UNDERSTANDING GROUP PSYCHOTHERAPY: AN INTERVIEW

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Some portions of this manual were excerpted from Instructor’s/Practitioner’s Manual: An Overview and Discussion Guide for the Video Series by Patricia P. Gadban, (1990) Wadsworth, Inc.

Published by Psychotherapy.net
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Instructor’s Manual for Understanding Group Psychotherapy, Volume Three: An Interview
with Irvin Yalom, MD

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPT
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 the video and post-viewing.

2. GROUP DISCUSSION QUESTIONS
Pause the video at different points throughout the interview 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
Allow the interview to play out so viewers can appreciate the flow of the conversation. It is best to watch the full video since issues untouched in earlier parts of the interview may be covered later. Encourage the viewers to voice their opinions; no therapist is perfect! What do viewers think works and does not work in Yalom’s approach? It is crucial for students and therapists to develop the ability to effectively critique others’ 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 time 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. PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST
Every psychotherapy is unique, influenced as much by the personality and style of the therapist as by the use of specific techniques and theories. Thus, while we can certainly pick up ideas from master therapists, each viewer must make the best use of relevant theory, technique and research that best fits their own personal style and the needs of their clients.
Interview Questions

Interview questions are presented in the order they appear in the video.

1. Who do you consider to have been the most important influences in your work?

2. You’re known for two kinds of work, really: your group psychotherapy and the existential psychotherapy. What’s the difference between the two, and do they overlap at all?

3. So, you don’t really see these two things as contradictory. I mean, in terms of existential therapy, if you’re talking about sort of an unbridgeable gap between individuals in this kind of basic isolation, and yet in group therapy, you’re talking about the importance of relationships. Is that really contradictory? I mean, are relationships a refuge from isolation?

3. So in this way, relationship therapy can actually be helpful in terms of having authentic relationships and being an authentic individual.

4. This kind of intrapersonal isolation, would that be something best dealt with in individual therapy?

5. Let’s turn a little bit to group work in general. Why do you think more therapists don’t do group work? I mean, in light of financial constraints and the like?

6. And do you think that most psychiatrists, or psychiatrists-in-training, are really being trained for individual as opposed to group?

7. Where do you think the directions of the training are, if not in terms of psychotherapy?

8. Another thing that struck me in terms of what you’re saying, that in a medicalized view of conditions, that some of the processes that you use, particularly in terms of trying to get the patient to take responsibility for their condition, would be difficult. I mean, how would you tackle the issue of responsibility where someone’s condition is supposed to be either genetic or biological. I mean, the issue of alcoholism or AIDS.
9. Well, with relationship to individual therapy, you’ve said that it’s the relationship itself between the patient and the therapist that’s the healing factor. In group therapy, what’s the healing factor?

11. I know you also do a lot with reflexive action, what you call the self-reflective loop, with your work in the here-and-now. Also, with your use of the videotaping. And I know, even in the inpatients group, you actually use them to see the observer. That suggests that there is also a cognitive component in healing. Do you see that as well?

12. Well, thinking of these kinds of things, there must also be an important factor in terms of the characteristics of the group members as they start. How do you select—let’s say, for outpatient groups—how do you select your members for the group? What are your criteria?

13. Then you don’t really think it’s important that they will be homogenous on any demographic characteristic, like age, race, sex?

14. In relationship to those longer-term personal growth aspects, do you ask for a long-term commitment from your patients, or do you in some way establish a contract with them for that?

15. I know that some therapists, in order to establish commitment, have felt that maybe if the patient makes a financial commitment, a three-month or six-month financial commitment, that that helps in terms of their staying in the group and then maintaining stability. Do you think that’s useful at all?

16. Do you find that is a rare occurrence? Have you had that happen a lot, where you’ve asked a person to remove themselves from the group?

17. So it sounds like, then, on the positive side, the actual achieving of commitment comes from the process of de-selection, as you called it, and also you seem to emphasize the preparation of the person for group. So those two things, along with your willingness to say, well, this is not going to work, help.

18. Speaking about the selection process, how do you select your co-leader?
19. We don’t have too much time left, but I did want to ask you some questions that were on my mind about your existential approach to therapy. When an individual comes to you beset with some neurotic problem or deeply depressed, doesn’t it create an even greater morbid situation for them to be confronting some of the issues that need to be faced in existential therapy?

20. If death anxiety is always there, then when does it become a problem, or is it such, I mean, is it such a basic problem that we all have to deal with it sometime, but does it become an abnormality at some point? To what an extent is death anxiety, in some full-blown sense, a real problem and pervasive?

21. Is it [death anxiety] an important feature of bereavement?

22. These are some of the issues that you talked about in your last book, *Love’s Executioner.* Do you expect in your next work that you are going to be doing something similar? What are your next directions?
Group Discussion Questions

Professors, training directors or facilitators may use a few or all of these discussion questions keyed to certain elements of the video or those issues most relevant to the viewers.

1. **The Ultimate Concerns:** Yalom talks about death, freedom, meaninglessness and isolation as the ultimate concerns that we all face in life. What relevance to psychotherapy do these concepts have for you? When clients come to you with problems like an inability to tolerate intimacy or uncontrollable, explosive anger, how do existential issues fit into the therapy?

2. **Isolation:** Does Yalom’s distinction of *intrapersonal* versus interpersonal, or existential isolation versus *interpersonal* isolation make sense to you? Does it seem like a useful distinction?

3. **Authentic Relationships:** Do you believe that clients can have authentic relationships with a room full of strangers in a therapy group? How might group therapy increase a client’s ability to have more meaningful and satisfying relationships?

4. **Relationship:** What do you think of Yalom’s idea that clients can work out their own troubles and issues in life through their relationships with others in the group via reflecting on their interactions? In what ways can the therapist facilitate the use of group relationships? What kinds of therapist interventions might inhibit the group from being in such an interactive group process?

5. **Removing Group Members:** Imagine you are leading a group and you are concerned that one of the members is not appropriate for this group. What factors would you consider in deciding whether this client stays in the group or not? What feelings, thoughts and reactions do you have as you think about removing the member? How would you talk about your decision with the client? With the group?
6. **Death Anxiety:** How are you able to identify death anxiety in a patient who does not talk about it? To what degree has death come up as a source of concern in clients you have worked with in the past? How do you think your own death anxiety affects your countertransference to dealing with this issue?

7. **Experience:** What feelings of inadequacy come up for you when you hear from a master therapist like Yalom? How do you sustain a sense of yourself as a “good enough” therapist when confronted with the reality of not being as experienced in certain areas of practice? How can new therapists or those new to certain areas of practice, use their less experienced status to work to their advantage with clients?

8. **To Group or Not to Group:** Do you or will you lead therapy groups? Would you want to be a member of a group? What is attractive or intriguing to you about group therapy? What is challenging or intimidating, either as a member or leader?

9. **Starting Groups:** Imagine you wanted to start a group in your current clinical setting. What type of group (e.g. modality, population) would you want to start? What challenges do you foresee (from clients, agency, etc.) in getting the group off the ground?
Reaction Paper for Classrooms and Training

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

• **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards, or use the questions as a way to approach discussion. 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 psychotherapy? What stands out in how Yalom approaches his work?

2. **What I am resistant to.** What issues/principles/strategies did you find yourself resisting, or what approaches made you feel uncomfortable? Did any techniques or interactions discussed push your buttons? What interventions would you be least likely to apply in your work? Explore these questions.

3. **What I found most helpful.** What was most beneficial to you as a therapist about the interview? What tools or perspectives did you find helpful and might you use in your own work?

4. **How I would do it differently.** Where did you find yourself feeling that you would work differently than Yalom? Describe these areas and explain why.

5. **Leading Groups:** Did the information in this video stimulate your interest in leading groups? If so, what type of group? If not, what are your concerns about leading groups?

6. **Other Questions/Reactions:** What questions or reactions did you have as you viewed the therapy in the video? Other comments, thoughts or feelings?
Suggestions for Further Readings, Websites and Videos

BOOKS


WEB RESOURCES
www.Psychotherapy.net Excerpts from two of Irvin Yalom’s recent books: The Schopenhauer Cure and The Gift of Therapy; and Barbara Jamison’s article “Letting the Patient Matter: Some Thoughts on Irvin Yalom’s View of the Therapeutic Relationship”

www.yalom.com Irvin Yalom’s website

www.salon.com/weekly/yalom960805.html The Salon interview with Irvin Yalom

www.agpa.org The American Group Psychotherapy Association
www.group-psychotherapy.com  Haim Weinberg’s extensive group psychotherapy resource guide

www.Ormont.org  Lou Ormont’s modern analytic group psychotherapy method, including numerous articles

www.existential-therapy.com  General resource on existential psychotherapy

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Understanding Group Psychotherapy, Volume One: Outpatients
–Irvin Yalom, MD

Understanding Group Psychotherapy, Volume Two: Inpatients
–Irvin Yalom, MD

The Gift of Therapy: A Conversation with Irvin Yalom, MD

Irvin Yalom: Live Case Consultation
Complete Transcript of
Understanding Group Psychotherapy,
Volume Three: An Interview

with Irvin Yalom, MD

BACKGROUND & THEORY

Gadban Commentary: During the shooting of the video series, Understanding Group Psychotherapy, I had the opportunity to interview Dr. Irvin Yalom, the noted authority on group psychotherapy and the leading proponent of the existential perspective. Dr. Yalom’s practice is centered in Palo Alto, California, and he teaches at the Stanford University Medical School.

Gadban: Who do you consider to have been the most important influences in your work?

Yalom: Probably Jerome Frank was someone who was always important to me. I was a resident in psychiatry at Johns Hopkins a long time ago now, about 1957, and I spent three years there, and he was an important mentor for me. At that time—he’s had a lot of research interests in psychiatry and psychotherapy—but at that time he was interested in group therapy, had written one of the very early books in group therapy, and I remember I used to watch him do a group through a very, very tiny, you know, two-way mirror. And he has continued to be important and serve as a mentor ever since then. I still stay in close touch with him. Perhaps another person was Rollo May. I did not meet Rollo May until about 10, 15 years ago, but early on in my residency, I read a book that he edited and wrote a few introductory essays on, called Existence, which was a very important book to me. So I’d say those two are two living people that I’ve had a lot of personal contact with that have been important.

Gadban: You’re known for two kinds of work, really: your group psychotherapy and the existential psychotherapy. What’s the difference between the two, and do they overlap at all?
Yalom: Well, they really are, I’d say, two separate and parallel strains of thinking and interests that I’ve had, and they came about quite differently. You know, group therapy, I became interested in, as I say, early on in my training. I was very impressed with the power of a therapy group, of harnessing that group for therapy. And early on I started doing a lot of groups. I finished my training at Hopkins, was drafted for a couple of years, did groups in the army, started doing teaching groups for residents at a civilian hospital nearby. And then, when I went to Stanford after that, I had an extremely facilitative chairman named Dave Hamburg who encouraged me a great deal to do empirical research. So I began doing a lot of research on group therapy, and maintained that interest straight through. And group therapy, in the way I do groups, is very interpersonally-based. That’s the frame of reference, whereas the existential therapy frame is something that’s not particularly pertinent to groups any more than it is, say, to individual therapy.

But that’s a type of interest that I’ve had, oh, even before I went to medical school, I think, from reading the great existential novelists: Dostoevsky and Tolstoy, Kafka and Camus, Sartre. So it was an interest that I took with me into medical school. I decided even before entering medical school that I would go into psychiatry, and once I entered the field, there was a part of me looking to see what relevance this had in my training, which tended to be at a relatively psychoanalytically-oriented institute. There was no place for it. And that’s why Rollo May’s book, Existence, really just opened up a whole new possibility for me.

Gadban: So, you don’t really see these two things as contradictory. I mean, in terms of existential therapy, if you’re talking about sort of an unbridgeable gap between individuals in this kind of basic isolation, and yet in group therapy, you’re talking about the importance of relationships. Is that really contradictory? I mean, are relationships a refuge from isolation?

Yalom: Well, when I talk about isolation in existential therapy, I’m thinking of that as one of the sources of dread that we all have to cope with. The writing that I’ve done in existential therapies is basically written around the organizing principle that there are certain facts of life, ultimate concerns, I call them, that bedevil all of us, that are primary sources of
dread for us. And these are linked to our existence and, you know, these are, as you are well aware of, you know, the ultimate concern of death and freedom and meaninglessness and isolation, the one that we are talking about. So it’s, to the idea of an existential isolation is the idea that no matter how close we try to merge, to relate to another person, there is something that can never be bridged; that we have to, we have to be born alone, we have to die alone. No one can die with us or for us. But that’s quite different from saying, well, there are other parts of the human being that we need to think about when we think of an entire motivational system for human behavior, and certainly one of them is our search and our need for affiliation. But, you know, I think there are some people who may never have come to terms with the existential concerns or with isolation, and therefore use relationships almost as a way to shield them from the fear of isolation. So you have people using another as a shield, a shield against this kind of loneliness. And that results in a certain very distorted, inauthentic way of being with the other. It’s not a caring for the other, it’s using other as a shield against loneliness.

**Gadban:** So in this way, relationship therapy can actually be helpful in terms of having authentic relationships and being an authentic individual.

**Yalom:** Absolutely, but it doesn’t do away with this sort of deeper sense of isolation. Yeah, I think of isolation as existing on various levels. There is such a thing as existential isolation. There is also something called interpersonal isolation; you know, the idea of social loneliness, and when we work with interpersonal isolation, we are looking at all the various reasons that people can’t seem to become intimate with one another. And there is also a kind of intrapersonal isolation, which means the fact that we are actually isolated from parts by our self. You know, the idea that there are parts of our self we split off, so we are not in touch with all the various parts. Some of them have been put into dissociation; they’re separate from us. Fritz Perls, when he worked with patients, thought that one of the goals of therapy was to help people reclaim all these little parts of themselves. That’s actually why, to the best of my knowledge, why he termed his therapy Gestalt Therapy: the idea of making one whole again, re-owning all these parts of oneself. So isolation has a lot of different meanings.

**Gadban:** This kind of intrapersonal isolation, would that be something
best dealt with in individual therapy?

**Yalom:** Yeah, I think it is, I think it is. I think it is a very personal kind of work. And, of course, we see the intrapersonal splits most dramatically in, say, multiple personality or other kind of states along the dissociative continuum. Those are, I think, more easily dealt with in individual than in group.

**CURRENT TRENDS**

**Gadban:** Let’s turn a little bit to group work in general. Why do you think more therapists don’t do group work? I mean, in light of financial constraints and the like?

**Yalom:** Yeah, it would certainly make eminent sense given the increase of HMOs, given the limited number of visits that are now accorded patients in therapy. For example, many insurance plans will, say, give a patient eight individual meetings. It makes tremendous sense, it is very commonsensical to think, well, for that amount of money, you could offer the patient 30 group sessions, which are going to do that patient much better, help that patient a great deal more than eight individual sessions. But still, it’s, you know, it’s always an uphill fight, in a sense. You’re always sort of trying to persuade therapists.

I get involved with the American Psychiatric Association’s Annual Convention. About every third year they ask me, well, to lead a teaching workshop in some way, to kind of re-encourage psychiatrists to be doing, to be doing group work. Maybe to some extent it’s economic, too: that most private practitioners, I think, prefer to do individual work. It’s hard to do, set up a group solo practice. And most group work is done in a clinical setting, but if you’re in a solo practice, it becomes a chore to get those many people together all at one time. It’s also exhausting. Most therapists can’t do more than one or two groups a day, at most. It depletes one of energy. A great deal of attention, concentration, is needed. So I think that’s one reason.

I think, also, psychiatrists are, by and large, loath to do groups. I think there are many reasons. One of them has to do with a whole question of the interpersonal orientation, I think, that’s needed: the focus on the here-and-now, which I think is the power cell of the small group. Many
therapists are somehow uncomfortable about doing that. They somehow equate here-and-now interaction with conflict, or with negativity, or maybe the idea of the encounter group movement in the 60s. Somehow they think there’s danger involved with that, so they tend to shy away from that. And many training programs simply don’t include good group therapy training early on, so people get taught much more early in their careers how to do individual therapy. If you try to lead a group using only what you learned in individual therapy, you know, generally you run into great difficulties in the groups.

Gadban: And do you think that most psychiatrists, or psychiatrists-in-training, are really being trained for individual as opposed to group?

Yalom: Well, I think so. I would say that to be true, speaking of psychiatric training, for sure that’s true. And as I was saying, that makes it difficult for them to really harness some of the most effective forces in a group. I mean, groups by and large, part of the natural evolution of a group is not to develop an interactional framework. The groups don’t do this on their own. This really requires some active input on the part of the therapist. And unless you’ve been trained to do that, you know, you won’t lead a group to this. So many individually trained therapists leading a group will start to do one-to-one therapy with each of the members of the group, and that’s not an effective way to do a group. But you know, it’s something even more than that. I mean, I think psychiatrists by and large aren’t being trained to do a lot of psychotherapy per se in their training program, and that’s been, I think, represents a serious problem in the field today.

Gadban: Where do you think the directions of the training are, if not in terms of psychotherapy?

Yalom: Well, as I see, as I see my own residents go through training now, and this whole current generation of psychiatrists, there is a huge swing of the pendulum back toward a biological emphasis. And I think it’s a cause for considerable alarm because, yes, there are certain advances—they like to think of them as breakthroughs—but there are certainly advances in certain discoveries of new families of medications for depression, let’s say, and for mania. But by and large, the whole field of psychiatry is being re-medicalized. Students are being trained in psychopharmacological modes, biological modes, but often go into practice, and pretty soon in their
practice they’re starting to do psychotherapy, for which they’ve really not been adequately trained. So I have a lot of concern about where the next generation of good psychotherapists is going to come from, you know?

You’d think that that might be the vacuum in the field for clinical psychology, you know, to fill, but, you know, that’s not happening either, because clinical psychology is perhaps making a, not a similar, but an analogous, I think, error, which is that so many young clinical psychologists are being trained with cognitive or behavioral methods, which also tends to objectify the patient, which also doesn’t give them the grounding that is necessary to develop a, you know, an authentic healing relationship with the patient. And so neither psychiatrist nor, I think, many clinical psychology programs are busy training the next generation of psychotherapists.

**Gadban:** Another thing that struck me in terms of what you’re saying, that in a medicalized view of conditions, that some of the processes that you use, particularly in terms of trying to get the patient to take responsibility for their condition, would be difficult. I mean, how would you tackle the issue of responsibility where someone’s condition is supposed to be either genetic or biological. I mean, the issue of alcoholism or AIDS.

**Yalom:** Yeah, that’s a very significant issue. Alcoholism is a good example for that, you know. It’s often been seen as a kind of irreconcilable conflict between, say, the disease model of alcoholism and psychotherapy. In fact, there has always been a conflict with AA in that regard. AA now certainly, fully, embracing the disease model of alcoholics, which, you know, in a sense states that there is a genetic predisposition towards alcoholism, passed along genetically in the family, and the evidence for that does seem to be quite persuasive. And in a sense, but that there tends to be, maybe, error of absolving the patient from sort of any responsibility in their treatment.

So, you know, I think it’s important if one is to do psychotherapy, at least you need to say, okay, the patient may not be responsible for their disease. They may not be responsible for their predisposition to alcohol. They may not be responsible for their unusual ways of coping with alcohol once it’s in the bloodstream. But there are certain things they are responsible for. You know, AA certainly will agree, too, in that regard, that they’re
responsible for the first drink. And in the therapy group, I impose the same sort of ideas about responsibility with alcoholic patients as with any, in that they’re entirely responsible for the interpersonal world that they create for themselves in the group. They’re responsible for the way they deal with others, the way they, the signals they send off to others. And in a sense they’re responsible for the way that others regard them. So I feel that one fully invokes the idea of responsibility with the alcoholic patients.

I think that’s a good example of how there is some confluence between the two fields, because responsibility, you know, responsibility assumption, the awareness of the extent to which one really is the author of one’s life predicament or life design, you know, that’s a central aspect of an existential approach in therapy. But that’s very important in group therapy, too. Because we focus very much on how each person is responsible for the kind of interpersonal niche that they carve out for themselves in the group. So, I mean, the two fields overlap, but nonetheless I think that when I do group therapy I’m primarily in an interpersonal frame of reference.

**Gadban:** Well, with relationship to individual therapy, you’ve said that it’s the relationship itself between the patient and the therapist that’s the healing factor. In group therapy, what’s the healing factor?

**Yalom:** Well, I think that there are lots of different ways that groups help people, but the analog in group therapy of the patient-therapist relationship I think is, well, what I’ve often talked about as cohesion: the idea of the patient’s entire relationship to the group, to all of the members in the group, and to the group as a whole. So the fact that one is accepted by the group, negotiates a group experience successfully, you know, I think all that’s the group therapy analog of relationships.

**Gadban:** Relationships.

**Yalom:** That’s right. But there are lots of other factors that go on in individual, in group therapy, too, that one can think of as therapeutic. You know, the idea that one can be useful to other people, the therapeutic factor of altruism, which incidentally you rarely ever come into contact with in individual therapy. But patients are very helpful to one another in the groups. I think that’s an important factor. The idea of catharsis, the aroused emotional release that so often occurs in group. The idea
of imitative learning, seeing how others deal with certain strategies and at some level incorporating some of these strategies. The idea of a primary recapitulation of one’s family, you know, because the group often does represent, in one’s unconscious, one’s earlier family: the therapist representing parents, and the other members representing sibs. And this time you more successfully negotiate that kind of experience. So I think there are a whole host of therapeutic factors. I wrote my, wrote my textbook on group therapy around the, what I thought were the major therapeutic factors. But this idea of group cohesion, I think, is the analog of that.

Gadban: I know you also do lot with reflexive action, what you call the self-reflective loop, with your work in the here-and-now. Also, with your use of the videotaping. And I know, even in the inpatients group, you actually use them to see the observer. That suggests that there is also a cognitive component in healing. Do you see that as well?

Yalom: Very definitely, especially when you work in an interpersonal frame of reference. You know, I think it’s necessary to work in the interaction or often in the here-and-how of the interaction. If it’s individual therapy, then it’s working in the relationship between the two of us. Not necessarily transferential relationships, that “I” represent some person from the past, but how you and I relate at this moment as human beings, and the group as well. We work very much in the here-and-now. But I think the here-and-now really has two different components. It’s not only the relationship in the here-and-now, or the letting the other matter, or being present, or giving feedback. But there’s also a time that you have to step back and begin to take a look at, well, what does this mean? How do we understand what’s going on between the two of us or all of us together in the group? You know, so it’s a way of making sense out of what’s happened, so that the patient is given some type of framework by what she can take, what he’s learned in this situation, and begin to transfer that learning to other situations. I know that in a lot of group therapy research, and encounter group research, we found that the groups that didn’t do that, that only focused on the pure experiences, by and large were ineffective.

And it also means the therapist has got to have a couple of different sets
of techniques in groups. You know, the therapist’s got to have a set of techniques that are sort of activating techniques. You learn techniques of plunging the group into the here-and-now, getting them away from talking about outside experiences or intellectual experiences. Helping them be more personal toward one another. But there is a whole different set of techniques. We could call these our, you know, interpretive techniques or explanatory techniques, by which we help them make sense out of what’s been happening in the here-and-now.

NUTS & BOLTS OF GROUPS

Gadban: Well, thinking of these kinds of things, there must also be an important factor in terms of the characteristics of the group members as they start. How do you select—let’s say, for outpatient groups—how do you select your members for the group? What are your criteria?

Yalom: Well, you know, basically what I do, and I think, really, all group therapists do this, is that we deselect members for our group. By that I mean we, if I’m starting a group, I start to interview patients who come to me and I deselect certain patients. I say, this patient can’t possibly work in this group, and so I don’t accept that patient, or I may not take this patient. But then I take everyone else that I think can work in the group and put them in the group. You know, a much more scientific idea would be, well, you know, let’s say I’ve got 20 patients on a waiting list, and I could only select the seven or eight perfect patients who would just be the right fit and make the perfect therapy group. But, you know, there is really no way to do that, where there has been lots of Ph.D. dissertations written on how you compose the ideal group. And frankly, it simply doesn’t work. I think the human being is infinitely complex and there isn’t any kind of initial tests that we can use or way of diagnosing the person that’s going to let us know how these people are going to interact. So, I think I can start off with any group of seven or eight people and help begin to mold them into an effective therapy group.

Gadban: Then you don’t really think it’s important that they will be homogenous on any demographic characteristic, like age, race, sex?

Yalom: No, not really. If I’m doing longer-term groups, I almost like to have a wide age range, so that people who are dealing with different stages
of life bring those into the group and it becomes a more, sort of, enriching experience, where many more issues are dealt with in the group. So I like to have a wide age range and a range of problems with which people are dealing. It is true that there are certainly shorter-term groups that are composed on a more homogenous basis, let’s say groups of patients with eating disorders or alcoholism, and they have certain advantages, you know. Sometimes they are more efficient in the short run; they gel quicker. People realize that the other people have the same sort of condition that they do. But usually, if you’re going to want to effect some substantial personality change, I think that they begin to plateau after a while. There is perhaps almost too much sameness in the group, so I tend to like a more heterogeneous group for the longer-term personal growth aspects of it.

**Gadban:** In relationship to those longer-term personal growth aspects, do you ask for a long-term commitment from your patients, or do you in some way establish a contract with them for that?

**Yalom:** Well, if I’m doing a group that’s ongoing, and by that I mean a group that doesn’t have a definite endpoint in mind, the group is going to go on, people may stay in that group as long as it takes them to get better. That might be anywhere from six months to a couple of years, you know. I don’t see patients make substantial personality changes in less than that period of time, less than six months. So I let people know about what I think is going to happen, how long I think they will probably need to be in the group. So they’re pretty well-informed about that. If I’m starting a long-term group and I hear from a patient that they are going to be, you know, leaving town, moving somewhere in three or four months, then, you know, these are people I wouldn’t include in that particular group. I’d look for a short-term group in which to include that patient.

**Gadban:** I know that some therapists, in order to establish commitment, have felt that maybe if the patient makes a financial commitment, a three-month or six-month financial commitment, that that helps in terms of their staying in the group and then maintaining stability. Do you think that’s useful at all?

**Yalom:** No, no, I’ve never done that. When I see a patient for an ongoing, long-term group, I suggest to the patient that they are not going to know whether that group is helpful to them at first. You know, it’s different
from individual therapy, and they are not going to feel gratification immediately; that sometimes they will feel frustrated, sometimes they don’t get the floor time, sometimes it will be uncomfortable for them. But not to make a judgment about whether the group is going to help them for the first several sessions, at least. I think I tell them that usually they are going to need about a dozen sessions before they get an idea of whether this group will be helpful to them or not. So I get a verbal commitment from patients to attend about a dozen sessions of the group before they make some sort of decision about continuing it.

I very rarely have people who drop out. It may be that the group is tremendously incompatible to an individual, and they can’t possibly stay in that group, and making some sort of long-term financial arrangement early on may not be a good idea. It might not be a good idea for the group to have that person continue, you know. Sometimes the situation arises where you want to ask the patient to leave the group. That group is not a right group for that individual. That individual won’t get help from the group, the group is not going to get helped by having that person in the group. So you have to take the step of removing the patient from the group and get that patient to some other form of therapy that will be more helpful.

**Gadban:** Do you find that, is that a rare occurrence? Have you had that happen a lot, where you’ve asked a person to remove themselves from the group?

**Yalom:** No, it’s not rare. It doesn’t happen very often, but it’s a very important step. Every time I have ever done that, and other therapists that I have supervised, every time they have done that, they have always been glad they did it. And if anything, the feeling is they waited too long to do that. You know, when I started to do group therapy, I used to have a big problem with dropouts, because when you start groups, every one has a certain percentage of patients that are going to drop out, you know? Figures in the literature range anywhere from 10 to 30% of people who drop out, say, in the first dozen sessions or so. And that’s a big problem for neophytes, neophyte group therapists, you know, because it’s threatening. They feel they can’t keep their group stable. They feel that if a patient drops out of the group, it’s a measure of their own lack of efficacy as a
therapist. They begin to have fantasies that everybody’s going to drop out. You know, they begin to feel like they’re going to come to the next week’s group and there is no one going to be there at all except them, and what will they tell their supervisor at that point?

I was very concerned, very threatened when I started doing groups, about that. In fact, the first research I did in the field was to study all the patients who had dropped out—about 35 from our entire clinic—to try and find out just why they did, you know, because what happens is the therapist then becomes frightened. The patient almost can blackmail the therapist. The therapist wants to be nice to that patient, wants to be seductive, anything so they come back the next week, and once that happens, you’ve really lost your therapeutic leverage.

But right now, I’ve just changed my whole set toward that, my whole attitude, and I never have any dropouts at all. Because I have the sense that I can have throw-outs, you know. So if I know that a patient can’t work in that group, and I have tried to look at all the obstacles that get in the way of that patients’ working, and I have tried to remove these obstacles one-by-one, and I know this patient is not going to get helped in this group, not going to make it, well, I’m not any longer interested in trying to seduce that patient, keep that patient going. But on the contrary, I want to take that person out of the group, and do it relatively quickly, so the group can get on and that patient can not continue to be exposed to a noxious environment. So I think the mere idea that you believe in the approach enough so that you’re willing to take someone out of the group and get someone else in there who will profit more from it makes all of the difference.

Gadban: So it sounds like, then, on the positive side, the actual achieving of commitment comes from the process of de-selection, as you called it, and also you seem to emphasize the preparation of the person for group. So those two things, along with your willingness to say, well, this is not going to work, help.

Yalom: That’s right, that’s right, exactly. You know, it would be nice if we could do that with extreme accuracy. All of us will make mistakes about, you know, selecting patients, not selecting certain patients, you know, and generally when we interview a patient, we have only a limited amount
of data. If you know that person has been in a previous group, that’s probably the best material of all to use. When you interview the patient, probably it’s good to spend some time taking a look at how that person relates to you, or whether that person can comment on what’s happened in the interview with you. Or especially if you’ve got a co-leader and there is a three-way interview, to see if you all can look into that interaction. If the patient can’t deal with that concept at all, then that should certainly be a red flag to you. But, you know, I think that most patients can be screened out. Now remember, when I say about screening out a patient, I mean screening out a patient for a specific therapy group, a patient who might not be a good candidate for one kind of group could be a very good candidate for another type of group, you know.

**Gadban:** Speaking about the selection process, how do you select your co-leader?

**Yalom:** Well, I’m in a full-time university position where I’ve been for a long time. I’ve been at Stanford for about 25 years now, and generally, I select my co-leaders from amongst my students. So I’m in a little unusual situation that way. But I’ve also been aware for a long time of how my students select their co-leaders, and what I tell them is that I think probably there are some advantage to a male-female pair, although it’s not essential, you know. I’ve led many groups with male co-leaders, and what happens there is the patients somehow begin to differentiate the two of you almost along sex lines. You know, they see one as more authoritarian and one as more supportive. But usually a male-female pair tends to recapitulate the family a little bit more vividly.

I think therapists are to select someone they work well with, that they can talk to, they feel open with. I tell them that, if possible—and there is often a training group for our students where there are actually members of a group—that’s a good time to get some information by which you can select your leader, your co-leader, because you really know them better, see how they operate in a group. I think that it’s a good idea to select someone who is rather different from you, so the two of you really complement, you know, add something different to one another. And then, of course, it’s good to work with someone with whom you are not highly competitive. You know, if therapists are competitive, each of them being busy trying to
make the star interpretation in the group and not supporting the other’s move, then that doesn’t work very well for a group. And that usually is evident when you work with therapists in supervision. You can see how they are competitive even to tell you what they have done.

**THE EXISTENTIAL APPROACH**

**Gadban:** We don’t have too much time left, but I did want to ask you some questions that were on my mind about your existential approach to therapy. When an individual comes to you beset with some neurotic problem or deeply depressed, doesn’t it create an even greater morbid situation for them to be confronting some of the issues that need to be faced in existential therapy?

**Yalom:** No, I don’t think so. I think you’re, I think one, that question makes the assumption that the existential issues are something that you are going to add on top of the patient’s concerns, you know, and I think my position is, these are issues that are with us all the time, and they may be transformed into other types of symptoms and other kinds of concerns. But, you know, they’re with us. We always are concerned. Just think about death anxiety for a minute. You know, I think it’s something that, it’s not something that I would impose on a patient by talking about it, but it’s there inside of the patient from earliest life. Children are pervasively concerned with their concerns about their own obliteration. They think about it at a far earlier age than we usually do, and it persists throughout life. All dreams that are nightmares are just examples of our concerns about anxiety, death anxiety, that’s just sort of broken into, exploded into consciousness.

**Gadban:** If death anxiety is always there, then when does it become a problem, or is it such, I mean, is it such a basic problem that we all have to deal with it sometime, but does it become an abnormality at some point? To what an extent is death anxiety, in some full-blown sense, a real problem and pervasive?

**Yalom:** There are many different forms that it can take. Some people may be so anxious about death that they somehow can’t face it at all. They may, you know, there are individuals who, in a sense can’t, or almost, as Otto Rank put it, refuse the loan of life in order not to accept the debt of
death. So in a sense, they don’t really live, or they are afraid of forming any kind of relationship that’s going to have some type of leaving or departing involved. So they begin to sequester themselves out, and in a sense people are so afraid of dying they never fully plunge themselves into living. I mean, that’s one form that anxiety can take. I mean, I know that there is a kind of trivialization sometimes of death anxiety by people saying, “Oh well, you know, everybody knows they’re going to die. Why make a big deal of it? We think about that all the time. Who doesn’t know that?” But, you know, that can be said of almost any kind of primary source of anxiety. I think the fact is that we only fully become aware of the full extent of death anxiety sometimes just a few times in our life, or maybe in our dreams, when it fully overtakes us. But it can guide, dominate our behavior in enormous ways.

Gadban: Is it an important feature of bereavement?

Yalom: I think it is. You know the old John Donne verse that has it, you know, “Don’t ask for whom the bell tolls. It tolls for thee.” You know, I think there is a very important truth in that, which is that, the individual who loses someone also undergoes an important confrontation with death during that time. If my beloved so-and-so can die, it also means that I, too, have to face death. And I think for many bereaved individuals, that constitutes an important part of the bereavement work: how you cope with this newfound confrontation with existential issues.

I’ve been studying a number of widows over a three or four year period, in which I would look very carefully at to what extent widows and widowers undergo an existential confrontation, and there is a certain percentage of them that do, perhaps as high as 25 percent of them, who become much more aware of their situation and existence, and one of the consequences of that is that a significant number of these undergo some type of personal growth as a result of their bereavement. So it’s not that they simply reconstitute, it’s not that they go back to the way that they were before they lost the spouse—they get through the grief and get through the bereavement—but it’s actually that they progress to a point that they had never before achieved, as a way of seeing their way differently in the world, beginning to think about their own sense of meaning in life, or what they want to do in their life, their sense of choicefulness; rearranging their own
The same thing is true if you work with terminally ill patients, that a number of patients who, when they really begin to realize that they have a fatal illness that they are not going to recover from, rather than be plunged into despair, can actually undergo some type of growth from the experience, from this new awareness, of kind of embracing their own finiteness into their existence.

Gadban: These are some of the issues that you talked about in your last book, *Love’s Executioner*. Do you expect in your next work that you are going to be doing something similar? What are your next directions?

Yalom: Well, I wrote this book, *Love’s Executioner*, really as a way of extending my thinking about existential therapy. Existential therapy is a large text, and I thought the way that I could perhaps teach more effectively was through a literary device, literary conveyance, and other existential thinkers have arrived at that conclusion long before I did, you know? Sartre and Camus always wrote in a narrative form because it brings these truths home with much more poignancy than the sort of language that tends to be too abstract and abstruse for it have real emotional meaning to us. So, that was my intent in writing these stories in *Love’s Executioner*, to try to bring home these principles and issues in a more immediately graspable form, and I would like to do something like that in the future, too. I’m very interested currently in working with Nietzsche, the philosopher Nietzsche, because I think, perhaps, so much of his corpus of philosophic work has tremendous relevance for psychotherapy, and it’s not yet been harvested. So I’m fascinated with his work in a way of trying to make what he has written more relevant to our everyday therapy.
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We wish to thank the following people for suggesting material for the interview:

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