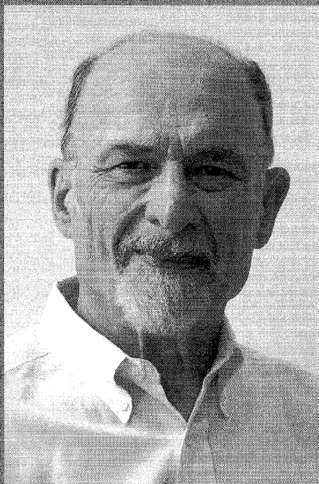
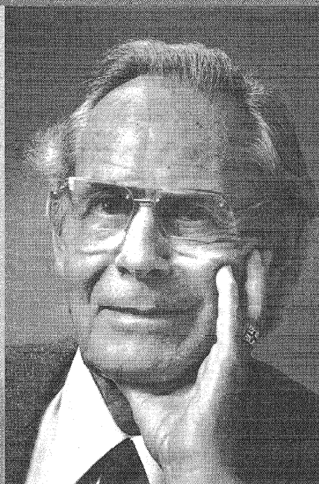


Irvin Yalom
Courtesy of Irvin Yalom



Rollo May (1909–1994)
Courtesy of Kirk Schneider

9 EXISTENTIAL PSYCHOTHERAPY[1]

Irvin D. Yalom and Ruthellen Josselson

OVERVIEW

Existential psychotherapy is a form of therapy that can be integrated with other approaches, not an independent "school" of therapy like cognitive behaviorism or psychoanalysis. Rather than being a technical approach that offers a new set of rules for psychotherapy, . . . it represents a way of thinking about human experience that can be—or perhaps should be—a part of all therapies.

Everyone must confront the timeless and intractable issues of the *ultimate concerns*: death, freedom, isolation, and meaning. An existential approach to therapy involves someone, a therapist, willing to walk unflinchingly with patients through life's deepest and most vexing problems. Existential psychotherapy is an attitude toward human suffering and has no manual. It asks deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation, and anomie. It also deals centrally with the questions of meaning, creativity, and love. Out of reflection on these human experiences, existential psychotherapists have devised attitudes toward therapy that do not distort human beings in the very effort of trying to help them.

Many therapists in fact, practice existential psychotherapy without labeling it as such. In his seminal work, *Existential Psychotherapy*, Yalom (1980) tells of taking part

[1] This chapter includes material from an earlier chapter in *Current Psychotherapies* by Rollo May and Irvin Yalom.

in an Armenian cooking class where the teacher, who did not speak English well, taught mainly by demonstration. But as hard as he tried, he could never quite make his dishes taste as good as hers. He decided to observe his teacher more carefully, and in one lesson noted that when she finished her preparation she handed her dish to her assistant, who took it into the kitchen to place into the oven. He observed the assistant and was astounded, and edified, to note that that before throwing the dish in the oven, she threw in handfuls of various spices that struck her fancy. These "throw-ins" he likened to the interactions that therapists have with their patients, which, because they are not conceptualized within their theoretical "recipe," go unnoticed. Perhaps, however, these off-the-record extras are the critical ingredients. And perhaps these throw-ins refer to the shared issues of human existence—in short, to existential psychotherapy.

Basic Concepts

Existentialists regard people as meaning-making beings who are both subjects of experience and objects of self-reflection. We are mortal creatures who, because we are self-aware, know that we are mortal. Yet it is only in reflecting on our mortality that we can learn how to live. People ask themselves questions concerning their being: Who am I? Is life worth living? Does it have a meaning? How can I realize my humanity? Existentialists hold that ultimately, each of us must come to terms with these questions and each of us is responsible for who we are and what we become.

Because existentialists are sensitive to the ways in which theories may dehumanize people and render them as objects, authentic experience takes precedence over artificial explanations. When experiences are molded into some preexisting theoretical model, they lose their authenticity and become disconnected from the individual who experienced them. Existential psychotherapists, then, focus on the subjectivity of experience rather than "objective" diagnostic categories.

The Ultimate Concerns

Issues such as "choice," "responsibility," "mortality," or "purpose in life" are ones that all therapists suspect are central concerns of patients. More and more, patients come to therapy with vague complaints about loss of purpose or meaning. But it is often more comfortable for the therapist to reframe these concerns into symptoms and to talk with patients about medication or to prescribe manualized exercises than to engage genuinely with them as they search for meaning in life. Many diagnosable presenting "symptoms" may mask existential crises.

The existential dilemma ensues from the existential reality that although we crave to persist in our being, we are finite creatures; that we are thrown alone into existence without a predestined life structure and destiny; that each of us must decide how to live as fully, happily, ethically, and meaningfully as possible. Yalom defines four categories of "ultimate concerns" that encompass these fundamental challenges of the human condition. These are freedom, isolation, meaning, and death.

Freedom

The term *freedom* in the existential sense does not refer to political liberty or to the greater range of possibilities in life that come from increasing one's psychological awareness. Instead, it refers to the idea that we all live in a universe without inherent design in which we are the authors of our own lives. Life is groundless, and we alone are responsible for our choices. This existential freedom carries with it terrifying responsibility and is always connected to dread. It is the kind of freedom people fear so much that they enlist dictators,

masters, and gods to remove the burden from them. Erich Fromm (1941) described "the lust for submission" that accompanies the effort to escape from that freedom.

Ultimately, we are responsible for what we experience in and of the world. Responsibility is inextricably linked to freedom because we are responsible for the sense we make of our world and for all of our actions and our failures to act. An appreciation of responsibility in this sense is very unsettling. If we are, in Sartre's terms, "the uncontested author" of everything that we have experienced, then our most cherished ideas, our most noble truths, the very bedrock of our convictions are all undermined by the awareness that everything in the universe is contingent. We bear the burden of *knowing* that we are responsible for all of our experience.

The complement to responsibility is our *will.* While this concept has waned lately in the social sciences, replaced by terms such as *motivation*, people are still ultimately responsible for the decisions they make. To claim that a person's behavior is explained (i.e., caused) by a certain motivation is to deny that person's responsibility for his or her actions. To abrogate such responsibility is to live inauthentically, in what Sartre has called *bad faith*. Because of the dread of our ultimate freedom, people erect a plethora of defenses, some of which give rise to psychopathology. The work of therapy is very much about the (re)assumption of responsibility for one's experience. Indeed, the therapeutic enterprise can be conceived of as one in which the client actively increases and embraces his or her freedom: freedom from destructive habits, from self-imposed paralysis of the will, or from self-limiting beliefs, just to name a few.

Isolation

Individuals may be isolated from others (*interpersonal isolation*) or from parts of themselves (*intrapersonal isolation*). But there is a more basic form of isolation, *existential isolation*, that pertains to our aloneness in the universe, which, though assuaged by connections to other human beings, yet remains. We enter and leave the world alone and while we are alive, we must always manage the tension between our wish for contact with others and our knowledge of our aloneness. Erich Fromm believed that isolation is the primary source of anxiety.

Aloneness is different from loneliness, which is also a ubiquitous issue in therapy. Loneliness results from social, geographic, and cultural factors that support the breakdown of intimacy. Or people may lack the social skills or have personality styles inimical to intimacy. But *existential* isolation cuts even deeper; it is a more basic isolation that is riveted to existence and refers *to an unbridgeable gulf between oneself and others.* It is most commonly experienced in the recognition that one's death is always solitary, a common theme among poets and writers. But many people are in touch with their dread of existential isolation when they recognize the terror of feeling that there may be moments when no one in the world is thinking of them. Or walking alone on a deserted beach in another country, one may be struck with a dreadful thought: "Right at this moment, no one knows where I am." If one is not being thought about by someone else, is one still real?

In working with people who have lost a spouse, Yalom was struck not only by their loneliness but also by the accompanying despair at living an unobserved life—of having no one who knows what time they come home, go to bed, or wake up. Many individuals continue a highly unsatisfying relationship precisely because they crave a life witness, a buffer against the experience of existential isolation.

The professional literature regarding the therapist–patient relationship abounds with discussions of encounter, genuineness, accurate empathy, positive unconditional regard, and "I–Thou" relating. A deep sense of connection does not "solve" the problem of existential isolation, but it provides solace. Yalom recalls one of the members of his cancer group who said, "I know we are each ships passing in the dark and each of us is a

lonely ship, but still it is mighty comforting to see the bobbing lights of the other nearby boats." Still, we are ultimately alone. Even a therapist cannot change that. Yalom comments that an important milestone in therapy is the patient's realization that, "there is a point beyond which [the therapist] can offer nothing more. In therapy, as in life, there is an inescapable substrate of lonely work and lonely existence" (1981, p. 137).

To the extent that one takes full responsibility for one's life, one also encounters the sense of existential isolation. To forego the sense that one is created or guarded by another is to confront the cosmic indifference of the universe and one's fundamental aloneness within it.

Meaning

All humans must find some meaning in life, although none is absolute and none is given to us. We create our own world and have to answer for ourselves why we live and how we shall live. One of our major life tasks is to invent a purpose sturdy enough to support a life; often we have a sense of discovering a meaning, and then it may seem to us that it was out there waiting for us. Our ongoing search for substantial purpose-providing life structures often throws us into a crisis. More individuals seek therapy because of concerns about purpose in life than therapists often realize. The complaints take many different forms: "I have no passion for anything." "Why am I living? Surely life must have some deeper significance." "I feel so empty—just trying to get ahead makes me feel so pointless, so useless." "Even now, at the age of 50, I still don't know what I want to do when I grow up."

In his memoir of being an existential psychotherapist, *The Listener*, Allen Wheelis (1999) tells about a moment with his dog, Monty:

> If then I bend over and pick up a stick, he is instantly before me. The great thing has now happened. He has a mission . . . It never occurs to him to evaluate the mission. His dedication is solely to its fulfillment. He runs or swims any distance, over or through any obstacle, to get that stick.
>
> And, having got it, he brings it back: for his mission is not simply to get it but to return it. Yet, as he approaches me, he moves more slowly. He wants to give it to me and give closure to his task, yet he hates to have done with his mission, to again be in the position of waiting.
>
> For him as for me, it is necessary to be in the service of something beyond the self. Until I am ready he must wait. *He is lucky to have me to throw his stick.* I am waiting for God to throw mine. Have been waiting a long time. Who knows when, if ever, he will again turn his attention to me, and allow me, as I allow Monty, my mood of mission? (as cited in http://www.yalom.com/lec/pfister)

Who among us has not had the wish, *If only someone would throw me* my *stick.* How reassuring it would be to know that somewhere there exists a true purpose in life rather than only the *sense* of purpose in life. If all purpose is self-authored, one must confront the ultimate groundlessness of existence. We throw our own sticks.

A sense of meaning emerges from plunging into an enlarging, fulfilling, self-transcending endeavor. The work of the therapist is to identify and help to remove the obstacles to such engagement. If one is authentically immersed in the river of life, then the question of meaning drifts away.

Death

Overshadowing all these ultimate concerns, the awareness of our inevitable demise is the most painful and difficult. We strive to find meaning in the context of our existential aloneness and take responsibility for the choices we make within our freedom to choose,

yet one day we will cease to be. And we live our lives with that awareness in the shadow. Death is always the distant thunder at our picnic, however much we may wish to deny it.

Of course, we cannot live every moment wholly aware of death. This would be, in Yalom's phrase, like staring at the sun. Because we cannot live frozen in fear, we generate methods to soften death's terror. We assuage it by projecting ourselves into the future through our children, by trying to grow rich and famous, by developing compulsive behaviors, or by fostering an impregnable belief in an ultimate rescuer. Our fear of death is a profound dread of nonbeing, the impossibility of further possibility, as Hegel put it. And fears of death can lurk disguised behind many symptoms as well. Yet confronting death allows us to live fuller, richer, and more compassionate lives.

Everything fades. This is the sad existential truth. Life is truly linear and irreversible. This knowledge can lead us to take stock of ourselves and ask how we can live our lives as fully as possible. Existential psychotherapy emphasizes the importance of living mindfully and purposefully, aware of one's possibilities and limits in a context of absolute freedom and choice. Death, in this view, enriches life.

The Therapeutic Stance: The Fellow Traveler

Awareness of the ultimate concerns as givens of existence fundamentally changes the relationship between therapist and patient to that of *fellow travelers.* From this vantage point, even labels of patient/therapist, client/counselor, analysand/analyst become inappropriate to the nature of the relationship, for they suggest distinctions between "them" (the afflicted) and "us" (the healers). However, *we are all in this together*, and there is no therapist and no person immune to the inherent tragedies of existence. Sharing the essence of the human condition becomes the bedrock of the work of existential psychotherapy.

HISTORY

Precursors

These major existential concerns are not new, of course. An unbroken stream of philosophers, theologians, and poets since the beginning of recorded history has wrestled with these issues. Down through history, these questions have occupied many thinkers.

The Greek philosopher Epicurus anticipated the contemporary idea of the unconscious when he emphasized that death concerns may not be conscious to the individual but might be inferred by disguised manifestations. He constructed a number of arguments to alleviate death anxiety, which he taught his students. Epicurus believed that the soul was mortal and perishes with the body; hence, there is nothing to fear in the afterlife. And why fear death, he wondered, when we can never perceive it? Another argument he advanced was that of symmetry: Our state of nonbeing after death is the same as before our birth. As Vladimir Nabokov, the great Russian novelist later wrote, "our life is a crack of light between two eternities of darkness" (p. 17). St. Augustine believed that only in the face of death is a person's self born. And many philosophers since the dawn of philosophy have concluded that the idea of death enriches life.

Beginnings

The contemporary term *existentialism* is most often associated with the French philosophers Jean Paul Sartre and Gabriel Marcel, who developed this philosophy in the 1940s. Existential therapists have also been influenced by the work of such philosophers as Martin Heidegger, Edmund Husserl, Emmanuel Levinas, and Martin Buber.

The central foundational philosophers of existential psychotherapy are two 19th-century intellectual giants, Søren Kierkegaard and Friedrich Nietzsche. Both were reacting to the mechanistic dehumanization of people in a technological world, and both can be counted among the most remarkable psychologists of all time. When one reads Kierkegaard's profound analyses of anxiety and despair or Nietzsche's acute insights into the dynamics of resentment and the guilt and hostility that accompany repressed emotional powers, it is difficult to realize that one is reading works written more than 150 years ago and not a contemporary psychological analysis.

The Swiss psychiatrist Ludwig Binswanger (1881–1966), a colleague and friend of Sigmund Freud, was the first physician to combine psychotherapy with existentialism. His famous, now classic, case of Ellen West, published in 1944 (see Binswanger, 1958), in which a patient with anorexia nervosa decides to commit suicide, provoked much debate within psychotherapeutic circles. Binswanger's work was part of a broader phenomenological–existential psychotherapeutic orientation that developed in central Europe in response to dissatisfaction with the theoretical frameworks of psychiatry and psychoanalysis. The members of this movement—among them Medard Boss, Eugene Minkowski, Erwin Straus, and Roland Kuhn—thought that the effort to detail human existence by means of an objective–descriptive scientific theory distracted attention from the authentic encounter that formed the basis of therapy. In 1988, a Society for Existential Analysis was formed in the United Kingdom that publishes a journal, *Existential Analysis.*

Existential psychotherapy was introduced to the United States in 1958 with the publication of *Existence: A New Dimension in Psychiatry and Psychology*, edited by Rollo May, Ernest Angel, and Henri Ellenberger. The main presentation and summary of existential therapy were in the first two chapters, written by May: "The Origins of the Existential Movement in Psychology" and "Contributions of Existential Psychology." The remainder of the book is made up of essays and case studies by the European existentialists (Henri Ellenberger, Eugene Minkowski, Erwin Straus, V. E. von Gebsattel, Ludwig Binswanger, and Ronald Kuhn).

Rollo May was trained as a psychoanalyst in the William Alanson White Institute, a neo-Freudian institute in New York, and was already a practicing analyst when he read in the early 1950s about existential therapies in Europe. His books, which sought to reconcile existential ideas with psychoanalysis, became important texts of existential psychotherapy, especially in the United States. He wrote, among other books, *Man's Search for Himself* (1953), *Freedom and Destiny* (1981), and *The Cry for Myth* (1991).

Erich Fromm, a founder (in 1946) of the William Alanson White Institute, also wrote many books that explored existential issues. *Escape from Freedom* (1941) focuses on the human tendency to submit to authority as a way of defending against the existential terrors of free choice. *The Art of Loving* (1956) addressed the dilemmas of existential isolation.

The first comprehensive textbook in existential psychotherapy was written by Irvin Yalom (1980) and titled *Existential Psychotherapy.* In this work and in his subsequent books of case studies, *Love's Executioner* (1989) and *Momma and the Meaning of Life* (1999), as well as in his novels, *When Nietzsche Wept* (1992) and *The Schopenhauer Cure* (2005), Yalom attempted to detail what an existential psychotherapist actually *does* in the therapeutic session. His book *Staring at the Sun: Overcoming the Terror of Death* (2008) focuses upon the experience and the treatment of high levels of death anxiety.

Other writers who have offered existential approaches to psychotherapy have also furthered its popularity in the United States. Victor Frankl wrote *Man's Search For Meaning* (1956), a widely read and highly influential text that sets out an approach to *logotherapy*, a form of psychotherapy focused on will, freedom, meaning and responsibility. Allen Wheelis (1973), a San Francisco existential psychoanalyst, wrote eloquently about his therapeutic encounters in which the specter of death and the search for

meaning play central roles. Of his 14 books, *How People Change* is the best known. He wrote the following of psychotherapy:

> If . . . the determining causes of which we gain awareness lie within, or are brought within, our experience, and if we use this gain in understanding to create present options, freedom will be increased, and with it greater responsibility for what we have been, are, and will become. (1973, p. 117)

Current Status

The spirit of existential psychotherapy has never supported the formation of specific institutes because it deals with the *presuppositions underlying therapy of any kind.* Its concern was with concepts about human beings and not with specific techniques. This leads to the dilemma that existential therapy has been quite influential, but there are very few adequate training courses in this kind of therapy simply because it is not training in a specific technique. Existentially oriented psychotherapists tend to further their knowledge through their own personal therapy and supervision and by reading philosophy and great literature.

Therapists trained in different schools can legitimately call themselves existential if their assumptions are similar to those described in this chapter. Irvin Yalom was trained in a neo-Freudian tradition. Even such an erstwhile behavior therapist as Arnold Lazarus uses some existential presuppositions in his multimodal psychotherapy. Fritz Perls and Gestalt therapy rest on existential grounds. All of this is possible because existential psychotherapy is a way of conceiving the human being.

Existential therapists are centrally concerned with rediscovering the living person amid the dehumanization of modern culture, and in order to do this, they engage in in-depth psychological analysis. Their focus is less on alleviating symptoms and more on greater awareness and freedom in relation to living.

Summing up the existential therapeutic position 25 years after he wrote his classic, influential text, Yalom (2008) describes the need for an inclusive perspective in psychotherapy in these words:

> Psychological distress issues *not only* from our biological genetic substrate (a psycho–pharmacologic model), *not only* from our struggle with suppressed instinctual strivings (a Freudian position), *not only* from our internalized significant adults who may be uncaring, unloving, neurotic (an object relations position), *not only* from disordered forms of thinking (a cognitive–behavioral position), *not only* from shards of forgotten traumatic memories, nor from current life crises involving one's career and relationship with significant others, *but also—but also*—from a confrontation with our existence. (2008, p. 180)

In the contemporary climate of focus on brief, manualized treatments oriented to symptom reduction, driven by market forces rather than human need, all the human-focused approaches to psychotherapy suffer (McWilliams, 2005). In most training programs, across professions, psychotherapy that focuses on the subtleties of human experience is being taught less and less in favor of technological expedience and compliance with the dictates of managed-care companies. Chagrined at seeing the life being squeezed out of psychotherapy as it was becoming more mechanized and less human and intimate, Yalom wrote a highly accessible guide for therapists, both novice and seasoned, titled *The Gift of Therapy* (2002). Judging from its enormous sales, there is a massive wish among psychotherapists to engage the issues of existence and presence with their patients. The tenets of existential psychotherapy will perhaps serve future generations when deeper forms of healing again become more, or more widely, possible.

PERSONALITY

Theory of Personality

In Tolstoy's *The Death of Ivan Illych*, the central character, Ivan Illych, a self-involved, self-satisfied, pompous bureaucrat, is dying in pain and suddenly realizes that he is dying badly because he has lived badly. "'Maybe I did not live as I ought to have done,' it suddenly occurred to him. 'But how could that be, when I did everything properly?'" (p. 145). Ivan Illych's realization of the impoverishment of his life leads him, in the last days of his life, to relate more authentically and empathically to his family, thus redeeming his life at the very end. The existential focus of a theory of personality concerns whether people are living as authentically and meaningfully as possible.

Existential psychotherapy is a *dynamic psychotherapy.* It takes from Freud the model of personality as a system of forces in conflict with one another. The emotions and behavior (both adaptive and pathological) that constitute personality may exist at different levels of consciousness, some entirely out of awareness, and may conflict. Thus, when we speak of the "psychodynamics" of an individual, we refer to that individual's conflicting conscious and unconscious motives and fears. Dynamic psychotherapy is psychotherapy based upon this internal conflict model of personality structure.

Existential Psychodynamics

In contrast to the Freudian model, which posits conflict between instincts and the demands of the environment (or the superego, which is the environment internalized), and in contrast to the interpersonal and object relational models that posit conflict stemming from interactions with significant powerful others in childhood, the existential model of personality postulates that the basic conflict is between the individual and the "givens," the ultimate concerns of existence. Thus, the existential system replaces the Freudian system of

DRIVE → ANXIETY → DEFENSE MECHANISM
with
AWARENESS OF ULTIMATE CONCERN → ANXIETY → DEFENSE MECHANISM

If we "bracket" the outside world, if we put aside the everyday concerns with which we ordinarily fill our lives and reflect deeply upon our situations in the world, then we must confront the dilemmas of the ultimate concerns (detailed above) that are an inescapable part of the human being's existence in the world. The individual's confrontation with each of these constitutes the content of the inner conflict from the existential frame of reference.

As people, we are influenced by the physical environment, the presence or absence of other people, genetics, and social or cultural variables. In other words, we are influenced by our destiny. That is, because we are stimulated in certain ways, we respond in certain ways. As subjects, however, we are aware of the fact that these things are happening to us. We perceive, ponder, and act on this information. We determine which experiences are valuable and which are not and then act according to these personal formulations. What is crucial is "man's capacity to stand outside himself, to know he is the subject as well as the object of experience, to see himself as the entity who is acting in the world of objects" (May, 1967, p. 75). As humans, we view the world, and we can view ourselves viewing it. It is this consciousness of self that allows people to escape determinism and personally influence what they do.

> Consciousness of self gives us the power to stand outside the rigid chain of stimulus and response, to pause, and by this pause to throw some weight on either side, to cast some decision about what the response will be. (May, 1953, p. 161)

A full understanding of a person involves both knowledge of that person's circumstances (the objective part) and how that person subjectively structures and values those circumstances (the subjective part).

Existential psychotherapy does not offer a theory of individual differences, but it attends carefully to how each individual deals with the ultimate concerns. Therefore, the existential understanding of personality is inherently tied to its approach to psychotherapy.

Variety of Concepts

May attributes anxiety to the fundamental clash between being and the threat of nonbeing. A certain amount of anxiety is therefore a normal and inevitable aspect of every personality. Anxiety confronts each of us with a major challenge. This unpleasant emotion intensifies whenever we choose to boldly assert our innate potentials. Emphatically affirming that we exist also brings a reminder that someday we will not. It is all too tempting to repress or intellectualize our understanding of death, deny our being-in-the-world (*Dasein*), and opt for the apparent safety of social conformity and apathy. The healthy course is to accept nonbeing as an inseparable part of being. This will enable us to live what life we have to the fullest:

> To grasp what it means to exist, one needs to grasp the fact that he might not exist, that he treads at every moment on the sharp edge of possible annihilation and can never escape the fact that death will arrive at some unknown moment . . . [Thus] the confronting of death gives the most positive reality to life itself. (May, 1958, p. 47)

Freedom

Ordinarily we do not think of freedom as a source of anxiety or conflict. Quite the contrary—freedom is generally viewed as an unequivocally positive concept. The history of Western civilization is punctuated by a yearning and striving toward freedom. Yet freedom in the existential frame of reference is riveted to dread.

From an existential viewpoint, conflicts over freedom ensue from the reality that the human being enters and ultimately departs an unstructured universe without a coherent, grand design. Freedom refers to the fact that the human being is responsible for and the author of his or her own world, own life design, and own choices and actions. The human being, as Sartre puts it, is "condemned to freedom" (1956, p. 631). Rollo May (1981) holds that freedom, in order to be authentic, requires the individual to confront the limits of his or her destiny. He defined destiny "as the pattern of limits and talents that constitutes the 'givens' in life. . . . Our destiny cannot be cancelled out . . . but we can choose how we shall respond, how we shall live out our talents" (p. 89).

If it is true that we create our self and our world, then it also means that there is no ground beneath us: There is only an abyss, a void, nothingness. This has terrifying implications. Such awareness of freedom and groundlessness conflicts with our deep need and wish for ground and structure, creates anxiety, and invokes a variety of defense mechanisms.

Awareness of freedom implies responsibility for one's life. Individuals differ enormously in the degree of responsibility they are willing to accept for their life situations and in their modes of denying responsibility. For example, some individuals displace responsibility for their situations onto other people, onto life circumstances, onto bosses and spouses, and, when they enter treatment, they transfer responsibility for their therapy to their psychotherapist. Other individuals deny responsibility by experiencing themselves as innocent victims who suffer from external events (and

remain unaware that they themselves have set these events into motion). Still others shirk responsibility by temporarily being "out of their minds"—they enter a temporary irrational state in which they are not accountable even to themselves for their behavior.

Another aspect of freedom is *willing.* To be aware of responsibility for one's situation is to enter the vestibule of action or, in a therapy situation, of change. Willing represents the passage from responsibility to action, moving from wishing to deciding (May, 1969). Many individuals have enormous difficulties in experiencing or expressing a wish. Wishing is closely aligned to feeling, and affect-blocked individuals cannot act spontaneously because they cannot feel and thus cannot wish. *Impulsivity* avoids wishing by failing to discriminate among wishes. Instead, individuals act impulsively and promptly on all wishes. *Compulsivity*, another disorder of wishing, is characterized by individuals driven by unconscious inner demands that often run counter to their consciously held desires.

Once an individual fully experiences a wish, he or she is faced with *decision.* Many individuals can be extremely clear about what they wish but still not be able to decide or to choose. Often they experience a decisional panic; they may attempt to delegate the decision to someone else, or they act in such a way that the decision is made for them by circumstances that they, unconsciously, have brought to pass.

Thus, personality is informed by how people deal with the dilemmas of freedom. From the duty-bound to the capricious to the dependent, people have an array of mechanisms to deny or displace their freedom.

Isolation

Coming to terms with existential isolation, our inherent aloneness in the universe, is a second dynamic conflict that structures the personality. Each individual in the dawn of consciousness creates a primary self by permitting consciousness to curl back upon itself and to differentiate a self from the remainder of the world. Only after the individual becomes "self-conscious" can he or she begin to constitute other selves. Yet the individual cannot escape the knowledge that (1) he or she constitutes others and (2) he or she can never fully share his or her consciousness with others. There is no stronger reminder of existential isolation than a confrontation with death. The individual who faces death invariably becomes acutely aware of existential isolation.

Awareness of our fundamental isolation may invoke an unfulfillable wish to be protected, to merge, and to be part of a larger whole. Bugenthal (1976) points out that all relationships are poised on the poles of being *a part of* and *apart from*, the twin perils of merger and isolation. Fear of existential isolation (and the defenses against it) underlies a great deal of interpersonal psychopathology. Often relationships are troubled by the effort of one person to *use* another for some function rather than to *relate* to the other out of caring for that person's being. If one is overcome with dread in the face of isolation, one will not be able to turn toward others but instead will use others as a shield against isolation. In such instances, relationships will be distortions of what might have been authentic relationships.

Some individuals experience panic when they are alone. These individuals begin to doubt their own existence and believe that they exist only in the presence of another, that they exist only so long as they are responded to or are thought about by another individual.

Many attempt to deal with isolation through *fusion*: they soften their ego boundaries and become part of another individual. They avoid personal growth and the sense of isolation that accompanies growth. Fusion underlies the experience of being in love. The wonderful thing about romantic love is that the lonely "I" disappears into the "we." Others may fuse with a group, a cause, a country, or a project. To be like everyone

else—to conform in dress, speech, and customs, to have no thoughts or feelings that are different—saves one from the isolation of the lonely self.

Compulsive sexuality is also a common response to terrifying isolation. Promiscuous sexual coupling offers a powerful but temporary respite for the lonely individual. It is temporary because it is only a caricature of a relationship. The sexually compulsive individual does not relate to the whole being of the other but relates only to the part of that individual that meets his or her need. Sexually compulsive individuals do not know their partners; they show and see only those parts that facilitate seduction and the sexual act.

Meaninglessness

The third existential influence on personality is meaninglessness. If each person must die, and if each person constitutes his or her own world, and if each is alone in an indifferent universe, then what possible meaning can life have? Why do we live? How shall we live? If there is no preordained design in life, then we must construct our own meaning in life. The fundamental question then becomes, "Is it possible that a self-created meaning is sturdy enough to bear one's life?" The third internal conflict stems from this dilemma: *How does a being who requires meaning find meaning in a universe that has no meaning?*

The human being appears to require meaning. Our perceptual neuropsychological organization is such that we instantaneously pattern random stimuli. We organize them automatically into figure and ground and may even create a story about them. When confronted with a broken circle, we automatically perceive it as complete. When any situation or set of stimuli defies patterning, we fit the situation into a recognizable pattern.

In the same way that individuals organize random stimuli, so too do they face existential situations: In an unpatterned world, an individual is acutely unsettled and searches for a pattern, an explanation, a meaning for existence.

A sense of meaning of life is necessary for still another reason: From a meaning schema, we generate a hierarchy of values. Values provide us with a blueprint for life conduct; values tell us not only *why* we live but *how* to live.

To grow as a person, one must constantly challenge one's structure of meaning, which is the core of one's existence, and this necessarily causes anxiety. Thus to be human is to have the urge to expand one's awareness, but to do so causes anxiety. Growth, and with it normal anxiety, consists of the giving up of immediate security for the sake of more extensive goals (May, 1967). The authentic person recognizes the hazards of exploring uncharted territory and does so nonetheless. The anxiety associated with moving forward into the unknown is an unfortunate concomitant of exercising one's freedom and realizing a quest for meaning.

As people tell the stories of their lives, their meanings are implicit. Their personal narratives are structured around their purposes and values, and the ways they narrate their lives reflect how they understand themselves as unique individuals and socially located beings. Narrative, then, becomes another dimension or level of personality (McAdams & Pals, 2006) and discloses the sense of personal unity and identity that construct meaning in life.

Death

The fourth and perhaps most central conflict is the confrontation with death. Death is the ultimate existential concern. It is apparent to all that death will come and that there is no escape. It is a terrible truth, and at the deepest levels we respond to it with mortal terror. "Everything," as Spinoza states, "wishes to persist in its own being" (1954, p. 6). From the existential point of view, a core inner conflict is between awareness of inevitable death and the simultaneous wish to continue to live.

the edge of the abyss but who will always bring them back. An excess of this particular defense mechanism results in a character structure displaying passivity, dependency, and obsequiousness. Often such individuals dedicate their lives to locating and appeasing an ultimate rescuer.

One of Yalom's patients, Elva, an elderly woman, came to therapy because she was traumatized by having her purse snatched. Located within and beneath the resulting panic was her inability to let go of her departed husband who, at a very deep level, she believed would continue to protect her. The purse snatching and ensuing sense of vulnerability challenged this belief in her husband as an ultimate rescuer. In this case, we see how such beliefs may be camouflaged by seemingly unrelated experiences.

PSYCHOTHERAPY

Theory of Psychotherapy

A substantial proportion of practicing psychotherapists consider themselves existentially (or humanistically) oriented. Yet few, if any, have received any systematic training in existential therapy. One can be reasonably certain of this because there are few comprehensive training programs in existential therapy. Although many excellent books illuminate some aspect of the existential frame of reference (Becker, 1973; Bugental, 1976; Koestenbaum, 1978; May, 1953, 1967, 1969; May et al., 1958), Yalom's book (1981) is the only one to present a systematic, comprehensive view of the existential therapeutic approach.

Existential therapy is *not* a comprehensive psychotherapeutic system; it is a frame of reference—a paradigm by which one views and understands a patient's suffering in a particular manner. Existential therapists begin with presuppositions about the sources of a patient's anguish and view the patient in human rather than behavioral or mechanistic terms. They may employ any of a large variety of techniques used in other approaches insofar as they are consistent with basic existential presuppositions and a human, authentic therapist–patient encounter.

The vast majority of experienced therapists, regardless of adherence to some particular ideological school, employ many existential insights and approaches. All competent therapists realize, for example, that an apprehension of one's finiteness can often catalyze a major inner shift of perspective, that it is the relationship that heals, that patients are tormented by choice, that a therapist must catalyze a patient's will to act, and that the majority of patients are bedeviled by a lack of meaning in their lives.

It is also true that the therapist's belief system determines the type of clinical data that he or she encounters. Therapists subtly or unconsciously cue patients to provide them with certain material. Jungian patients have Jungian dreams. Freudian patients discover themes of Oedipal competition. Cognitive therapists are attuned to "irrational" beliefs. The therapist's perceptual system is affected by her or his ideological system. Thus, the therapist tunes in to the material that she or he wishes to obtain. So too with the existential approach. If the therapists tune their mental apparatus to the right channel, it is astounding how frequently patients discuss concerns emanating from existential conflicts. Moreover, there are patients who have had a long-term enduring interest in existential issues. These people connect deeply to a therapist who can speak with them about their existential dilemmas and who places importance on the issues that concern them.

An existential therapist is someone with a sensibility to existential issues. No therapist focuses on existential issues all the time. These issues are important to some, not all, patients at some, not all, stages of therapy.

The basic approach in existential therapy is strategically similar to other dynamic therapies. The therapist assumes that the patient experiences anxiety that issues from

Death plays a major role in one's internal experience. It haunts the individual like nothing else does. It rumbles continuously under the membrane of life. The child at an early age is pervasively concerned with death, and one of the child's major developmental tasks is to deal with the terror of obliteration. To cope with this terror, we erect defenses against death awareness. These defenses are denial based; they shape character structure and, if maladaptive, result in clinical maladjustment.

Psychopathology, to a very great extent, is the result of failed death transcendence; that is, symptoms and maladaptive character structure have their origin in the individual terror of death. There are many defense mechanisms that might be employed for dealing with the anxiety emerging from awareness of death, among them an irrational belief in personal "specialness" and an irrational belief in the existence of an "ultimate rescuer" (Yalom, 1980).

Specialness. Individuals have deep, powerful beliefs in personal inviolability, invulnerability, and immortality. Although at a rational level we recognize the foolishness of these beliefs, nonetheless, at a deeply unconscious level, we believe that the ordinary laws of biology do not apply to us. People can camouflage their fears of death behind a belief that one's specialness will somehow override the dread decree. Again, Tolstoy's Ivan Illych offers an apt example:

In the depth of his heart he knew he was dying, but not only was he not accustomed to the thought, he simply did not and could not grasp it.

> The syllogism he had learnt from Kiezewetter's Logic, "Caius is a man, men are mortal, therefore Caius is moral," had always seemed to him correct as applied to Caius, but certainly not as applied to himself. That Caius—man in the abstract—was mortal, was perfectly correct, but he was not Caius, not an abstract man, but a creature quite, quite separate from all others. He had been little Vanya, with a mamma and a papa . . . What did Caius know of the smell of that striped leather ball Vanya had been so fond of? Had Caius kissed his mother's hand like that . . . ? Had Caius been in love like that? Could Caius preside at a session as he did? Caius really was mortal, and it was right for him to die, but for me, little Vanya, Ivan Illych, with all my thoughts and emotions, it's altogether a different matter. It cannot be that I ought to die. That would be too terrible. (pp. 131–2)

What psychotherapists might simply label narcissism or entitlement may actually be subterfuge for the belief that specialness is an antidote to death. Similarly, workaholism or preoccupation with getting ahead, with preparing for the future, amassing material goods, or becoming more powerful or more eminent can be compulsive ways of unconsciously trying to ensure immortality.

Where the defense of specialness operates satisfactorily for a time, a crisis in the lives of these individuals occurs when their belief system is shattered and a sense of unprotected ordinariness intrudes. They frequently seek therapy when the defense of specialness is no longer able to ward off anxiety—for example, at times of severe illness or at the interruption of what had always appeared to be an eternal, upward spiral. In cases of trauma, it is sometimes the "Why me?" question that haunts the trauma survivor. To ask, "Why not me?" is to undermine the defensive sense of specialness, a specialness that ultimately (and irrationally) seems to protect against death.

The Belief in the Existence of an Ultimate Rescuer. A second denial system is belief in an ultimate rescuer. People may imagine their rescuer to be human or divine, but the belief is in someone who is watching over them in an indifferent world. In order to keep the specter of death at bay, people may unconsciously create a belief in a personal omnipotent savior who eternally guards and protects their welfare, who may let them get to

some existential conflict that is at least partially unconscious and that suffering ensues from "problems in being" (Wheelis, 1973). The patient handles anxiety by a number of ineffective, maladaptive defense mechanisms that may provide temporary respite from anxiety but ultimately so cripple the individual's ability to live fully and creatively that these defenses merely result in still further secondary anxiety. The therapist helps the patient to embark on a course of self-investigation in which the goals are to understand the unconscious conflict, to identify the maladaptive defense mechanisms, to discover their destructive influence, to diminish secondary anxiety by correcting these heretofore restrictive modes of dealing with self and others, and to develop other ways of coping with primary anxiety.

Although the basic strategy in existential therapy is similar to other dynamic therapies, the content is radically different. In many respects, the process differs as well; the existential therapist's different mode of understanding the patient's basic dilemma results in many differences in the strategy of psychotherapy. For example, because the existential view of personality structure emphasizes the depth of experience at any given moment, the existential therapist does not spend a great deal of time helping the patient to recover the past. The existential therapist strives for an understanding of the patient's *current* life situation and *current* enveloping unconscious fears. The existential therapist believes, as do other dynamic therapists, that the nature of the therapist–client relationship is fundamental in good psychotherapeutic work. However, the accent is not upon transference but instead upon the relationship as fundamentally important in itself, especially in regard to engagement and connection. The existential therapist works in the present tense. The individual is to be understood and helped to understand himself or herself from the perspective of a here-and-now *cross-section*, not from the perspective of a historical *longitudinal section.*

Consider the use of the word *deep.* Freud defines *deep* as "early," and so the deepest conflict meant the earliest conflict in the individual's life. Freud's psychodynamics are developmentally based. *Fundamental* and *primary* are to be grasped chronologically: Each is synonymous with "first." Thus, the fundamental sources of anxiety, for example, are considered to be the earliest calamities: separation and castration.

From the existential perspective, *deep* means the most fundamental concerns facing the individual at that moment. The past (i.e., one's memory of the past) is important only insofar as it is part of one's current existence and has contributed to one's current mode of facing ultimate concerns. The immediate, currently existing ground beneath all other ground is important from the existential perspective. Thus, the existential conception of personality is in the awareness of the depths of one's immediate experiences. Existential therapy does not attempt to excavate and understand the past; instead, it is directed toward the future's becoming the present and explores the past only as it throws light on the present. The therapist must continually keep in mind that we create our past and that our present mode of existence dictates what we choose to remember of the past. The therapeutic focus is on the self-experience of the patient and attends to the patient's capacity for self-actualization, even self-transcendence, through engagement in life.

Process of Psychotherapy

In the existential framework, anxiety is so riveted to existence that it has a different connotation from the way anxiety is regarded in other frames of reference. The existential therapist hopes to alleviate crippling levels of anxiety but not to eliminate it. Life cannot be lived (nor can death be faced) without anxiety. The therapist's task, as May reminds us (1977, p. 374), is to reduce anxiety to tolerable levels and then to use the anxiety constructively.

We can best understand the process of psychotherapy in the existential approach by considering the therapeutic leverage inherent in some of the ultimate concerns. Each of the ultimate human concerns (death, freedom, isolation, and meaninglessness) has implications for the process of therapy.

Existential Psychotherapy and Freedom

A major component of freedom is *responsibility*—a concept that deeply influences the existential therapist's therapeutic approach. Sartre equates responsibility with *authorship*: To be responsible means to be the author of one's own life design. The existential therapist continually focuses upon each patient's responsibility for his or her own distress. Bad genes or bad luck do not cause a patient to be lonely or chronically abused or neglected by others. Until patients realize that they are responsible for their own conditions, there is little motivation to change.

The therapist must identify methods and instances of responsibility avoidance and then make these known to the patient. Therapists may use a wide variety of techniques to focus the patient's attention on responsibility. Many therapists interrupt the patient whenever they hear the patient avoiding responsibility. When patients say they "can't" do something, the therapist immediately comments, "You mean you 'won't' do it." As long as one believes in "can't," one remains unaware of one's active contribution to one's situation. Such therapists encourage patients to *own* their feelings, statements, and actions. If a patient comments that he or she did something "unconsciously," the therapist might inquire, "Whose unconscious is it?" The general principle is obvious: Whenever the patient laments about his or her life situation, the therapist inquires how the patient created that situation.

Often it is helpful to keep the patient's initial complaints in mind and then, at appropriate points in therapy, juxtapose these initial complaints with the patient's in-therapy behavior. For example, consider a patient who sought therapy because of feelings of isolation and loneliness. During the course of therapy, the patient expressed at great length his sense of superiority and his scorn and disdain of others. These attitudes were rigidly maintained; the patient manifested great resistance to examining, much less changing, these opinions. The therapist helped this patient to understand his responsibility for his personal predicament by reminding the patient, whenever he discussed his scorn of others, "And you are lonely."

Responsibility is one component of freedom. Earlier we described another, *willing*, which may be further subdivided into *wishing* and *deciding*. Consider the role of *wishing*. How often does the therapist participate with a patient in some such sequence as this:

"What shall I do? What shall I do?"
"What is it that stops you from doing what you want to do?"
"But I don't *know* what I want to do! If I knew that, I wouldn't need to see you!"

These patients know what they should do, ought to do, or must do, but they do not experience what they *want* to do. Many therapists, in working with patients who have a profound incapacity to wish, have shared May's inclination to shout, "Don't you ever *want* anything?" (1969, p. 165). These patients have enormous social difficulties because they have no opinions, no inclinations, and no desires of their own.

Often the inability to wish is imbedded in a more global disorder—the inability to feel. In many cases, the bulk of psychotherapy consists of helping patients to dissolve their affect blocks. This therapy is slow and grinding. Above all, the therapist must persevere and, time after time, must continue to press the patient with, "What do you feel? What do you want?" Repeatedly the therapist will need to explore the source and nature of the block and of the stifled feelings behind it. The inability to feel and to wish

is a pervasive characterological trait, and considerable time and therapeutic perseverance are required to effect enduring change.

There are other modes of avoiding wishing in addition to blocking of affect. Some individuals avoid wishing by not discriminating among wishes, by acting impulsively on all wishes. In such instances, the therapist must help the patient to make some internal discrimination among wishes and assign priorities to each. The patient must learn that two wishes that are mutually exclusive demand that one be relinquished. If, for example, a meaningful, loving relationship is a wish, then a host of conflicting interpersonal wishes—such as the wish for conquest or power or seduction or subjugation—must be denied.

Decision is the bridge between wishing and action. Some patients, even though they are able to wish, are still unable to act because they cannot *decide.* One of the more common reasons that deciding is difficult is that every yes involves a no. Renunciation invariably accompanies decision, and a decision requires a relinquishment of other options—often options that may never come again. The patient must come to terms with the unalterable fact that *alternatives exclude.*

The therapist must help patients make choices. Patients must recognize that they themselves, not the therapist, must generate and choose among options. In helping patients to communicate effectively, therapists teach that one must *own* one's feelings. It is equally important that one owns one's decisions. Some patients are panicked by the various implications of each decision. The "what ifs" torment them. *What if I leave my job and can't find another? What if I leave my children alone and they get hurt?* It is often useful to ask the patient to consider the entire scenario of each "what if" in turn, to fantasize it happening with all the possible ramifications, and then to experience and analyze emerging feelings.

Patients may also feel paralyzed by an inability to tolerate uncertainty. A young woman scientist came to therapy because she was unable to decide whether to move back to her hometown to be near her family, which she very much wanted to do, or to stay in her current city and job, neither of which she liked. Most of all, she hoped to meet a man who could be a life partner, something she had been unable to do in any of the cities she had recently lived in while she was studying and pursuing her career goals. In scientific fashion, she had researched all possibilities, exhaustively checking, for example, dating Web sites to see which men were looking for partners in her hometown. None of them seemed suitable. What if she gave up her prestigious job for a lesser one in her hometown and *still* didn't meet anyone? She would then still be lonely and now full of regret and remorse. What she wanted was for someone to tell her what was the right decision. The therapeutic task with her was to help her face the inevitability of uncertainty in life: There are never guarantees, no matter how scientifically one approaches one's decisions.

A general posture toward decision making is to assume that the therapist's task is not to *create* will but instead to *disencumber* it. The therapist cannot flick the decision switch or inspire the patient with resoluteness. It is the therapist's task to help remove the obstacles to decision making. Once that is done, the individual will naturally move into a more autonomous position in just the way, as Karen Horney (1950) put it, an acorn develops into an oak tree.

The therapist must help patients understand that decisions are unavoidable. One makes decisions all the time and often conceals from oneself the fact that one is deciding. It is important to help patients understand the inevitability of decisions and to identify how they make decisions. Many patients decide *passively* by, for example, letting another person decide for them. They may terminate an unsatisfactory relationship by unconsciously acting in such a way that the partner makes the decision to leave. In such instances, the final outcome is achieved, but the patient may be left with many negative repercussions. The patient's sense of powerlessness is merely reinforced, and he or she

continues to experience himself or herself as one to whom things happen rather than as the author of his or her own life situation. The *way* one makes a decision is often as important as the content of the decision. An active decision reinforces the individual's active acceptance of his or her own power and resources.

Existential Isolation and Psychotherapy

No relationship can eliminate existential isolation, but aloneness can be shared in such a way that love compensates for its pain. The experience of existential isolation is so anguishing that defenses are fairly quickly and firmly instituted against it. Yet the capacity to acknowledge deeply our isolated situation in existence also makes it possible to move toward authentic relationships with other (similarly isolated) beings. Patients who grow in psychotherapy learn not only the rewards of intimacy but also its limits: They learn what they *cannot* get from others.

An important step in treatment consists of helping patients address existential isolation directly. Those who lack sufficient experiences of closeness and true relatedness in their lives are particularly incapable of tolerating isolation. Adolescents from loving, supportive families are able to grow away from their families with relative ease and to tolerate the separation and loneliness of young adulthood. On the other hand, those who grow up in tormented, highly conflicted families find it extremely difficult to leave the family. The more disturbed the family, the harder it is for children to leave—they are ill equipped to separate and therefore cling to the family for shelter against isolation and anxiety.

Many patients have enormous difficulty spending time alone. Some may feel they exist only in the eyes of others. Consequently, they construct their lives in such a way that they eliminate time alone. Two of the major problems that result from this are the desperation with which they seek certain kinds of relationships and the use of others to assuage the pain accompanying isolation. The therapist must find a way to help the patient confront isolation in a dosage and with a support system suited to that patient. Some therapists, at an advanced stage of therapy, advise periods of self-enforced isolation during which the patient is asked to monitor and record thoughts and feelings.

The anxiety of existential isolation is best assuaged through the creation of meaningful and mutual relationships with others. Many patients who feel unloved actually suffer from difficulties in the capacity to love. Too occupied with what they need from others, they cannot give to others and cannot participate in reciprocity and mutuality. To love means to be actively concerned with the welfare and growth of another. In *The Art of Loving*, Erich Fromm (1956) wrote "the ability to be alone is the condition for the ability to love (p. 94)." Two partners unable to tolerate aloneness create an A-frame that holds them both up but is a poor basis for marriage.

The authentic human encounter must be modeled by the therapist, who is available to meet the patient in the space between "I" and "Thou." It is the therapeutic relationship that heals. Presence, genuineness, and receptiveness on the part of the therapist form the attitude that invites true *meeting* in a real relationship with the patient. The aim of the therapist is to bring something to life in the patient rather than to impose something. The therapist stays with this task selflessly, attempting to enter the patient's world and experience it as the patient experiences it. The existential therapist tries to do this from a position of being a fellow traveler—not as a technique of psychotherapy.

Meaninglessness and Psychotherapy

To deal effectively with meaninglessness, therapists must first increase their sensitivity to the topic, listen differently, and become aware of the importance of meaning in the lives of individuals. For some patients, the issue of meaninglessness is profound and

pervasive. Carl Jung once estimated that more than 30% of his patients sought therapy because of a sense of personal meaninglessness (1966, p. 83).

The therapist must be attuned to the overall focus and direction of the patient's life. Is the patient reaching beyond himself or herself? Or is he or she entirely immersed in the daily routine of staying alive? Yalom (1981) reported that his therapy was rarely successful unless he was able to help patients focus on something beyond these pursuits. Simply by increasing their sensitivity to these issues, the therapist can help them focus on values outside themselves. Therapists, for example, can begin to wonder about the patient's belief systems, inquire deeply into the loving of another, ask about long-range hopes and goals, and explore creative interests and pursuits.

Viktor Frankl, who placed great emphasis on the importance of meaninglessness in contemporary psychopathology, stated that "happiness cannot be pursued, it can only ensue" (1963, p. 165). The more we deliberately search for self-satisfaction, the more it eludes us, whereas the more we fulfill some self-transcendent meaning, the more happiness will ensue.

Therapists must find a way to help self-centered patients develop curiosity and concern for others. The therapy group is especially well suited for this endeavor: The pattern in which self-absorbed, narcissistic patients take without giving often becomes highly evident in the therapy group. In such instances, therapists may attempt to increase an individual's ability and inclination to empathize with others by requesting, periodically, that patients guess how others are feeling at various junctures of the group.

But the major solution to the problem of meaninglessness is engagement. Wholehearted engagement in any of the infinite array of life's activities enhances the possibility of one's patterning the events of one's life in some coherent fashion. To fashion a home, to care about other individuals and about ideas or projects, to search, to create, to build—all forms of engagement are twice rewarding: They are intrinsically enriching, and they alleviate the dysphoria that stems from being bombarded with the unassembled brute data of existence.

The therapist must approach engagement with the same attitudinal set used with wishing. The desire to engage life is always there with the patient, and therefore the therapist's activity should be directed toward the removal of obstacles in the patient's way. The therapist begins to explore what prevents the patient from loving another individual. Why is there so little satisfaction from his or her relationships with others? Why is there so little satisfaction from work? What blocks the patient from finding work commensurate with his or her talents and interests or finding some pleasurable aspects of current work? Why has the patient neglected creative or spiritual or self-transcendent strivings?

Death and Psychotherapy

An increased awareness of one's finiteness stemming from a personal confrontation with death may cause a radical shift in life perspective and lead to personal change. A patient named Carlos, dying of cancer, had increased his preoccupation with having sex with as many women as possible. But as Yalom, his therapist, insisted that he reflect on how he had been living his life, Carlos made astonishing change in his last months. As he lay dying, he thanked his therapist for having saved his life.

Death as an Awakening Experience

An *awakening experience* is a type of urgent experience that propels the individual into a confrontation with an existential situation. The most powerful awakening experience is confrontation with one's personal death. Such a confrontation has the power to provide

a massive shift in the way one lives in the world. Some patients report that they learn simply that "existence cannot be postponed." They no longer put off living until some time in the future; they realize that one can really live only in the present. The neurotic individual rarely lives in the present but is either continuously obsessed with events from the past or fearful of anticipated events in the future.

A confrontation with an awakening experience persuades individuals to count their blessings, to become aware of their natural surroundings: the elemental facts of life, changing seasons, seeing, listening, touching, and loving. Ordinarily what we *can* experience is diminished by petty concerns, by thoughts of what we cannot do or what we lack, or by threats to our prestige.

Many terminally ill patients, when reporting personal growth emanating from their confrontation with death, have lamented, "What a tragedy that we had to wait till now, till our bodies were riddled with cancer, to learn these truths." This is an exceedingly important message for therapists. The therapist can obtain considerable leverage to help "everyday" patients (i.e., patients who are not physically ill) increase their awareness of death earlier in their life cycle. With this aim in mind, some therapists have employed structured exercises to confront the individual with personal death. Some group leaders begin a brief group experience by asking members to write their own epitaph or obituary, or they provide guided fantasies in which group members imagine their own death and funeral.

Many existential therapists do not believe that artificially introduced death confrontations are necessary or advisable. Instead, they attempt to help the patient recognize the signs of mortality that are part of the fabric of everyday life. If the therapist and the patient are tuned in, there is considerable evidence of death anxiety in every psychotherapy. Every patient suffers losses through death of parents, friends, and associates. Dreams are haunted with death anxiety. Every nightmare is a dream of raw death anxiety. Everywhere around us are reminders of aging: Our bones begin to creak, age spots appear on our skin, we go to reunions and note with dismay how everyone *else* has aged. Our children grow up. The cycle of life envelops us.

An important opportunity for confrontation with death arises when patients experience the death of someone close to them. The traditional literature on grief primarily focuses on two aspects of grief work: loss and the resolution of ambivalence that so strongly accentuates the dysphoria of grief. But a third dimension must be considered: The death of someone close to us confronts us with our own death.

Often grief has a very different tone, depending upon the individual's relationship with the person who has died. The loss of a parent confronts us with our vulnerability: If our parents could not save themselves, who will save us? When parents die, nothing remains between ourselves and the grave. At the moment of our parents' deaths, we ourselves constitute the barrier between our children and their death.

The death of a spouse often evokes the fear of existential isolation. The loss of the significant other increases our awareness that, try as hard as we can to go through the world two by two, there is nonetheless a basic aloneness we must bear. Yalom reports a patient's dream the night after learning that his wife had inoperable cancer.

> I was living in my old house in __________ [a house that had been in the family for three generations]. A Frankenstein monster was chasing me through the house. I was terrified. The house was deteriorating, decaying. The tiles were crumbling and the roof leaking. Water leaked all over my mother. [His mother had died six months earlier.] I fought with him. I had a choice of weapons. One had a curved blade with a handle, like a scythe. I slashed him and tossed him off the roof. He lay stretched out on the pavement below. But he got up and once again started chasing me through the house. (1980, p. 168)

The patient's first association to this dream was "I know I've got a hundred thousand miles on me." Obviously his wife's impending death reminded him that his life and his body (symbolized in the dream by the deteriorating house) were also finite. As a child, this patient was often haunted by the monster who returned in this nightmare.

Children try many methods of dealing with death anxiety. One of the most common is the personification of death—imagining death as some finite creature: a monster, a sandman, a bogeyman, and so on. This is very frightening to children but nonetheless far less frightening than the truth—that they carry the spores of their own death within them. If death is "out there" in some physical form, then possibly it may be eluded, tricked, or pacified.

Milestones provide another opportunity for the therapist to focus the patient on existential facts of life. Even simple milestones, such as birthdays and anniversaries, are useful levers. These signs of passage are often capable of eliciting pain (consequently, we often deal with such milestones by reaction formation, in the form of a joyous celebration).

Major life events, such as a threat to one's career, a severe illness, retirement, commitment to a relationship, and separation from a relationship, can be important awakening experiences that offer opportunities for an increased awareness of death anxiety. Often these experiences are painful, and therapists feel compelled to focus entirely on pain alleviation. In so doing, however, they miss rich opportunities for deep therapeutic work that reveal themselves at those moments.

Birthdays, grief, reunions, dreams, or the empty nest prime the individual for awakening. These become occasions for reflection on how one has lived one's life. In *Thus Spake Zarathustra*, Nietzsche (1954) poses a challenge: what if you are to live the identical life again and again throughout eternity—how would that change you? The idea of living your identical life again and again for all eternity can be jarring, a sort of *petite* existential shock therapy. It often serves as a sobering thought experiment, leading one to consider seriously how one is really living.

Properly used, regret is a tool that can jar patients into taking actions to prevent its further accumulation. One can examine regret both by looking behind and by looking ahead. If regret reflects what has not been fulfilled, one can choose either to amass more regret or to plan one's life to make the changes that will avoid regret. The therapeutic question becomes, "How can you live now without building new regrets? What do you have to do to change your life?"

Death as a Primary Source of Anxiety

The fear of death constitutes a primary fount of anxiety: It is present early in life, it is instrumental in shaping character structure, and it continues throughout life to generate anxiety that results in manifest distress and the erection of psychological defenses. However, it is important to keep in mind that death anxiety exists at the very deepest levels of being, is heavily repressed, and is rarely experienced in its full sense. Often, death anxiety per se is not easily visible in the clinical picture.

Even though death anxiety may not explicitly enter the therapeutic dialogue, a theory of anxiety based on death awareness may provide therapists with a frame of reference that greatly enhances their effectiveness. Death anxiety is directly proportional to the amount of each person's "unlived life." Those individuals who feel they have lived their lives richly, have fulfilled their potential and their destiny, experience less panic in the face of death.

There are patients, however, who are suffused with overt death anxiety at the very onset of therapy. Sometimes, there are life situations in which the patient has such a

rush of death anxiety that the therapist cannot evade the issue. In long-term, intensive therapy, explicit death anxiety is always to be found and must be considered in the therapeutic work.

Mechanisms of Psychotherapy

Existential psychotherapy is not limited to and may not even be focused on a discussion of these ultimate concerns, although the alert therapist aims not to shy away from them or change the subject. Still, the mechanisms of existential psychotherapy maximize the possibility of a clear view of these fundamental human experiences by fostering engagement with the anxieties of existence and being. Through authenticity and presence, the therapist strives to counter avoidance and withdrawal. The mechanisms of existential psychotherapy involve a focus on the here and now and a view of the therapist–patient relationship as one of fellow travelers. The therapeutic stance is founded on empathy and may also include the use of dreams. Existential psychotherapy is the synergy of the therapeutic relationship plus ideas.

Empathy

Empathy is the most powerful tool we have in our efforts to connect with other people: It is the glue of human connectedness and permits one to feel, at a deep level, what someone else is feeling. The existential therapist attempts to see the world from the point of view of the patient. *Patients view the therapy hours in very different ways from therapists.* Again and again, therapists, even highly experienced ones, are surprised to rediscover this phenomenon when their patients describe an intense emotional reaction about the previous hour that the therapist cannot recall. It is extraordinarily difficult to really know what the other feels; far too often we, as therapists, project our own feelings onto the other.

Therapists don't have to have had the same experience as patients to be empathetic. They might try to follow the maxim that "I am human and let nothing human be alien to me." This requires that therapists be open to that part of themselves that corresponds to any deed or fantasy offered by patients, no matter how heinous, violent, lustful, or sadistic.

The Here and Now

The nitty-gritty of *doing* therapy involves intense focus on the here and now. What is happening in the interpersonal space between patient and therapist, right here, right now? Therapy is a social microcosm in the sense that sooner or later, if the therapy is not highly structured, the interpersonal and existential problems of the patient will manifest themselves in the here and now of the therapy relationship. If, in life, the patient is demanding or fearful or arrogant or self-effacing or seductive or controlling or judgmental or maladaptive interpersonally in any other way, then these traits will be displayed in living color in the here and now of the therapy hour. The therapist need only be alert to what is happening in the interaction with the patient and to try to find the analogues to what the patient reports to be his or her difficulties in outside relationships. In order to fully access the here and now, therapists have to access their own feelings and use these as a barometer of what is happening in the interaction. If the therapist is bored, there is something the patient is doing to induce that boredom. Perhaps the patient fears intimacy or is silently rageful toward the therapist. Only by acknowledging his or her feelings in the immediacy of the interaction can the therapist access what is being enacted by the patient. To do this well, the therapist must both have deep self-knowledge and the skill to give feedback tactfully and kindly, to avoid accusation of the patient and

Fellow Travelers

Sometimes many hours go by without the voicing of any existential content, but the therapist–patient relationship is influenced by the existential perspective in every single session. Existential therapists experience and present themselves as real, self-revealing *fellow travelers*.

We all, whether in the role of patients or therapists or just human beings, must come to terms with our eventual death, with our aloneness in the universe, with finding meaning in life, and with recognizing our freedom and taking responsibility for the lives we lead. The wise therapist recognizes that these are issues with which we must struggle together; the therapist is only privileged in the sense of being able, one hopes, to talk honestly about what these concerns entail.

A stark confrontation with the ultimate concerns of life leads to a recognition of the primacy of connectedness in human life. What is central to existential psychotherapy is the relationship between therapist and patient. But there are no prescribed formulas for this relationship. The therapeutic venture is always spontaneous, creative, and uncertain. Indeed, the therapist creates a new therapy for each patient. The therapist gropes toward the patient with improvisation and intuition. The heart of psychotherapy is a caring, deeply human meeting between two people, one (generally, but not always, the patient) more troubled than the other. Both are exposed to the same existential issues of meaning, isolation, freedom, and death. There is no distinction between "them" (the afflicted) and "us" (the healers).

Genuineness, so crucial to effective therapy, takes on a new dimension when a therapist deals honestly with existential issues. We have to abandon all vestiges of a medical model that posits that a patient suffering from a strange affliction needs a dispassionate, immaculate, expert healer. We all face the same terror, the wound of mortality, the worm at the core of existence. In order to be truly present with patients dealing with death anxiety, the therapist must be open to his or her own death anxiety, not in a glib or superficial way but with a profound awareness. This is no easy task, and no training program prepares therapists for this type of work.

Fellow travelers focusing on the here and now, on the relational space between them, expose together the dilemmas of human interaction that often underlie the blocks to finding the meaning and connection in life that soften the terrors of death. Focus on the dynamics of the therapeutic relationship as it unfolds enables vitality and engagement. The therapist's most valuable instrument is his or her own self and therefore, the personal exploration that can only be conducted in one's own therapy is necessary. Psychotherapy is a psychologically demanding enterprise, and therapists must develop the awareness and inner strength to cope with the many occupational hazards of psychotherapy. Only through personal therapy can therapists become aware of their own blind spots and dark sides and thus become able to empathize with the extensive range of human wishes and impulses. A personal therapy experience also permits the student therapist to experience the therapeutic process from the patient's seat: the tendency to idealize the therapist, the yearning for dependency, the gratitude toward a caring and attentive listener, the power granted to the therapist. Self-knowledge is not achieved once and for all; therapists can only benefit from re-entering therapy at many stages of life.

Therapist Transparency

As a fellow traveler along the same road as the patient, the therapist tries to be as authentic and genuine as possible. The therapist must be willing to disclose his or her feelings in the here and now, fully open to what is being engendered in his or her

above all, to be ready when necessary to acknowledge his or her own contribution to the problematic interaction.

Attention to the here and now invites attention to the *immediacy* of the interaction in the moment in which it occurs. Patients may find this unfamiliar or resist the intimacy that here-and-now processing engages. Yet it is here that the greatest vitality in the therapy hour will be manifest as a fully present therapist forges an authentic connection with a fully present patient, both sharing the phenomenology of their experiences.

It is the task of the therapist to maintain focus on what is transpiring in the relationship as it develops. A simple check-in brings this relationship to the center of attention, asking, for example, such questions as: "How are you and I doing today?" "Are there feelings about me you took home from the last session?" "I've noticed a real shift in the session today. At first it seemed we were very distant and in the past 20 minutes, I felt much closer. Was your experience the same? What enabled us to get closer then?" *Therapy is always an alternating sequence of interaction and reflection upon that interaction.*

What occurs in the here and now will always have analogues in the patient's life. As patients take risks with self-experience in the present of the therapy hour, they will become more courageous to take such risks in their outside lives. As patients come to recognize their blocks to full engagement, their constriction, their flights from responsibility, their difficulties in relating to others, they will better understand what impedes their life projects and relationships. Patients develop a new internal standard for the quality of a genuine relationship. Having achieved it with the therapist, they may well have the confidence and willingness to form similarly good relationships in the future.

The therapist never makes decisions for patients and is alert to any internal convictions that s/he knows what is best for the patient. The role of the therapist is "catalytic" (Wheelis, 1973). Therapy is aimed toward removing roadblocks to purposeful living and helping patients assume responsibility for their actions, not providing solutions.

Dreams

Dreams are a very important access road to the inner life of patients. They comment on the therapy relationship, on existential experiences, and on unconscious fantasies and contain metaphors for the deepest aspects of the person. Yalom (2002) recounts the following story in *The Gift of Therapy* to demonstrate how dreams can enliven and direct the therapy. One of his patients had the following dream:

> I was on the porch of my home looking through the window at my father sitting at his desk. I went inside and asked him for gas money for my car. He reached into his pocket and as he handed me a lot of bills he pointed to my purse. I opened my wallet and it already was crammed with money. Then I said that my gas tank was empty and he went outside to my car and pointed to the gas gauge, which said, "full." (p. 232)

In his analysis of this dream, Yalom points out the following:

> The major theme in this dream was emptiness versus fullness. The patient wanted something from her father (and from me since the room in the dream closely resembled the configuration of my office) but she couldn't figure out what she wanted. She asked for money and gasoline but her wallet was already stuffed with money and her gas tank was full. The dream depicted her pervasive sense of emptiness, as well as her belief that I had the power to fill her up if she could only discover the right question to ask. Hence she persisted in craving something from me—compliments, doting, special treatment, birthday presents—all the while knowing she was off the mark. My task in therapy was to redirect her attention—away from gaining supplies from another and towards the richness of her own inner resources. (p. 233)

inner experience by the interaction with the patient. From an existential psychotherapy standpoint, it is the *examined* therapeutic relationship that heals.

Existential therapists are willing to let patients matter to them and also to acknowledge their errors. Disclosure by the therapist always facilitates therapy. Still, the reflective therapist must also be mindful of the boundaries and the meanings of the boundaries on such disclosure and resist temptations to engage in various forms of exploitation of the patient. Therapists reveal themselves when it enhances therapy, not because of their own needs or rules. This is why personal therapy is so important for doing this kind of work.

Therapist disclosure should be primarily about feelings in the here and now, in the relationship with the patient. Such disclosure must be well processed and tactful, never impulsive. For example, the therapist might tell the patient when s/he feels closer to the patient as a result of the patient's sharing, or more distant as a result of the patient's reluctance to confront some more emotionally charged issues. "I find myself afraid of your criticism, probably like others in your life." "I feel that your putting me on a pedestal makes me feel farther away from you." "I feel I have to be very careful about what I say because you seem to scan everything I say for signs of my approval or disapproval." The therapist uses disclosure in the service of the welfare of the patient, not as an end in itself. Therapists must take care not to disclose what might be (or feel) destructive to the patient. They must respect the pace of therapy and what the patient is or is not ready to hear.

APPLICATIONS

Who Can We Help?

The clinical setting often determines the applicability of the existential approach. In each course of therapy, the therapist must consider the goals appropriate to the clinical setting. To take one example, in an acute inpatient setting where the patient will be hospitalized for as brief a time as possible, the goal of therapy is crisis intervention. The therapist hopes to alleviate symptoms and to restore the patient to a precrisis level of functioning. Deeper, more ambitious goals are unrealistic and inappropriate to that situation.

In situations where patients not only desire symptomatic relief but also hope to attain greater personal growth, the existential approach is generally useful. A thorough existential approach with ambitious goals is most appropriate in long-term therapy, but even in briefer approaches, some aspect of the existential mode (e.g., an emphasis on responsibility, deciding, an authentic therapist–patient encounter, grief work, and so on) is often incorporated into the therapy.

An existential approach to therapy is appropriate with patients who confront some boundary situation—that is, a confrontation with death, the facing of some important irreversible decision, a sudden thrust into isolation, or milestones that mark passages from one life era into another. But therapy need not be limited to these explicit existential crises. Existential psychotherapy can be applied to a diverse range of patients in different modalities (Schneider, 2007). In every course of therapy, there is abundant evidence of patients' anguish stemming from existential conflicts. The availability of such data is entirely a function of the therapist's attitudinal set and perceptivity. The decision to work on these levels should be a joint patient–therapist decision.

Treatment

Existential therapy has its primary applications in an individual therapy setting. However, various existential themes and insights may be successfully applied in a variety of other settings, including group therapy, family therapy, couples therapy, and so forth.

The concept of responsibility has particularly widespread applicability. It is a keystone of the group therapeutic process, in which patients learn how their behavior is viewed by others, how their behavior makes others feel, how they create the opinions others have of them, and how others' opinions shapes their views of themselves. Group members begin to understand that they are responsible for how others treat them and for the way in which they regard themselves (Yalom, 2005). Indeed, patients can see how they create in others the very reactions that trouble them in their outside lives (Josselson, 2007).

In group therapy, all members are "born" simultaneously. Each starts out on an equal footing. Each gradually scoops out and shapes a particular life space in the group. Thus, each person is responsible for the interpersonal position he or she creates in the group (and in life). The therapeutic work in the group then not only allows individuals to change their way of relating to one another but also brings home to them in a powerful way the extent to which they have created their own life predicaments—clearly an existential therapeutic mechanism.

Often the therapist uses his or her own feelings to identify the patient's contribution to his or her life predicament. For example, a depressed 48-year-old woman complained bitterly about the way her children treated her: They dismissed her opinions, were impatient with her, and, when some serious issue was at stake, addressed their comments to their father. When the therapist tuned in to his feelings about this patient, he became aware of a whining quality in her voice that tempted *him* not to take her seriously and to regard her somewhat as a child. He shared his feelings with the patient, and it proved enormously useful to her. She became aware of her childlike behavior in many areas and began to realize that her children treated her precisely as she "asked" to be treated.

Not infrequently, therapists must treat patients who are panicked by a decisional crisis. Yalom (1981) describes one therapeutic approach in such a situation. The therapist's basic strategy consisted of helping the patient uncover and appreciate the existential implications of the decision. The patient was a 66-year-old widow who sought therapy because of her anguish about a decision to sell a summer home. The house required constant attention to gardening, maintenance, and protection and seemed a considerable burden to a frail aging woman in poor health. Finances affected the decision as well, and she asked many financial and realty consultants to assist her in making the decision.

The therapist and the patient explored many factors involved in the decision and then gradually began to explore more deeply. Soon a number of painful issues emerged. For example, her husband had died a year ago and she mourned him still. The house was still rich with his presence, and drawers and closets brimmed with his personal effects. A decision to sell the house also required a decision to come to terms with the fact that her husband would never return. She considered her house her "drawing card" and harbored serious doubts whether anyone would visit her without the enticement of her lovely estate. Thus, a decision to sell the house meant testing the loyalty of her friends and risking loneliness and isolation. Yet another reason centered on the great tragedy of her life—her childlessness. She had always envisioned the estate passing on to her children and to her children's children. The decision to sell the house thus was a decision to acknowledge the failure of her major symbolic immortality project. The therapist used the house-selling decision as a springboard to these deeper issues and eventually helped the patient mourn her husband, herself, and her unborn children.

Once the deeper meanings of a decision are worked through, the decision generally glides easily into place, and after approximately a dozen sessions, the patient effortlessly made the decision to sell the house.

Existentially oriented therapists strive toward honest, mutually open relationships with their patients. The patient–therapist relationship helps the patient clarify other

relationships. Patients almost invariably distort some aspect of their relationship to the therapist. The therapist, drawing from self-knowledge and experience of how others view him or her, is able to help the patient distinguish distortion from reality.

The experience of an intimate encounter with a therapist has implications that extend beyond relationships with other people. For one thing, the therapist is generally someone whom the patient particularly respects. But even more important, the therapist is someone, often the only one, who *really* knows the patient. To tell someone else all one's darkest secrets and still to be fully accepted by that person is enormously affirmative.

Existential thinkers such as Erich Fromm, Abraham Maslow, and Martin Buber all stress that true caring for another means to care about the other's growth and to want to bring something to life in the other. Buber (1965) uses the term *unfolding*, which he suggests should be the way of the educator and the therapist: One uncovers what was there all along. The term *unfolding* has rich connotations and stands in sharp contrast to the goals of other therapeutic systems. One helps the patient unfold by *meeting*, by existential communication. Perhaps the most important concept of all in describing the patient–therapist relationship is what May et al. term *presence* (1958, p. 80). The therapist must be fully present, striving for an authentic encounter with the patient.

Evidence

Psychotherapy evaluation is always a difficult task. The more focused and specific the approach and the goals, the easier it is to measure outcome. Symptomatic relief or behavioral change may be quantified with reasonable precision. But more ambitious therapies, which seek to affect deeper layers of the individual's mode of being in the world, defy quantification. These problems of evaluation are illustrated by the following vignettes reported by Yalom (1981).

> A 46-year-old mother accompanied the youngest of her four children to the airport, from which he departed for college. She had spent the last 26 years rearing her children and longing for this day. No more impositions, no more incessantly living for others, no more cooking dinners and picking up clothes. Finally she was free.
>
> Yet as she said good-bye she unexpectedly began sobbing loudly, and on the way home from the airport a deep shudder passed through her body. "It is only natural," she thought. It was only the sadness of saying good-bye to someone she loved very much. But it was much more than that, and the shudder soon turned into raw anxiety. The therapist whom she consulted identified it as a common problem: the empty nest syndrome. (p. 336)

Of course she was anxious. How could it be otherwise? For years she had based her self-esteem on her performance as a mother, and suddenly she found no way to validate herself. The whole routine and structure of her life had been altered. Gradually, with the help of Valium, supportive psychotherapy, an assertiveness training group, several adult education courses, a lover or two, and a part-time volunteer job, the shudder shrank to a tremble and then vanished. She returned to her premorbid level of comfort and adaptation.

This patient happened to be part of a psychotherapy research project, and there were outcome measures of her psychotherapy. Her treatment results could be described as excellent on each of the measures used—symptom checklists, target problem evaluation, and self-esteem. Obviously she had made considerable improvement. Yet, despite this, it is entirely possible to consider this case as one of missed therapeutic opportunities.

Consider another patient in almost precisely the same life situation. In the treatment of this second patient, the therapist, who was existentially oriented, attempted to

nurse the shudder rather than to anesthetize it. This patient experienced what Kierkegaard called "creative anxiety." The therapist and the patient allowed the anxiety to lead them into important areas for investigation. True, the patient suffered from the empty nest syndrome; she had problems of self-esteem; she loved her child but also envied him for the chances in life she had never had; and, of course, she felt guilty because of these "ignoble" sentiments.

The therapist did not simply allow her to find ways to fill her time but also plunged into an exploration of the *meaning* of the fear of the empty nest. She had always desired freedom but now seemed terrified of it. Why?

A dream illuminated the meaning of the shudder. The dream consisted simply of holding in her hand a 35-mm photographic slide of her son juggling and tumbling. The slide was peculiar, however, in that it showed movement; she saw her son in a multitude of positions all at the same time. In the analysis of the dream, her associations revolved around the theme of time. The slide captured and framed time and movement. It kept everything alive but made everything stand still. It froze life. "Time moves on," she said, "and there's no way I can stop it. I didn't want John to grow up . . . whether I like it or not time moves on. It moves on for John and it moves on for me as well."

This dream brought her own finiteness into clear focus and, rather than rush to fill time with various distractions, she learned to appreciate time in richer ways than previously. She moved into the realm that Heidegger described as *authentic being:* She wondered not so much at the *way* things are but *that* things are. She recognized that life is seriously linear and irreversible, that everything fades, and that she still had time to live purposefully and meaningfully. Although one could argue that therapy helped the second patient more than the first, it would not be possible to demonstrate this conclusion on any standard outcome measures. In fact, the second patient probably continued to experience more anxiety than the first did; but anxiety is a part of existence, and no individual who continues to grow and create will ever be free of it.

These gains continue to elude randomized-control objective forms of research. Yet nearly all psychotherapy research, especially research on common factors, has substantiated a central premise of existential psychotherapy—that it is the relationship that heals (Frank & Frank, 1991; Gelso & Hayes, 1998; Norcross, 2002; Safran & Muran, 1996; Wampold, 2001).

Psychotherapy in a Multicultural World

Existential psychotherapy considers the situation of the whole person located in society and culture. Cultural, racial, or national identities are not add-ons—they are essential aspects of the phenomenology of the client and intrinsic to the treatment. Existential psychotherapy is oriented to all aspects of human uniqueness and difference and takes into account and investigates the meanings of age, sexual orientation, ethnicity, and so on.

All humans, regardless of cultural background, share in the dilemmas of existence and must come to terms with the ultimate concerns of freedom, isolation, meaninglessness, and death. The potential difficulties come when treating people who have adopted wholesale formulas for managing these concerns that were provided by their cultural, often religious, systems.

Yalom had such a struggle with a young orthodox rabbi who requested a consultation with him. The rabbi said he was in training to become an existential therapist but was experiencing some dissonance between his religious background and the psychological formulations of existential psychotherapy. At first deferential during the session, the rabbi's demeanor slowly changed, and he began to voice his beliefs with such zeal as to make Yalom suspect that the real purpose of his visit was to convert him to the religious life.

Yalom acknowledged the fundamental antagonism between their views. The rabbi's belief in an omnipresent, omniscient personal God watching him, protecting him, and providing him a life design was indeed incompatible with the core of the existential stance that we are free, alone, thrown randomly into an uncaring universe, and mortal.

"But you," the rabbi responded with intense concern on his face, "how can you live with only these beliefs? And without meaning? How can you live without belief in something greater than yourself? What meaning would there be if everything is destined to fade? My religion provides me with meaning, wisdom, morality, with divine comfort, with a way to live."

To this, Yalom responded, "I don't consider that a rational response, Rabbi. Those commodities—meaning, wisdom, morality, living well—are *not* dependent on a belief in God. And, yes, *of course,* religious belief makes you feel good, comforted, virtuous—that is exactly what religions are invented to do. You ask how I can live. I believe I live well. I'm guided by human-generated doctrines. I believe in the Hippocratic oath I took as a physician and dedicate myself to helping others heal and grow. I live a moral life. I feel compassion for those about me. I live in a loving relationship with my family and friends. I don't need religion to supply a moral compass."

Yalom has never had a desire to undermine anyone's religious faith, but strong religious belief that overshadows personal struggle with the ultimate concerns may preclude exploration of existential issues. Most, perhaps all, cultures create belief systems that defend against the terrors of stark confrontation with existential concerns. The dilemma for the existential therapist is to recognize the way in which these belief systems provide a sense of meaning for the patient, to stay authentic with regard to his or her own beliefs, and still find ways to increase the patient's engagement with purpose and meaning in life.

A depressed patient whose cultural background dictates unquestioning filial obedience found it difficult to pursue her own life goals. Efforts to engage her in addressing her own responsibility for her choices in life were met with her declaring that she must do what her father requires of her. The existential therapist must then help this patient see herself as making a deliberate choice in this regard—to obey her father rather than to follow her own desires. Obedience itself can be an existential choice for which one can take full responsibility.

CASE EXAMPLE

A Simple Case of Divorce

A 50-year-old scientist, whom we will call David, had been married for 27 years and had recently decided to separate from his wife. He sought therapy because of the degree of anxiety he was experiencing in anticipation of confronting his wife with his decision.

The situation was in many ways a typical midlife scenario. The patient had two children; the youngest had just graduated from college. In David's mind, the children had always been the main element binding him and his wife together. Now that the children were self-supporting and fully adult, David felt there was no reasonable point in continuing the marriage. He reported that he had been dissatisfied with his marriage for many years and on three previous occasions had separated from his wife, but, after only a few days, had become anxious and returned, crestfallen, to his home. Bad as the marriage was, David concluded that it was less unsatisfactory than the loneliness of being single.

The reason for his dissatisfaction with his marriage was primarily boredom. He had met his wife when he was 17, a time when he had been extremely insecure, especially in his relationships with women. She was the first woman who had ever expressed interest in him. David (as well as his wife) came from a blue-collar family. He was exceptionally intellectually gifted and was the first member of his family to attend college. He won

a scholarship to an Ivy League school, obtained two graduate degrees, and embarked upon an outstanding academic research career. His wife was not gifted intellectually, chose not to go to college, and during the early years of their marriage worked to support David in graduate school.

For most of their married life, his wife immersed herself in the task of caring for the children while David ferociously pursued his professional career. He had always experienced his relationship to his wife as empty and had always felt bored with her company. In his view, she had an extremely mediocre mind and was so restricted characterologically that he found it constraining to be alone with her and embarrassing to share her with friends. He experienced himself as continually changing and growing, whereas his wife, in his opinion, had become increasingly rigid and unreceptive to new ideas. The prototypic scenario of the male in midlife crisis seeking a divorce was made complete by the presence of the "other woman"—an intelligent, vivacious, attractive woman 15 years younger than himself.

David's therapy was long and complex, and several existential themes emerged during the course of therapy. Responsibility was an important issue in his decision to leave his wife. First, there is the moral sense of responsibility. After all, his wife gave birth to and raised his children and had supported him through graduate school. He and his wife were at an age where he was far more "marketable" than she; that is, he had significantly higher earning power and was biologically able to father children. What moral responsibility, then, did he have to his wife?

David had a high moral sense and would, for the rest of his life, torment himself with this question. It had to be explored in therapy, and, consequently, the therapist confronted him explicitly with the issue of moral responsibility during David's decision-making process. The most effective mode of dealing with this anticipatory dysphoria was to leave no stone unturned in his effort to improve the marriage.

The therapist helped David examine the question of his responsibility for the failure of the marriage. To what degree was he responsible for his wife's mode of being with him? For example, the therapist noted that he himself felt somewhat intimidated by David's quick, facile mind: The therapist also was aware of a concern about being criticized or judged by David. How judgmental was David? Was it not possible that he squelched his wife, that had he engaged differently with her, he might have helped her to develop greater flexibility, spontaneity, and self-awareness?

The therapist also helped David consider whether he was displacing onto the marriage dissatisfaction that belonged elsewhere in his life. A dream pointed the way toward some important dynamics:

> I had a problem with liquefaction of earth near my pool. John [a friend who was dying from cancer] sinks into the ground. It was like quicksand. I used a giant power auger to drill down into the quicksand. I expect to find some kind of void under the ground but instead I found a concrete slab five to six feet down. On the slab I found a receipt of money someone had paid me for $501. I was very anxious in the dream about that receipt since it was greater than it should have been.

One of the major themes of this dream had to do with death and aging. First, there was the theme of his friend who had cancer. David attempted to find his friend by using a giant auger. In the dream, David experienced a great sense of mastery and power during the drilling. The symbol of the auger seemed clearly phallic and initiated a profitable exploration of sexuality—David had always been sexually driven, and the dream illuminated how he used sex (and especially sex with a young woman) as a mode of gaining mastery over aging and death. Finally, he is surprised to find a concrete slab (which elicited associations of morgues, tombs, and tombstones).

He was intrigued by the numerical figures in the dream (the slab was "five to six feet" down and the receipt was for precisely $501). In his associations, David made the

interesting observation that he was 50 years old and the night of the dream was his 51st birthday. Though he did not consciously dwell on his age, the dream made it clear that at an unconscious level, he had considerable concern about being over 50. Along with the slab that was between five and six feet deep and the receipt that was just over $500, there was his considerable concern in the dream about the amount cited in the receipt being too great. On a conscious level, he denied his aging.

If David's major distress stemmed from his growing awareness of his aging and diminishment, then a precipitous separation from his wife might have represented an attempt to solve the wrong problem. Consequently, the therapist helped David plunge into a thorough exploration of his feelings about his aging and his mortality. The therapist's view was that only by fully dealing with these issues would he be more able to ascertain the true extent of the marital difficulties. The therapist and David explored these issues over several months. He attempted to deal more honestly with his wife than before, and soon he and his wife made arrangements to see a marital therapist for several months.

After these steps were taken, David and his wife ultimately decided that there was nothing salvageable in the marriage and they separated. The months following his separation were exceedingly difficult. The therapist provided support during this time but did not try to help David eliminate his anxiety; instead, he attempted to help David use his anxiety in a constructive fashion. David's inclination was to rush into an immediate second marriage, whereas the therapist persistently urged him to look at the fear of isolation that on each previous separation had sent him back to his wife. It was important now to be certain that fear did not propel him into an immediate second marriage.

David found it difficult to heed this advice because he felt so much in love with the new woman in his life. The state of being in love is one of the great experiences in life.

In therapy, however, being in love raises many problems; the pull of romantic love is so great that it engulfs even the most well directed therapeutic endeavors. David found his new partner to be the ideal woman, no other woman existed for him, and he attempted to spend all his time with her. When with her, he experienced a state of continual bliss: All aspects of the lonely "I" vanished, leaving only a very blissful state of "we-ness."

What finally made it possible for David to work in therapy was that his new friend became somewhat frightened by the power of his embrace. Only then was he willing to look at his extreme fear of being alone and his reflex desire to merge with a woman. Gradually he became desensitized to being alone. He observed his feelings, kept a journal of them, and worked hard on them in therapy. He noted, for example, that Sundays were the worst time. He had an extremely demanding professional schedule and had no difficulties during the week. Sundays were times of extreme anxiety. He became aware that part of that anxiety was that he had to take care of himself on Sunday. If he wanted to do something, he himself had to schedule the activity. He could no longer rely on that being done for him by his wife. He discovered that an important function of ritual in culture and the heavy scheduling in his own life was to conceal the void, the total lack of structure beneath him.

These observations led him, in therapy, to face his need to be cared for and shielded. The fears of isolation and freedom buffeted him for several months, but gradually he learned how to be alone in the world and what it meant to be responsible for his own being. In short, he learned how to be his own mother and father—always a major therapeutic objective of psychotherapy.

SUMMARY

Existential psychotherapy views the patient as a full person, not as a composite of drives, archetypes, conditioning, or irrational beliefs or as a "case." People are regarded as struggling, feeling, thinking, and suffering beings who have hopes, fears,

and relationships, who wrestle to create meaningful lives. It takes a life-affirming approach to an essentially tragic view of life. Anxiety will always be present but can be channeled into creative, life-enhancing pursuits. Awareness of the inevitability of death can enrich life.

The original criticism of existential therapy as "too philosophical" has lessened as people recognize that all effective psychotherapy has philosophical implications. The genuine human encounter between patient and therapist engenders possibility of new meanings, new forms of relationship and a possibility of self-actualization. The central aim of the founders of existential psychotherapy was that its emphases would influence therapy of all schools. That this has been occurring is quite clear. Existential therapy is not a technique. It is "an encounter with one's own existence in an immediate and quintessential form" (May, 1967, p. 134) in the company of a therapist who is fully present.

Our present age is one of disintegration of cultural and historical mores, of love and marriage, the family, the inherited religions, and so forth. Given these realities, the existential emphasis on meaning, responsibility, and living a finite life fully will become increasingly important.

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Becker, E. (1973). *Denial of death*. New York: Free Press.
Pulitzer Prize-winning book. Becker's thesis is that human behavior and mental disorder have their deepest roots in our denying our deaths. The book is a useful resource, particularly for therapists, for reflecting on and coming to terms with death anxiety. Among its topics are meditations on the need for illusions and "immortality projects."

Wheelis, A. (1973). *How people change*. New York: Harper & Row.
This is a short, lyrical, highly readable and accessible book that demonstrates the *attitude* of existential psychotherapy. Wheelis dramatizes the difficulty of intentional change and discusses the need for will, courage, and action in the effort to change.

Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.
This is the textbook of existential psychotherapy that elucidates in more detail the ideas presented in this chapter. A major task of the book is to build a bridge between theory and clinical application. It includes many case examples as well as the philosophical foundations of this approach.

Yalom, I. D. (2002). *The gift of therapy*. New York: HarperCollins.
This book includes the wisdom of existential psychotherapy in 85 one- to two-page "lessons." Each lesson is illustrated with a brief case example.

CASE READINGS

Lindner, R. (1987). The jet-propelled couch. In *The Fifty-Minute Hour*. New York: Dell.

A great classic in the psychotherapy literature which, while not directly existential in its thinking, demonstrates that we are all more human than otherwise, that we are, quite literally "fellow travelers." No student of psychotherapy should miss this story.

Yalom, I. D. (1989). *Love's executioner and other tales of psychotherapy*. New York: Basic Books. [A case study from this book, "If Rape Were Legal . . . ," is reprinted in D. Wedding & R. J. Corsini (Eds.). (2011). *Case studies in psychotherapy*. Belmont, CA: Brooks/Cole.]

The actual practice of existential psychotherapy is best illustrated in these longer tales of the therapist–patient encounter. Of note are the examples of how therapist genuineness and self-disclosure foster healing.

Yalom, I. D. (1999). *Momma and the meaning of life*. New York: Basic Books.

More tales of psychotherapy. See especially a story entitled "Seven Lessons in the Therapy of Grief," which demonstrates how slow and complex is the process of resolving grief in the face of death anxiety.

Yalom, I. D., & Elkins, G. (1974). *Everyday gets a little closer*. New York: Basic Books.

An illuminating work in which Yalom and his patient, Ginny Elkins, each keep notes and write a record of their therapy sessions. The final product allows an extraordinary look at how differently patient and therapist experience the therapeutic encounter.