy in this manual, break participants into groups of two and have them role-play a therapy
session following Viederman’s approach to brief psychodynamic treatment. One person will start out as the therapist and the other person will be the patient; then participants will switch roles. Patients may discuss actual issues around death, dying and grief in their own lives, or may role-play a friend, acquaintance or a patient of their own. Invite therapists to practice some of the techniques Viederman used in the video, such as:

- helping the patient develop awareness of his or her emotional state, by echoing the patient’s implicit affect;
- encouraging self-revelation by underlining the patient’s emotional responses and meanings;
- painting a picture of the patient’s experience;
- commenting tactfully on the therapeutic relationship;
- commenting on aspects of the patient’s personality (mostly supportive of self-esteem) to convey to the patient that he or she is recognized.

After the role-plays, have the pairs come together to discuss their experiences. First, have the patients talk about what the session was like for them, both in terms of discussing issues around death and dying, as well as experiencing the therapist’s interventions. Then, have the therapists talk about their experiences. Finally, open up a general discussion of the strengths and the challenges in applying Viederman’s approach to brief psychodynamic treatment for issues related to death, dying and grief.

An alternative is to do this 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 patient. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Viederman’s approach to brief psychodynamic treatment for issues related to death, dying and grief.
PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and clients can be self-conscious in front of a camera. Therapists often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: Therapists’ personal styles are often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personalities. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.

PRIVACY AND CONFIDENTIALITY

Because this video contains actual therapy sessions, please take care to protect the privacy and confidentiality of the client who has courageously shared her personal life with us.
Viederman’s Approach to Death, Dying and Grief in Psychotherapy

There are no algorithms or manuals that can define Viederman’s therapeutic approach to death, dying and grief. Each clinician must develop his or her own style based on his or her experience. However, there are basic concepts and specific techniques that when illustrated can be integrated and learned.

An outline of some of the maneuvers utilized in this video may be useful:

A. Echoing the patient’s implicit affect or therapeutically developing the patient’s awareness of her emotional state.

B. Underlining the patient’s emotional responses and meanings, so as to encourage further revelation. This maneuver would include active clarification of aspects of her life experience pertinent to her current response.

C. Creating the climate of the patient’s experience when it has not been directly expressed. Painting a picture of the experience.

D. Commenting tactfully on the quality of the interaction with the consultant to relieve inhibitions in communication. Using observed qualities of the interaction to examine characteristic patterns of behavior with the patient.

E. Commenting on aspects of the patient’s personality (mostly supportive of self-esteem) to convey to the patient that she is recognized. These aspects include the patient’s basic perception of the world and her attitude to the world.

Understanding the patient’s experience and communicating this understanding becomes the vehicle by which the clinician can reach the patient. Central to this approach is a dynamic view of behavior that implies that underlying desires, wishes, and fears and their accompanying fantasies condition experience. Actively engaging patients using this dynamic understanding can rapidly affect them. The mistaken notion that supportive engagements simply require being nice to a patient dominates the view of most physicians.
Supportive interventions are truly effective when based on a dynamic understanding of the patient’s personality and major conflicts. The elucidation of the patient’s experience as a patient and the consultant’s communication of that understanding facilitate the establishment of a bond that relieves distress and acts as a catalyst for a future collaborative therapeutic relationship.
Reaction Paper for Classes and Training

Video: *Death, Dying, and Grief in Psychotherapy Volume I: A Brief Psychodynamic Treatment with Milton Viederman, 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 concise. Do NOT provide a full synopsis of the video. This is meant to be a brief 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 brief psychodynamic treatment for grief in the face of death? What stands out to you about how Viederman works?

2. **What I found most helpful:** As a therapist, what aspects of the model presented did you find most beneficial? What tools or perspectives did you find helpful, and what 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, and/or 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 style of working?

4. **How I would do it differently:** What might you have done differently than Viederman in the sessions 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 therapy sessions with Viederman? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

WEB RESOURCES
Faculty web page for Milton Viederman, MD
www.med.cornell.edu/research/mviederman/index.html
Association for Death Education and Counseling
www.adec.org
The Center for Thanatology
www.thanatology.org

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET
Time Limited Dynamic Psychotherapy with Hanna Levenson, PhD
Psychotherapy with Medically Ill Children (Child Therapy with the Experts Series) with Gerald Koocher, PhD
Object Relations Therapy (Psychotherapy with the Experts Series) with Jill Savege Scharff, MD
Coping with the Suicide of a Loved One: An REBT Approach (REBT in Action Series) with Albert Ellis, PhD

RECOMMENDED READINGS


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.

PART ONE

INTRODUCTION

1. **Role of the past:** Viederman said, “The past is only important as a living past. Not as an intellectual history, but as a past active in the present.” What do you think he means by this? Do you agree or disagree? What is your overall conception of how to make best use of the past in psychotherapy? For example, do you tend to take a detailed history, or do you wait until the client spontaneously brings up events from the past? What indicators do you use to gauge whether exploration of the past is useful to the client’s current issues?

SESSION ONE

2. **Beginning:** What did you think of how Viederman began the session with the patient by saying, “Tell me what brings you here. It’s been difficult”? What did you think of his decision to start with an empathic statement before she had shared anything yet? How do you think this might have impacted what she chose to express next?

3. **Responding to hopelessness:** How did you find yourself reacting when the patient spoke about her hopelessness about her husband’s recovery? How do you think you would have responded to her hopelessness if you had been her therapist? What did you think of how Viederman responded?

4. **Assessment of personality:** Viederman’s assessment of the patient’s personality was that she was an “intelligent, expressive, intensely related woman who was psychologically minded and highly motivated… a woman who was a defined person…who expressed her needs clearly and coherently…who knew what
she was about and who affected the world.” Does Viederman’s assessment align with yours? If not, how does your assessment of the patient’s personality differ? How do you think his assessment of her influenced his approach to working with her?

5. Pursuit of historical antecedents: When the patient said, “I like control,” Viederman immediately inquired into the origins of her need to be in control by asking her, “Where does that come from, when you go back to your earlier life?” What did you think of this intervention? How do you think this inquiry into her earlier life impacted the session? How do you think that helping people understand how they got to be the way they are helps them make changes in their lives?

6. Interpretation of core conflict: Viederman expressed to the patient his interpretation that it is important for her to be different from her mother, who, from his understanding, “cultivated helplessness.” What did you think of this interpretation? Do you agree with him that this was her core conflict? How do you think this interpretation contributed to the rest of their work together? Can you see yourself making a similar interpretation? Why or why not?

SESSION TWO

7. Relief of symptoms: In her second session with Viederman, the patient reported that she felt more relaxed, not as unhappy, and less stressed, and she talked about how she felt 100-percent better when she left the first session. What do you think Viederman said or did that may have contributed to this degree of symptom relief? Were you surprised at all by her report, or was it what you would have expected given what you saw in the first session?

SESSION THREE

8. Transference: Did you agree with Viederman when he said that the patient’s comment that he is a genius indicates an ideal transference, and that this is in keeping with her wish to have an ideal parent as a source of support? Why or why not? If you have you had patients who exhibit this kind of transference
with you, how has it felt for you to be seen by your patients this way? How do you tend to work with this kind of transference?

9. **Fear of loneliness:** In session one, Viederman helped the patient uncover her underlying fear of being alone for the first time in her life, and by session three she said that since she’s been in therapy she hasn’t thought much about loneliness. What do you make of this shift? How did you react when Viederman said, “I guess my presence mutes that feeling of being alone.” Did you agree or disagree with this interpretation? Do you tend to bring attention to the therapeutic relationship in sessions? Why or why not? If so, what are some ways you do this?

**PART TWO: EIGHT MONTH FOLLOW-UP**

10. **Grief:** What reactions did you have to the patient’s letter to Dr. Viederman that he read at the end of the video? How did it impact you when he read that at times her sorrow is overwhelming? Did that surprise you at all given how she presented in the follow-up session? Why or why not?

**OVERALL**

11. **Being with grief:** How was it overall for you to witness this woman’s pain and sorrow as she spoke about her husband’s illness? What are the challenges and rewards you have faced in working with people who are experiencing grief or anticipatory grief? Is this a population you are drawn to work with? Why or why not?
INTRODUCTION

Viederman: This video consists of two independent parts that illustrate different phenomena. The first is an edited psychotherapy in which various themes and concepts are discussed as the therapy evolves. It is complete in its own right. It begins with a discussion of the nature of therapeutic engagement.

Part II, separate but related, examines the issues of grief and change in the concept of a patient’s life crisis. What unites these separate presentations is the fact that they are illustrated by the same patient, and that the second is to be viewed, at least in part, as the outcome of the first.

When the patient requested a consultation, I had no knowledge of what the problems were or what I would recommend. I will demonstrate how the initial therapeutic consultation evolved into a brief therapy with a defined termination. It is important to emphasize that whatever treatment is decided upon at the end of a consultation, the therapeutic engagement begins at the time of first meeting with the patient. Central to my point of view is an active response to the patient. By activity, I refer to two related behaviors. First, the consultant must be active in formulating in his own mind hypotheses about the meaning of a patient’s communication and behavior at any moment in time.

The second aspect of activity involves utilizing these inferences with immediate work with the patient. One might view the interview as a detective story, or perhaps more properly, an experiment. One forms alternate hypotheses. One tests these hypotheses with comments to the patient and observes the response to determine the validity of the
presumptions.

The interview may seem to wind through the corridor of the patient’s experience and life history and appear to be without formal structure or clear form. It moves in unexpected ways. However, structure exists in the therapist’s mind as he returns to themes not initially followed.

However, there are two broad categories of information. The first has to do with the phenomenon of the patient’s experience, their symptoms and signs, all of which lead to a formal diagnosis, the familiar subject of modern descriptive psychiatry. The second is the domain of psychodynamics -- of motivations and conflicts, personality, and the patient’s life history. The third consideration has to do with what I consider the uniqueness of the dialogue, for no two discussions with patients are alike. Each dyad develops a special language and a unique and personal way of talking to each other. Moreover, the dialogue resembles a conversation, an unusual one, and an asymmetrical one in that the two parties have different roles, but a conversation nonetheless.

Two concepts are central to my way of thinking. Meaning is an intervening variable and the psychodynamic life narrative. Meaning as an intervening variable suggests that between the stimulus and the painful, emotional response lies a special meaning to the patient. Hence, there is no one-to-one relationship between the stimulus and the response. And it is the task of the consultant to determine the nature of that meaning.

The second, the psychodynamic life narrative, is a construct that gives meaning to the patient’s emotional response to their current situation, whether this might be depression or anxiety or anything else, and places this meaning in the context of the patient’s life and shows it to be a logical, and even inevitable product of his early life experience, his special vulnerability.

The past is only important as a living past. Not as an intellectual history, but as a past active in the present. Hence, past history is not a sterile compartment in the psychiatric history separated from the current life experience not mechanically recited by the patient. We all of us live with myths about our lives, and these myths often conceal
the sources of our difficulties. What the therapist attempts to do is to participate with the patient in constructing a new vision of the patient’s experience. In some respects, all useful dynamic therapeutic endeavors are designed to construct a new vision of the present in dynamic relationship to the past.

Viederman: The treatment is a three-hour psychotherapy that evolved in the context of a consultation. I will comment on process, by which I mean observations, interventions, and patient response. I will also use specific segments to develop certain concepts central to the psychotherapeutic endeavor, especially those sections illustrating clarifications or interpretations and the responses. I mean by this, interaction in which the patient’s experience is formulated and echoed in which empathetic responses are mirrored. The patient’s response to interpretation or clarification early in the process seems somewhat removed and intellectualized though thoughtful. It is only as the process continues that strong ethic becomes connected with the discoveries that she is making and hence, become true insights.

The patient is the 54-year-old wife of a retired contractor who developed lymphoma about 10 years ago. He had done quite well during the first eight years only then to have recurrences with complications and ultimately a bone marrow transplant. The course had been checkered by remissions and relapses, and I’d seen the patient himself some months before when he was in the hospital. The therapeutic sequence consists of three sessions at weekly intervals.

FIRST SESSION

Viederman: At the beginning of this encounter, I am evaluating the most immediate and primary concerns of the patient asking her what brought her to me.

Viederman: Tell me what brings you here. It’s been difficult.

Pat: Yes. I think that I’ve performed very well in crises, and now that the extreme crises has somewhat abated, I’m finding it hard to just kind of cope with dealing with, you know, my husband as a patient. And I’m finding it particularly hard to balance hope with practical realistic expectations. The struggle of, you know, getting a blood
report out on Tuesday and it looks good, and then on a Thursday it isn't as good. You know, living by those numbers up and down.


Pat: No. It’s a roller coaster. And being—you know, should I allow myself to be hopeful if the numbers are good, or should I constantly keep preparing for when it isn’t good? I’m not particularly hopeful that this transplant has done anything. I mean it’s—I’m not hopeful for a cure. And so therefore, I just keep wondering, you know, when the other shoe will fall and when the doctor will say, “Well, there’s no more we can do.” And I just find it hard to juggle how I should be on a day-to-day basis. Should I be optimistic? Should I be cheery? Should I be—what should I be? It’s hard. I’m finding it hard.

Viederman: How does he behave with you when he’s in that state? You know, feeling sick.

Pat: He withdraws.

Viederman: He withdraws. Because you don’t know what’s going on with him.

Pat: Often. So I always have to ask, you know. I mean I’m constantly asking, you know. I sort of have to nag.

Viederman: Right. Now this change, now really, you’ve been living with this for nine years now. But this is new as I hear it.

Pat: Yes. I really feel, you know, I feel totally worn down. And you know the transplant was really our last hope. So now there isn’t….

Viederman: So you’re not hopeful? That’s really one of the essential issues. You try to grasp hope but you don’t do it with full vigor.

Pat: He was allowed to go out to eat and three days later he got diarrhea and five days later we go to the doctor and get a test and his white count is up to 18, and you know, so the minute he’s allowed to go out and lead somewhat of a normal life, he gets sick.

Viederman: So he’s very vulnerable.

Pat: Very vulnerable.
Viederman: And this is very much unlike the way he was.

Pat: You know, I feel responsible for him.

Viederman: Responsible? What do you mean?

Pat: Well, for taking care of him. So you know, when he came home from the hospital, you know, everything had to be clean, we had to guard what he ate and all that kind of stuff. And then the minute he’s out of that control he gets sick. So that makes me mad. You know, I feel like I was doing the best job I possibly could and what difference does it make?

**Viederman commentary:** During this period, I observed the patient and observed that she was clearly an intelligent, expressive, intensely related woman who was psychologically-minded and highly motivated to overcome the immediate distress that she was feeling in the crisis that had developed. I sensed a woman who was a defined person. A woman who expressed her needs clearly and coherently. A woman who knew what she was about and who affected the world. It was this initial evaluation that formed the substrate for my early intervention.

Her responses confirmed my view of her. I emphasize here the importance of early assessment of personality. What I call sculpting the configuration of personality as a guide to intervention that forms the basis for the establishment of a relationship.

The patient began by describing the disarming aspects of the uncertainty that she has been feeling. Constant movement from hope to despair as her husband improved and then had recurrences of illness. She has been on a roller coaster as she said. Moreover, she had difficulty in communicating with a stoical husband. I intervened frequently to crystallize what she was saying. Namely, that she was struggling with the inner state of not knowing what to expect, and that I could share it in a limited way by entering her world. The patient indicated that she was doing the best job that she could, but wondered what difference it made. I responded by indicating that I supposed that made her feel helpless.

Viederman: And then there’s that terrible feeling of hopelessness that there’s nothing--that’s not a bad--that’s a feeling that’s very alien to
you is my guess.

Pat: Yes. I—that’s true. I usually feel I can find a way to deal.

Viederman: You’re a woman who’s been in control of her life to an extent.

Pat: Yes, absolutely. And I like control.

Viederman: Where does that come from? When you go back to your earlier life?

Pat: I’m an only child.

Viederman: Oh, really? And what else?

Pat: I don’t know, I mean--.

Viederman: What about your family? Where do you think that came from when you think of it?

Pat: Well my father was very much in control. My father was a judge, so he was a very authoritative figure and very much in control. And my mother was somewhat in control, although in her latter years, she really--she wasn’t. And it felt that she didn’t--she wasn’t. So you know, I mean, I feel that I deal with things….

Viederman: More effectively than she.

Pat: More effectively.

Viederman: Is it important for you that you be different from your mother?

Pat: Yes. I think so.

Viederman: In what ways? In general.

Pat: She was extremely dependent upon my father. She liked to, you know, she liked to stay at home in a very simple role, you know. I mean, of her generation. She was a woman of her generation. And, you know, she liked to make a joke out of the fact that she couldn’t balance a checkbook and you know, she was….

Viederman: So, she sort of cultivated helplessness.

Pat: Yeah, to a certain extent. Yes.
Viederman: And that was something you would have no control over is my guess.

Pat: No. That’s not my....

Viederman: You’re not going to cultivate helplessness. In fact, you can’t stand it when you experience it.

Pat: That’s right.

**Viederman commentary:** I note the patient’s helplessness and make an inference that I present to her. She is a woman who likes to be in control of her life. She acknowledges this unambiguously. Its importance as a theme is evident since she is describing the distress related to being out of control and confronting uncertainty.

I then inquire about the origin of this need to be in control. She responds by revealing that her father, a judge, was authoritarian and her mother the opposite. A woman certainly not in control. At this point I make the interpretation that it is important for her to be different from her mother. She confirms this by describing the dependency of her mother, who remained at home. I label the mother’s behavior as the cultivation of helplessness and emphasize that she is the opposite of her mother. That she doesn’t cultivate helplessness; that she can’t stand it. The patient responds positively to my active interventions.

Interpretations are statements made to the patient, which direct her attention to elements of which she is unaware, whereas clarifications organize material, which is conscious to her. In this regard, it is a new organization of conscious material. In pointing out to the patient that it was important to her to be different from her mother, I was touching on an area that she had not formally thought about, but which she could recognize readily. This thought did produce conflict in her for it involved, as it turns out, a denigrated view of the mother as weak and dependent. The suggestion that this was in part defended against in her previous mental activity is supported by the fact that her initial response is a pensive agreement and only later, as we shall see, does she acknowledge with intense emotion her resistance to this identification. The resistance to this identification, the wish and need to be different, is called a counter-identification.
The usefulness of investigating the past becomes apparent in this section. The patient’s extreme discomfort about being out of control and helpless reflected her sense that she was like her mother, and it is only by examining the past that we can begin to understand the nature of the conflict that this posed for the patient. I asked her if she had experienced anything similar to what she was experiencing now. Her initial response was to say no, that although she cared for both of her parents in their prolonged terminal illnesses, she had not felt that way.

**Viederman:** Have you been in this role before?

Pat: I have been in this role before. I know it well.

Viederman: But what is different about it now?

Pat: What is different is that if--I’ve always had my husband, and now, if he dies I won’t have him and I will truly be alone. And that is different.

Viederman: That’s a big difference. You’ve never been alone before?

Pat: No. I’ve been married to him since I was 21 years old.

Viederman: You moved from home to marriage then?

Pat: Yes. So, that will be different.

Viederman: And that frightens you a great deal, doesn’t it?

Pat: Yes.

**Viederman commentary:** The act of examination of what makes this situation unique leads the patient to the awareness that she has lived with her husband for almost all of her adult life. Beyond the painful experience of caring for loved ones, the real threat in this situation is being alone for the first time in her life. I actively pursue how this situation is different from the one in which she cared for her parents to arrive at an understanding of what frightens her. I emphasize that this is what is unique about this situation and the reason it evoked the disruption that led to the consultation.

I call this conceptualization “meaning as an intervening variable.” By this I mean that between the stimulus--the husband’s illness--and the distress that she feels, is the special meaning of the experience, namely
the fear of being alone. The patient had not been aware of this before.

What emerges next is the more specific precipitant of the patient’s current experience of being distraught. Her husband had improved and they had plans to go out for dinner only to have this interrupted when he developed diarrhea and became sick once again. This was a more immediate precipitant of the anxiety generated by uncertainty.

**Pat:** Like, you know, we also when he was told that he could go out to eat, he also then decided he would plan a trip in, next fall. You know, I said, “Well, that’s great.” And, you know, I just can’t even--this just feels so fake. You’re planning something in the fall, you know. I can’t even imagine he will even be here in the fall. So kind of pretending, for me, it’s like pretending and talking about it and it feels fake to me.

**Viederman:** How did that come up that planning for the fall? Who brought that up?

**Pat:** He did. Because he decided--yeah, he felt he was going to be okay. He could go out to eat now, he was going to be all right. And so he decided, you know, that he would.... Started talking about playing golf in the spring and, you know, he wanted to go to Italy and so, you know--.

**Viederman:** So, that’s another problem that you feel he asks you to participate and...

**Pat:** Oh, I can’t even think about that. I can hardly think about next week, much less....

**Viederman:** But he expects to play a role in that fantasy. It must be hard for you now, isn’t it?

**Pat:** That’s hard.

**Viederman:** Because how can you sort of talk with him enthusiastically about such a plan....

**Pat:** And, I don’t want to get excited about something if it isn’t going to happen. Because it hurts too much when it doesn’t happen. So, I don’t want to have to think about it.

**Viederman:** Sure. Sure. Sure. So how do you deal with him when that comes up?
Pat: I fake it.

Viederman: That’s hard isn’t it, to fake it? You don’t look like a good faker to me.

Pat: No, I’m not a very good faker.

Viederman commentary: The patient and her husband are living with different levels of awareness of reality. The husband, in his denial, imposes the demand upon the patient to behave in an inauthentic way. A way that is contrary to her general view of herself. In taking note of a personal attribute that the patient values, I support her self-esteem, though this does not resolve the problem.

SECOND SESSION: ONE WEEK LATER

Pat: Because I rested and I feel better. The nervous tension is done. And so I feel, you know, more relaxed and I guess better able to deal. I’m not as unhappy; I’m not as stressed; I’m not as crazy. It’s a hard thing for me to do though because I’ve always defined myself by being a highly energized person. So, when I’m not that way, it doesn’t feel like me. It almost feels, you know, like I’m sick, or I’m dying. So it’s hard for me to do it, but I think that’s probably for now the way I have to deal stress.

Viederman: It sounds like you’re ceasing to try to control everything. Is that what you’re saying?

Pat: Yes.

Viederman: Is that accurate? Is that what you’re saying?

Pat: Yes.

Viederman: But it’s hard for you because it gives you…

Pat: I am a control freak.

Viederman: Excuse me. It seems that you’re a different person when you’re acting that way so it makes it hard for you.

Viederman commentary: The patient’s decreased control has led to a feeling of depersonalization, a change in the experience of herself. A state in which she feels she is not the familiar person she knows. She
has the sense that she too is dying. A possible identification with her husband. This is called “mild depersonalization.” What narrowly this patient experiences herself is someone in control of her life with an organized plan of activities, and with a fairly comfortable and predictable view of how her life will evolve. This has been disrupted in her current situation. A related phenomenon is called “de-realization.” This is analogous to depersonalization, but represents the patient’s sense that the world around her has changed and it is not the familiar world she knows. This can occur dramatically during earthquakes or natural disasters, but also may occur when a markedly changed reality imposes itself upon the patient.

In response to the patient’s indication that she felt improved, I then asked her what permitted her to feel better.

Pat: Just starting to talk to you, you know, admitting that I was out of control, so to speak. And just raising my own consciousness. Getting in touch with that and saying, “Hey, this is where I am and this is a problem. It isn’t really working right now, so it’s time to change and to do something about that.” I mean I think that’s what allowed me to—you know, I’ve looked at the problem. I’ve paid attention to it.

Viederman: What was your reaction to our meeting last time?

Pat: I felt much better when I left. Just 100% better. And what I--why I think I feel so much better is I feel there’s now someone I can talk to, even though I have friends I can talk to, you know, you can’t use your friends for everything. And it wasn’t--you know, I was talking to friends, and it wasn’t working. So I think it was time to talk to somebody who would give me, you know, just total leeway to do anything, you know, to come here and just say anything to you.

Viederman: Even to cry.

Pat: And to cry for an hour, whatever.

Viederman commentary: In this second session the patient reveals the moderate relief of symptoms related to what I call “presence of the therapist.” This is a sense that a dialogue has begun with a person in empathetic resonance with her experience who communicates the sense that he understands what is happening, and in this respect, has
entered her life. This global response, which depends upon the degree of emotional contact and resonance that has been established between patient and therapist is important, but it is to be separated from what will later develop, namely the very specific insights that the patient begins to emotionally experience about the sources of her current dismay.

Pat: I’d really be happy if I knew, you know, if it was going to continue.

Viederman: Of course. That’s what it’s all about isn’t it? Have you ever in your life lived with this type of uncertainty? I don’t mean the same situation, maybe even not the same intensity, but is it reminiscent for you of anything in your past life? Anything. Tell me what comes to mind.

Pat: No.

Viederman commentary: At the beginning, the patient states very simply she would be happy if she knew that her husband’s improvement was going to continue. I comment simply, “Of course. This is what it’s all about.” This interchange is a minor one, yet is essential to the nature of the interaction and occurs frequently throughout the sessions. This is the fabric of the interchange and relates simply to the therapist’s acknowledgement of a patient’s concern at a moment in time.

I then begin an inquiry into the sources of the patient’s current emotional reaction. Her initial negative response does not deter continued exploration.

Pat: Well, health, you have no control over it. But everything else you have some control over. I’ve never felt…

Viederman: But not everyone feels that way.

Pat: Yeah, but I feel that.

Viederman: I know. I just want to comment on that. So it’s health really that…. 

Pat: It’s really health. I mean, you know, the other things in life eventually I always felt I could figure out a way to deal with it.

Viederman: Does that go way back even before your parents were sick? That sense that health was something that couldn’t be controlled?
Pat: I guess I’ve always known it intellectually. But I think I grew up with that maxim. I mean my parents would stress that. I mean, you know, “Just be thankful you have your health. It’s the most important thing.”

Viederman: Were they focused much on health, your parents?

Pat: Yeah, I mean….

Viederman: Your mother, your father, particularly?

Pat: I think so, yeah.

Viederman: Tell me more in detail about that.

Pat: Well, I…. You know, I think that we…. I just remember that as kind of a maxim as perhaps--but I don’t want to put too much emphasis on it. But I mean they didn’t dwell on it, but I remember I think always feeling that, you know, the one thing you have to be thankful for is good health, because that’s the one unknown. That’s the one thing that can change everything. I think I kind of…. My father was older, so I think….

Viederman: Were there sudden illnesses in the family?

Pat: No. I mean my mother had been ill for--my mother had tuberculosis as a young person.

Viederman: Before you were born?

Pat: Yeah. So she was always not particularly well.

Viederman: Oh, she wasn’t particularly well?

Pat: Well, I mean she was frail. She would get pneumonia.

Viederman: She was seen as vulnerable then really?

Pat: Very, yes.

Viederman: And liable to get sick.

Pat: Yes.

Viederman: Oh. You know, as we begin to talk about it, there may be something here, you know. But the idea of someone around you of importance getting sick, after all that’s what we’re talking about now.
She had pneumonias and she did get sick periodically?
Pat: Yes.

Viederman: Do you remember how you reacted to that?
Pat: Probably, I’m sure I was very upset. Yes, I would say then growing up I had to deal frequently, or a lot, with illness with her. And she had, when I was in high school when I was a senior in high school, she had a hysterectomy because she would have had cancer, you know, cervical cancer if she hadn’t. She had a pre-cancerous condition. And then following that, when I went away to college, she had a, what was then called a nervous breakdown and had shock treatments.

**Viederman commentary:** Here it is pointed out to the patient that her perception about the uniqueness of health as an area over which one has no control is specific to her. And although she has no idea of what this is about, it emerges that her mother was very fragile and vulnerable. As this theme is developed and becomes clear, there is a subtle interchange in which I say simply, “Oh,” to underline what the patient has said. The patient laughs with the recognition that she has revealed something herself, namely her mother’s fragility, as related to the sense of loss of control over health. This small interaction reflects a quality of working alliance that includes play and humor in the interpretive process.

With encouragement the patient begins to paint a picture of the experience of her vulnerable mother, but the experience at this point remains emotionally isolated. In other words, stated without feeling. And in this respect does not have special meaning to the patient. Isolation of affect is a defense mechanism in which an individual is able to describe an experience or a fantasy, but without experiencing the affective component.

I continue to focus on the mother’s vulnerability, and in essence create with the patient the atmosphere of her childhood experience. As this is done, the isolation of affect breaks down and the patient begins to experience feeling.

Pat: And I think what may be driving me crazy is I think that because she was vulnerable and needed to rest and prone to sickness, you know, I was not that way. Not only because I didn’t want to be that
way, but because I am--I have a very strong constitution. I have tremendous amount of energy. I am very adventuresome and I am very secure. My mother was a very insecure person. You know, I’m really the opposite.

Viederman: But you know, I guess it gets us right back to feeling not like yourself and because I think that your reaction to this situation makes you feel that you’re like your mother in a way. In spite of in all other respects, and never before have you felt this way. That’s what you’re starting to say. That’s where you seem so unreal, unlike the person you know.

Pat: Yeah. In a sense I kind of have to be just a companion to my husband.

Viederman: And that’s what your mother was to your father.

Pat: Yes. My father was the center of her universe. And I think that’s absolutely true that my husband is now the center of my universe. And, yeah. And so our… that’s a very good… I never would have put that together. Our life--my life now with my husband is very much like my parent’s life. Which, you know, they had tremendous love and it was wonderful.

Viederman: But it’s not your thing.

Pat: Not my thing. That’s right. But I do it well.

Viederman: I’m sure. I think you probably do everything well, but it’s a considerable cost, you know.

Pat: Yeah. That’s a very good point. I would have never put that together. Maybe that’s what made me so crazy is that I felt I was slipping into that kind of a role and I am losing myself and not having any life of my own. And however appropriate it is to have slipped into that role.

Viederman commentary: These segments reveal the full emotional experience of a feared identification with a weak, vulnerable, and dependent mother. It is important to emphasize that the initial interpretation of the patient’s reluctance to be like her mother was made in the first session, but was not integrated as an insight. This
raises the issue of explanation, meaning and insight. Explanations are cognitive structures. They are rational statements often used to convey understanding of behavior. In themselves they are devoid of emotional conviction. The implication here is that, “I’m doing this for this and this reason and we don’t have to look further.” Insight, imbued with meaning, is an emotional experience that carries with it a sense of conviction.

Hence, the patient in the first session was aware of her wish not to be like her mother, but in this session she reveals the fact that her extreme distress, her craziness as she put it, reflects the literal experience of feeling like her mother in this new situation. This is an insight and not a rationalization. This is an important distinction in life and in psychotherapy. It is insight that gives meaning to experience. It is for this reason that premature interpretations experienced as explanation are accepted by the patient and act as resistance to true insight.

The patient continues in this session by further elaborating in an emotional way a feared identification with her mother. How distressed she was with the mother’s illness and her concern that her wish for a life of her own is not selfish. She wonders what will happen to her. Whether there will be anyone to care for her as she has cared for her husband. In this she reveals her own dependency. She has defended herself against this awareness through a counter-identification with the mother. This is a latent theme that will once again emerge at the end of the treatment.

THIRD SESSION: ONE WEEK LATER

Pat: I have to tell you that what you helped me with last week had lasting benefits all week long and I feel so much better, and it just astounds me. It really does. It astounds me. The whole bit with my mother, you know, and not wanting to be like her just, I mean I can’t believe that it’s had this effect. So I have--my older daughter is in Europe and over Christmas she said something to me that really bothered me. Not that--just made me very curious. She--we were talking about something and I said, “You know, it drives me really crazy is having to stay home and wait for a repairman or something.” And this was in the context of a conversation. She said, she looked at me and said, “I wonder why?” And I looked back at her and I
said, “Well, wouldn’t it drive you crazy?” I mean, you know, like this was the norm. This is the norm. What’s the matter with you that it wouldn’t drive you crazy? And the reason it drives me crazy is because my mother used to say to me, “You have a wonderful home. Why don’t you stay home? What’s the matter with you? Why do you want to go out and do all these things?” And you know, I emailed after--I went home, I emailed my daughter in Europe, “Breakthrough! Viederman is a genius.

**Viederman commentary:** This segment reveals the manner in which meaning and true insight molds the experience of everyday life. The rather banal experience of the impact for this patient of waiting for a repairman takes on significance by virtue of its link with a central theme related to conflict about identification with mother.

*Important to note here is the importance of an ideal transference. The patient has endowed me with a special status in her life and special powers--being a genius. This is in keeping with her wish to have an ideal parent as a source of support. This may be an unconscious wish that is ubiquitous as patients approach treatment, especially when they are in crisis situations. They long for the protection of a powerful omniscient person. It is important to emphasize however, that this is not developed de novo, but develops with intensity in the context of a helpful and meaningful, interpretive stance and empathetic resonance with the patient. The ideal transference that I have described is to be distinguished from the idealized transference which is a frequent occurrence in treatment and which involves an idealizing attitude toward the therapist--an attitude which covers unconscious feeling frequently of an aggressive nature.*

The patient continues by discussing a disturbing argument that she had with her daughter.

Pat: And I had had an argument with her that week preceding my starting to come to see you when I was crazy, and she was very upset with me. You know, and finally I said, “You must be more compassionate.” Well she got very upset that I had accused her of not being compassionate. Of all people in this world, she is 100% compassionate. But my feeling was that she could deal with me as
long as I was being strong, but if I fell apart, then that really upset her. Which made me feel like I couldn’t fall apart and who was there for me? And, you know, it really bothered me a little bit and so I was a bit nervous for them to come and I started just thinking about, “Well, you know, Pat, you’re upset because you do not want to lose the relationship with your daughter because our relationship is very similar to the one that I had with my mom. And I really did—we did really lose—we really drifted apart. And now it’s frightening to me that that would happen with Lauren, because we’re very, very close, and I, you know, always thought I was very, very close to my mother. And then everything sort of changed and I lost her support for who I was and, you know, thought, god, if I show weakness or whatever, will I lose my daughter?

And you know, I thought—so I really started to think about it and I sort of—I worked it out. “The reason you’re so upset is because of what happened with your mother, and that’s not going to happen with your daughter. It’s two different…”

Viederman: And that connection really clarified and relieved you enormously.

Pat: Yes. And I was able to work it out all by myself before they came for lunch. We had a wonderful time at lunch. There was no, you know, underlying tension, nothing. And I thought, “Oh, this is terrific!”

Viederman: I can do this myself.

Pat: I can do… But you know it just—it was so powerful. So incredibly powerful.

Viederman: The awareness was so liberating.

Pat: Yeah. Amazing to me. I mean it just really did amaze me, so thank you.

Viederman commentary: The patient describes in great pride in having begun to examine emotional distress utilizing the tools that she is acquiring in psychotherapy. She began to think about why she was so upset about this conflict with her daughter. Through her associative connections, she came to a meaningful understanding of the
fear that her relationship with her daughter would deteriorate as had been the case with her mother in the context of her movement toward independence and a different way of life.

The patient is accelerated by the sense of power this gives her. The increased sense that she is in control of herself and her life--values very important to her. This is associated with a sense of autonomy and in this respect, even a sense that she can operate without me, that she is not dependent upon me. In this section the patient also reveals a phenomenon seen in psychotherapy called “working through.” This implies that after a particular interpretation is made, or a particular insight is achieved with meaning, the patient then begins to note the implications of this implication in other areas of her life. It is in this context that substantial change occurs by recognizing that her fear of being trapped at home relates to her fear of being like her mother. The patient is liberated from this concern. As these experiences of working through continue, the patient begins to experience herself in a new way.

The patient continues for the rest of this session to elaborate themes that emanate from the discoveries that she made. In discussing the argument with her daughter she realizes in retrospect that it was that upsetting experience that was the immediate precipitant for her decision to call me. Hence, as the therapy proceeds the patient becomes more and more precisely aware of the immediate motivation for the consultation.

It began with her sense of upset in a general way, then seemed associated with the disappointment that occurred when she could not go out to dinner with her husband because of a relapse and finally, more precisely, when she realized it was the dispute with her daughter that was an immediate stimulus for a request for consultation.

The patient elaborated on the circumstances that led to the alienation from her mother. It occurred when there had been a conflict in her marriage and a brief separation. She was extremely dissatisfied with her husband’s complete immersion in his business and she asked for a separation at this time. She returned to business school and worked at a Wall Street brokerage firm for a number of years. All of this contrasted with her mother’s image of the perfect marriage. Although the couple
reunited much more happily with a significant change in the husband’s behavior, the relationship with the mother remained conflicted. Yet she remained sad and disappointed rather than angry with her mother and recognized that her mother experienced much dissatisfaction with herself. An indication that she had come to terms with the mother’s failure.

She continues by describing the uncertainties of her husband’s illness and her attempt to enjoy what she has so as not to waste the time remaining with her husband only later to have regrets. In describing her inner state she says, “And I don’t even feel like it’s the quiet before the storm. I feel it’s here to stay. You know, I feel that I’m grounded.” We talk about ending the contact for the moment and decide that she may call me for another meeting. We also discussed my availability to her husband if he so wishes. Then, as we are about to separate, a latent theme asserts itself.

Pat: How do people go through it alone?

Viederman: It seems so hard at times.

Pat: And so many people do. They do go through it all alone. I don’t know how I’ll do it.

Viederman: Well you know the importance of not feeling alone and I think that’s one of the things that our relationship does is to give you the sense that you’re not alone in this. And you know, you spoke about being alone before too. You know, the first time you came in we spoke of your fear of being alone and obviously that’s an important theme for you. I guess my presence mutes that feeling of being alone.

Pat: Yeah. I hadn’t thought about that. You know, I really haven’t thought about that. So that’s good because that’s scary. And I’ve for… since I’ve been coming to see you I haven’t really even given it a thought.

Viederman: So it’s sort of moved away.

Pat: Pretty good.

Viederman: In the context of our relationship, you know.

**Viederman commentary:** Clearly the impending separation has
re-evoked the patient’s anxiety about being alone. My presence had muted that sense of loneliness since I was a presence in the patient’s life. This is directly interpretive to the patient, and when she says, “That’s pretty good,” she means that she understands the implications of what I have said, that it has meaning to her. And she then confirms this by indicating since we have been meeting she has not had thoughts of loneliness or being alone.

Implicit in what is evolving at this point is the patient’s partially unconscious dependent relationship upon me. Our separation confronts her with the initial fear of being alone and touches on the question that she raised in the second session. “Who will take care of me?” This is not resolved in this therapy, but the patient’s explicit awareness of my availability acts to decrease her sense of rupture and vulnerability. The patient herself gave us the clue in the first minutes of the interview. She describes the context of the consultation, “My husband is a patient,” rapidly to reveal her distress at his vulnerability. As her fear of identification with the dependent mother became clear, she becomes more comfortable but never acknowledges her wish for a similar dependency, an unconscious wish gratified in her relationship with her husband.

In summary, and interpretation based upon an inference that I made in the first six minutes of the first interview, namely her fear of identification with the mother, became a central theme and was elaborated and worked through in a three-session therapy.

There were additional themes that related to control, the problem of dealing with uncertainty about illness related genetically to her mother’s illness when she was a child, her concern about reproducing her relationship with her mother with her daughter, and the theme of being alone with no one to take care of her.

Regarding the psychotherapy, I offer three caveats. First I emphasize that another therapist might have pursued another course and interpretive strategy. There are psychoanalytic theoreticians who contend that the powerful mutative interpretations reside uniquely in interpretation of the transference, and that the emotional revisiting of the past is of less significance. This is not my view, nor is it the only view
in psychoanalytic thinking.

The second issue relates to the role of interpretation of conflict. Did the patient undergo a significant change in her perception of herself in relationship to the world, or did she experience a transference cure, namely a relinquishment of symptoms to obtain the admiration and love of the therapist? Both factors contributed to her current state though I believe insight was an important component. It is apparent that unresolved conflicts remain. The patient maintains an ongoing dependent transference expressed in her statement that she is only a phone call away. Moreover, when I speak of the positive ideal transference I did not minimize the possibility of ambivalence in the transference--an idealized transference, especially at termination when the symbolic abandonment may generate anger.

These feelings do not appear to me to be available for interpretation at the moment of termination. I let the patient speak for herself.

The patient’s husband became sick once again and the focus turned to him. In particular, some months later, I received a call requesting that I have a telephone session with him since he was in a hospital 30 miles from New York City. He had become increasingly aware of the fact that he would not improve. His intolerance of the quality of life that was offered him and his continuing debilitation without real hope for improvement led him to refuse a new treatment, Thalidomide. I acknowledged his wish to maintain dignity and control. His wife, in a separate conversation, needed support in coming to the same conclusion.

Three weeks later his wife called and revealed that her husband had died. She requested an appointment.

FOLLOW-UP: EIGHT MONTHS LATER

Viederman: Part Two will address the patient’s grief response and her response to the treatment. We will also examine a change that occurred in her relationship with her older daughter in the context of the crisis of her husband’s death.

How is one to evaluate the impact of a therapy that terminated eight months before? There are two criteria that may be used. Neither of them can be seen in a linear relationship to the original therapy as
cause and effect since many other variables have contributed to the result. Nonetheless, one can establish meaningful hypotheses about the response to treatment.

Obviously, the patient is doing well in the immediate aftermath of her husband’s death. As you will observe in the next two segments, she’s not symptomatic, experiences neither anxiety nor depression, but is in the throes of a normal grief response. Though she feels generally good, waves of grief invade her as she remembers aspects of her relationship with her husband. She is hopeful and looks forward to the future. She experiences no guilt about her husband’s death neither in failing him in responding to his needs, the guilt of omission, nor of unconscious hostility, the guilt of commission. She continues to be intensely related to the people around her, yet she properly and thoughtfully considers the possibility that the full impact of the loss has not yet occurred and she wonders what the future will bring, but she remains confident. These are indications of a normal grief response rather than a depressive response to loss.

The second criteria in evaluating an interpretive dynamic therapy is the question of whether resolution of conflict played a significant role in the change. A central conflict related to the patient’s unconscious identification with her dependent mother was interpreted and worked through in the brief psychotherapy.

The patient feared that she would be unable to tolerate the loss of a dependency object and the ensuing loneliness. As we shall see, she appears to have negotiated the problem of being alone.

Viederman: Well you were saying that it seems like a long time. It seems like years. There’s so much that’s happened.

Pat: Yes. But it’s good. You know, I sort of can’t believe… I’m waiting for the other shoe to fall because I really am okay. I feel, you know, fine, I’m at peace with everything. The process was a natural process. It went well, as well as it could have gone. You know, the service that we had for Bill was absolutely wonderful and it was truly a celebration. Truly a celebration. Oh, very powerful. Nothing but genuine pleasure and respect and support and love for everything that I had set up.
Viederman: You were surrounded by supportive people.

Pat: Absolutely. There was not a negative, other than my older daughter who had given me hell for the week, but that’s to be expected. And that we’ve worked through. You know, very, very positive reactions by everybody. So I was, “That’s nice.” You know. “I did it right.”

**Viederman commentary:** The patient began by describing the immediate experience of her husband, Bill’s death and the celebration of his memorial. She speaks comfortably without sadness or evident grief at this point while there is a tenderness as she describes the quality of his death. She also announces potential difficulty with her daughter that will emerge later in the material. She expresses concern about doing everything right. A theme that was evident in the first interview.

Pat: And so he just had days where he just sort of slipped away into unconsciousness. He would open his eyes but I think, as I like to put it, he could receive our love and our talking to him, but he could not receive anything ugly. He just slipped away. Peacefully, with a lot of, you know, love and care all around him. And the nurses, you know, even though he wasn’t conscious, they shaved him and they washed him and they turned him every half hour and, you know, they were just wonderful. So I know he went very peacefully in a loving environment. And that was good. You know. And I got a call at 2:30 in the morning on Friday morning that he had died. And, you know, I didn’t even cry, and I mean, I cry a lot.

And it was that night when I left the hospital I thought, “You know, it’s okay.” And he died, so it was nice.

Viederman: It was okay when you left the hospital. You felt that.

Pat: I was ready for him to go.

Viederman: Before he died. Sometimes we’re ready.

Pat: I was ready. I wasn’t ready the day before.

Viederman: What made the difference?

Pat: You know, I don’t know. I don’t know whether it was because the minister came. I don’t know if, you know, each day was like a month.
You live so much, the day is so full of stuff. I think I had worked through a lot and he was just-- he really wasn’t conscious. Even though he would open his eyes, he wasn’t there.

Viederman: He was already moving away.

Pat: He was already moved away.

**Viederman commentary:** Here she describes the circumstances of her husband’s prolonged final hospitalization. She is very affected by the way the nurses treated him. Even in his stuporous and comatose state he was cared for with dignity. It is to be noted that anticipatory grief prepared her for the loss which did not come as a disturbing shock.

Pat: But those are-- these life death decisions are incredible to be in a situation to be making them. I mean this is not an everyday occurrence, and it’s very powerful and the rest of the world seems so small. It’s huge, it’s just huge. And to have sort of been there, it was a very powerful time. I mean it was as intense as life can get. It’s not all bad. It’s not bad, it’s fabulous as a matter of fact.

**Viederman commentary:** The decision to take him off antibiotics was a difficult one. There were hours of intense discussion with the physician. The patient states that her role had been to fight the cancer for all these years. To fight for life. Now she was confronted with a situation in which she had to accept death, just a she said, physicians do. She had been disappointed initially when Bill had refused to accept Thalidomide as a new treatment since he deemed it futile. It took her two days to accommodate to this. But she recognized that it was his decision and his body.

Her meetings with the doctor were of great importance. He was very open in revealing his own experience with his dying father whom he had suctioned in the very room in which Bill was dying. She then describes the intensity of her feelings and reactions to the life and death decisions that confronted her. She is invigorated by the sense of her active participation in the process. We then turn to a more specific impact of the experience.

Viederman: How did it change you do you think?

Pat: Well, none of the little things bother me. I’m much calmer and it
really changed my orientation toward my older daughter because the doctor had given us this project to work on healing with her and Bill, in talking to Ann, had said how he wanted Ann and me to be okay together. And so that was the charge he gave to Ann. And of course, the doctor gave it to me, “All right, you have your work to do. Your work is cut out.”

So I was able to do that. I never got mad. I never got angry. She didn’t flip me out, which she always does. So I knew I was making progress whether or not it was having any effect on her I wasn’t so sure about because she was really testy. However, are you ready for this? In the memorial service there were four people who spoke and Ann decided that morning she was going to speak, so she was the last. And she got up and she talked--she was wonderful--and she talked about her dad and how he was transformed by his illness and then at the end she said, “I really want to acknowledge my mother’s role.” And, you know, nobody else had even mentioned that, which was appropriate. I didn’t want anybody to mention that. But she reached out.

Viederman: It was very touching, especially coming from her.

Pat: Ann was talking to me and she really reached out. And then after the service everybody commented on Ann. Everybody. I mean she became the hero, or the heroine. And I was mad. I was angry and I thought, “Why am I reacting like this? This kid reached out to you.” And I was angry because she was able to do this in a public forum and it made her look really good and I didn’t trust it. And I was sort of upset for the whole afternoon about this. It was in the back of my--I was obviously involved in a whole lot of other things, but I was--this was just in the back of my mind. And everybody who came up to me and said, “Ann was so wonderful.” And I just smiled and said, “Yes, she was. It was very nice.” And I’m thinking, “Aargh.”

And so that night I sat down with Lauren. Lauren had some things that were bothering her, not about Ann, and so she talked about those. And I said, “I got to tell you I am feeling nothing but anger about Ann.” And I said, “This isn’t right. What is wrong with me?” So I just talked it out with her and I said, “I am angry that she said this,” and I said, “I cannot receive her love. I block her love. She reached out
to me and that was not manipulation, that was a genuine reaching out. And she can do it in a public forum easier than she could do it to me because I’m so scary on a one-to-one basis.”

Viederman: Really?

Pat: Yeah.

Viederman: That was an insight for you?

Pat: It was huge. And I thinking I accused her all week long of being unable to receive our love, and what have I done? So that was very big and I was really--I felt ashamed and I thought, “All right, she’s taught you.”

**Viederman commentary:** The patient had been given a commission by a highly valued doctor to work out her relationship with the older daughter with whom she had had constant conflict. In a situation of great emotional intensity at the memorial service for her father, the daughter was able to express admiration for her mother. The patient found herself unable to accept this and became enraged, viewing what the daughter said as a manipulation to attract attention to herself. In a discussion with her younger daughter, with whom she has a good relationship, she began to reexamine her behavior with the older daughter much as she had done with her mother in the therapy. She came to the realization that she has been blocking the daughter’s effort to express love toward her and began to recognize her central role in the difficulty with this child.

The genetic antecedents of this conflict are revealed in the next segment as I invite her to examine them.

Pat: I’m meeting her this afternoon at 4 to have the afternoon and dinner with her tonight. So, we are really working and now the guard is down a little bit. And that’s huge. That’s really wonderful. But for me to realize how I literally blocked what she had to say and turned it into something negative I thought, “I wonder if you do that all the time with her? The kid doesn’t have a chance.” So that’s not good.

Viederman: What do you think the struggle with her is about?

Pat: Well, Ann is, her affect drives me crazy. So if I were in a room
with people and I met her, I would not be drawn to her, to her way
of talking and her behavior. It just isn’t something that I like. I’m
wondering, I mean I’m going way back to when she was born and
thinking, “Am I jealous of her?” Because she was my first child. I was
22 years old. I knew nothing about anything. I was an only child,
used to being the center of my parent’s life....

Viederman: And attention.

Pat: And getting all the attention. And you know I was married
and my husband, all he did was work, so I was not the center of his
attention. And then I had this child, and the child became the center
of everybody’s attention.

Viederman: The child became the center of everyone’s attention. And
you know that’s exactly what happened at the service.

Pat: Exactly. Well, and that’s what Ann is very good at doing that
because....

Viederman: Capturing. Sort of, there’s a real competitive theme
between you two.

Pat: Competitive. And you know I am very competitive. I am a
competitive... and I know that about myself. I am very competitive. I
just wasn’t aware that perhaps I was jealous of my daughter. That’s not
a nice thing to learn about yourself.

Viederman commentary: My invitation to examine the roots of her
conflict leads the patient to recognize the source of her jealousy toward
her daughter. She comes to an awareness that she, as an only child, had
been the center of her parent’s attention. She felt displaced and angry
with the birth of her oldest child. Her description of the experience
speaks for itself. This has become an important insight for the patient
and reflects a major change in her perception of herself.

What are the ingredients of the change this patient underwent and how
does this relate to the concept of crisis? A crisis situation develops when
a dramatic new reality is imposed upon the individual. Such a situation
demands new coping devices an accommodation to the modified view
of reality. A crisis disturbs the usual psychological equilibrium and
frequently evokes regressive wishes to find the comforting presence
of benevolent, nurturant figures. However, the requirement for an altered perspective on one’s life trajectory adds an additional disruptive element.

Such was the situation when the patient was confronted with Bill’s death. Her husband, in a bedside commission, had encouraged his daughter to improve the relationship with her mother. The physician encouraged the patient to modify the highly conflicted relationship she had with her daughter. He thereby set an ideal for her and she, in her desire to please, was motivated to achieve this ideal to do it right.

Her daughter’s expression of admiration first intensified the competitive feelings associated with the patient’s desire for attention, and then led her to examine the sources of her rage. What motivated the daughter to express herself so powerfully during the memorial service is unknown to us though one might expect that she was confronted with similar ingredients of crisis. In any case, her statement to the patient evoked the conflict that had been generated from the moment of her birth. The patient reexamined her experience.

Just as she had struggled in the therapy with conflict in her own relationship with her mother, she was now to confront her difficulties in her role as a mother. The catalytic presence of her younger daughter acted as a foil and encouraged the initial acknowledgement of the inappropriateness of her emotional reaction. She was available for insight, and a simple question about the potential sources of her conflict with her daughter led to the realization that she had been jealous of this child who had stolen the attention that she had considered to be her birthright as a first and only child.

From a conceptual point of view, she was moved to achieve an ideal suggested by an admired authoritative figure, the physician whose presence catalyzed a shift in the context of psychological disequilibrium, regressive inclinations toward a parental figure, and the need to reorder the trajectory of her life. The challenge generated by this crisis under felicitous circumstances led to an awareness of a major conflict and a significant change in her relationship with her daughter.

Viederman: But I wanted to ask you about this, to have a chance to talk to you about it. You had spoken about concern about being alone.
Pat: Yes.

Viederman: How has that been for you?

Pat: Well, I haven’t been alone, you know. People call all the time, you know. “What are you doing for dinner tonight?” People are making sure that I’m not alone. I’m still in the honeymoon stage. I’m in this very supportive world right now. I do… so I’m fine. You know, people thought, “How are you?” I’m absolutely fine. I’m fine. I’m okay. I’m waiting for it to hit. Am I numb? Am I going to fall apart in a week or two weeks or in the middle of winter? Am I absolutely just going to dissolve and get depressed? I really don’t think so. I’m not as concerned about being alone as I was. I’m certainly not concerned about living in that house alone. I mean I’ve spent the whole past year basically… Bill was in the hospital a lot and I lived there alone. I have two dogs who tremendous company to me. So I’m not afraid of being alone in my house in the country, you know.

The fact that I don’t have a husband I think I’ve adjusted to that because I’ve thought about that particularly in the past year a lot. I think I’ve… by voicing the anxiety and getting affirmation that I’ll be okay, I believe that. And I’m actually… have a sense of release now and am able to do a whole lot of things I haven’t been able to do in a very long time, and I’m excited about that. I’ve had so much time to process everything, which is terrific. So therefore, I mean, if Bill had died suddenly it’s a whole different bag of tricks. I mean I don’t know how people cope with that. I don’t know how they deal. That would be awful. But I have had time. I mean he’s been sick a long time. I mean from the time he was diagnosed I knew he was going to die. There was a finite… And you immediately start to deal with that fact and what it would be like after they’re gone. I dealt with that—probably every day I thought about that. So therefore, I was prepared when he died and it’s not really any different.

Viederman: I see that.

Pat: Yeah, and, you know, I haven’t had my husband as I knew him for a long time. So that makes a big difference.

**Viederman commentary:** At this point, we return to the anxious
concern that the patient raised in the first session of the psychotherapy, namely her fear of being alone. Although she is aware of the possibility that this may a honeymoon phase and that the full impact of the loss may be experienced later, she appears confident and secure. She realized that she has been working this through in the context of anticipated loss. In this regard, she states that she faced the fear before.

Beyond the implication that she spent much time alone over the past year, a core conflict has been interpreted in the brief psychotherapy. Here the patient recognized her unconscious identification with her dependent mother. Her doubts about managing alone related to this feared identification.

Has the interpretation of this conflict and the full emotional recognition of this feared identification helped the patient to resolve it, to modify her self-representation, and to confront the future alone with equanimity and assurance? Not entirely. The threat of a dependent transference may well sustain her, but the patient has changed. It is interesting to note that she refers to her husband in two ways. Earlier she speaks of living alone without a husband. I emphasize the “a,” the impersonal. Here she is referring to the need for a person upon whom she can be dependent and who will protect her from loneliness. Her statement that she can live without this reflects some resolution of conflict.

Later she talks of the loss of her husband. This is personal and involves the loss of the specific person with whom she shared her life.

Viederman: It’s a very moving story, the story you tell.

Pat: It’s good. It’s a good story. I’m at peace.

**Viederman commentary:** Three weeks later I received the following letter: “Dear Dr. Viederman, I felt I really did not thank you for all the wonderful care and support that you gave to Bill and myself this past year. You made such a difference to Bill when you saw him in the hospital after his transplant. And you were extremely helpful to both of us in guiding us through the ups and downs of his temporary recovery. I would hope that I could call you with questions in the next year. I am starting to thaw out and the sorrow at times is overwhelming. It does cheer me up when I think of your help and know that you’re only a phone call away. Fondly.”
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About the Contributors

**Milton Viederman, MD**, is Emeritus Professor of Psychiatry at the Weill Medical College of Cornell University and until recently directed the Consultation-Liaison Service at the New York Presbyterian Hospital. Among the institutions at which Dr. Viederman has lectured are Oxford University, Harvard University, Duke University Medical School, University of Chicago, and UCLA School of Medicine. His honors include four Outstanding Teacher Awards at Cornell and two at the Columbia Psychoanalytic Center for Training and Research, the Ruth Easer Memorial Lecture at Mt. Sinai Hospital in Toronto, Ontario, Outstanding Lifetime Achievement Award from the Society for Liaison Psychiatry, the Robert Liebert Award in Applied Psychoanalysis, the Dr. Nathan Seidel Lecture on the Art of Medicine at the Beth Israel Hospital in Boston, among others.

A psychodynamic perspective and an interest in the narrative structure of people’s lives formed his Consultation-Liaison experience. Many of his publications address therapeutic change in the psychoanalytic situation and therapeutic possibilities during consultation. His recent publications include: *George Seurat: A Life Divided*, *Active Engagement During the Consultation Process, Presence and Enactment in the process of Psychotherapeutic Change*, *The Uses of the Past and the Actualization of a Family Romance*, *Metaphor and Meaning in Conversion Disorder*, *The Therapeutic Consultation: Finding the Patient*, and *A Model for Interpretative Supportive Dynamic Psychotherapy*.

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