Chapter 2
Emotional Pain and Suffering: The Search for Global Solutions

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The Commonality of Impoverished Mental Health

The extent of the mental health crisis was recently highlighted by the Mental Health Taskforce for the National Health Service (NHS) in England (Mental Health Taskforce, 2016). In their 5-year forward view, they noted that approximately one in four adults in the UK experience at least one mental health disorder in any given year. Further, as in Australia, mental health is the largest single cause of disability in the UK, with a cost to the economy of over £105 billion. This is approximately the budget for the entire NHS. Further, while half of the mental health problems in England were shown to emerge in individuals by the age of 14, child services were shown to be hopelessly ill-equipped to meet the needs of the young. Children from low-income families were at highest risk of the development of mental health problems, having more than three-fold odds of a diagnosis compared to children from high-income families. The report highlighted the costs to the individual and the wider community of failing to treat psychopathology as it emerges. For example, children with conduct disorder were twice as likely to leave school without any qualifications, four times more likely to become drug dependent and 20 times more likely to serve a prison term (Mental Health Taskforce, 2016). Despite this, most troubled children get no support from public NHS mental health services. For the relatively few that are seen, the average wait for routine appointments for psychological therapy was 32 weeks in the 2016 financial year.

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Hayes and Smith (2005) argued that the extent of global psychological suffering is also revealed by the response of communities to the introduction of government-funded access to psychological services. They pointed out that progressive initiatives by governments to increase access to community mental health services have typically been followed by an inundation of individuals seeking care, usually in far greater numbers than anticipated by planning bodies. For example, the increased access to psychological services (IAPT) programme now treats a staggering 900,000 individuals in England each year. Having said this, the NHS estimates that this still only represents 15% of those with anxiety-related conditions and depression in England. The needs of the masses are simply not being met.

The introduction of Medicare-funded access to psychological services in Australia led to such a growth in expenditure that the number of available sessions in the scheme had to be reduced in several revisions across its opening decade. Since 2006, over 36 million individual treatment sessions have been provided to nearly 9 million Australians through the Better Access to Psychologists initiative. In a country with only 25 million citizens, this is an astonishing uptake of services. In response to the burgeoning costs of the Australian scheme, the number of sessions available for an individual with a Mental Health Treatment Plan from a general practitioner has been reduced from 18 per year to 10 per year. Not surprisingly, the recent submission from the Australian Psychological Society (APS) about the scheme has called for an increase to as many as 40 sessions per year for chronic, unremitting cases (APS, 2018). Clearly, the initiative is simply not meeting the mental health crisis in the Australian community.

Fairburn and Patel (2014) argued that health researchers need to 'scale up' their interventions if they are to have an impact on community mental health outcomes. They suggested that the traditional model of one-to-one, in-clinic intervention faces unsolvable problems of access and cost. Further, they argued that in-clinic interventions only reach those who actively seek treatment from a healthcare professional (Loucas et al., 2014). Fairburn and colleagues have championed 'direct-to-user' products in healthcare, such as internet-delivered 'e-therapy' (Fairburn & Patel, 2014). However, to date, studies of community use of such programmes are not encouraging. The most recent review of community uptake of standalone, e-therapy programmes suggests that they are typically rejected by end users. Fleming et al. (2018) reviewed all effectiveness trials of all available standalone, online programmes for anxiety and mood disorders. In a consistent finding across all programmes, non-completion and dropout were the norm. In fact, no e-therapy programme could boast more than a 20% rate of completion among users. MoodGYM and MoodGYMII, the largest online depression treatment programmes in the world, have been repeatedly shown to be complete by less than 3% of users in community-based, effectiveness trials (Fleming et al., 2018).

Treatment Intractability: The Current Effectiveness of Psychological Treatments

The reasons for the public's rejection of automated online treatment programmes may be many, but some have speculated that standard psychological treatment procedures are less effective than the industry suggests, and that without a therapeutic relationship, rapport and interpersonal support, individuals simply abandon cognitive-behavioural procedures. Many reviews have questioned the effectiveness of supposed gold standard cognitive behavioural therapy (CBT) procedures. Westen and Morrison (2001) provided a particularly thorough review of manualised trials of empirically supported therapies (ESTs; Kendall, 1998) for panic disorder (PD), major depressive disorder (MDD) and generalised anxiety disorder (GAD). Universally, their findings were troubling.

In panic disorder, Westen and Morrison (2001) reported that 2 years after treatment, patients continue to have approximately one panic attack per week (averaged across manualised studies). This is despite the fact that most studies had excluded possible participants with moderate to severe agoraphobic avoidance, primary depression, substance abuse and suicidality. Even immediately at post-treatment, only 54% of individuals in these carefully selected samples were 'improved' as defined by the researchers at the time. Improved status typically involved only 20% symptom reduction on standard scales.

Westen and Morrison (2001) reported similarly negative outcomes in generalised anxiety disorder. Even after excluding subjects with comorbid depression, dysthymic disorder, somatic disorders, panic, obsessive-compulsive disorder (OCD) and substance abuse, 'improvement rates' across studies averaged 44% for GAD patients at immediate post-treatment. But perhaps the most negative findings in their meta-analysis were reported for depression. In intention-to-treat analyses, after screening out those with suicidal risk and substance use disorders, only 37% of patients were 'improved' at post-treatment. Of those who completed treatment, only 54% were 'improved'. Alarmingly, the author's note that at post-treatment:

> the degree of symptomatology did not constitute a return to mental health … in fact, both of these post-treatment means (i.e. Hamilton Rating Scale and BDI) are above the criteria used by researchers to indicate clinically significant depression. (p. 880–881)

After analysing 12- to 18-month follow-up data for studies on depression, the authors concluded that only 28.5% of the intent-to-treat sample remained 'improved' (i.e. were 'improved' at post-treatment and again at follow-up) (Westen & Morrison, 2001).

In summary, this thorough review revealed that manualised treatment with empirically established procedures conducted in expert research centres *did not* eliminate the psychological distress experienced by participants. On the contrary,

the majority of individuals continued to experience clinically significant levels of distress. In fact, nearly 40% of participants who completed all components within these structured trials for GAD, PD and MDD reported returning to a treatment service for more support within 18 months of the completion of their original trial. Iverach, Menzies, and Menzies (2014) referred to this phenomenon as the 'revolving door' in mental health. Individuals receive treatment, improve modestly and are discharged only to return with the same disorder or a related condition. Current treatment offerings within the industry of psychology do not eliminate suffering for the majority individuals.

Results from comparative research trials tend to reveal similarly poor functional outcomes among participants, although these are often obscured by the main analyses on the primary outcomes. For example, Soares et al. (2018) compared cognitive behaviour therapy with psychodynamic therapy for major depressive disorder in a randomised controlled trial involving 247 patients. Their abstract states that:

> Clinically significant changes were found in both psychotherapy models, and CBT showed higher response rates. Regarding the Beck Depression Inventory-II [F(1,120) = 4.07, p = 0.046] and Outcome Questionnaire 45.2 [F(1.114) = 7.99, p =0.006], CBT had a better effect than SEDP. Hence, the results obtained have contributed to the literature, served to corroborate the importance and effectiveness of psychodynamic psychotherapy, as well as explored the mechanisms of change, remission, and response in the treatment of MDD, which have been ignored to a large extent. (p. 686)

While this sounds impressive, a close reading of the paper reveals particularly poor responses among participants in both groups. For example, of those who completed the treatment programmes, only 46% and 42% of participants in the CBT and psychodynamic groups, respectively, had entered the 'functional population'. This was defined as scoring below the 80th percentile on the Beck depression inventory (BDI). Staggeringly then, even at immediate post-treatment, the most likely outcome for an individual in the trial who completed all components, regardless of intervention condition, was to remain in the top 20% of the population in terms of BDI scores. Further, more than half of the participants abandoned their treatment before completion. None of these outcomes were described in the abstract.

Why Do Psychological Treatments Fail to Produce Lasting Change?

In sum, current psychological treatment procedures are often rejected by consumers, lead to less than ideal outcomes and typically require individuals to seek further psychological services in the future. Why is this occurring? Iverach et al. (2014) provocatively argued that our gold standard treatments may not only be inadequate but may also be part of the cause for the revolving door in mental health. They suggested that common treatments for anxiety and mood disorders target the symptoms of the current presentation rather than the core transdiagnostic variables that drive mental health disorders. They suggested that existential issues underlie most of the major

non-psychotic mental health problems, and that these issues are not being addressed within the industry of clinical psychology. Menzies (2018) criticised the field for abandoning its earlier links to philosophy, sociology and anthropology, arguing that insights gained about human suffering in these fields are being ignored. In particular, building on the work of anthropologist Ernest Becker and earlier stoic and existentialist philosophers, Iverach et al. (2014) argued that the critical role of death anxiety in human suffering is being routinely overlooked by clinical psychologists.

The Dread of Death

Throughout recorded history, fears of death have been a central experience of the human condition (Furer & Walker, 2008). As a result, our species' attempts to explore and cope with our own mortality have spanned art, theatre, philosophy, music and literature. Evidence of this struggle with our own impermanence stretches as far back as Gilgamesh's 4000-year-old laments over his friend's death, and his burgeoning realisation of his own impermanence (see further, Menzies, 2018). More than 2000 years ago, the dread of death was also a popular subject among ancient Greek and Roman Stoic philosophers, who argued that we should practise accepting death, rather than being distressed at the thought of it, given that it is outside of our control. Religious and ritualistic practices have similarly featured death themes heavily across the ages. In the fifth century BC, Herodotus, considered to be the father of history, reported that at the dinner parties of wealthy Egyptians, a man would carry around the image of a corpse in a coffin, present it to each guest and say: 'Look upon this body as you drink and enjoy yourself; for you will be just like it when you are dead' (Herodotus, 1996, p. 125). Skulls have featured in various religious traditions, such as in the ritualised handling of skull-shaped bracelets in Buddhism, and in the use of human skulls as desk adornments in monastic cells in medieval Europe.

William James famously referred to our ability to contemplate mortality, a capacity arguably unique to our species, as the 'worm at the core' of our existence (James, 1985/1902, p. 119). This idea is echoed more recently in the words of Yalom (2008), who proposes that our lives are 'forever shadowed by the knowledge that we will grow, blossom, and inevitably, diminish and die' (p. 1). Thoughts of death have the power to create a sense of despair, loneliness, meaninglessness and powerlessness (Noyes, Stuart, Longley, Langbehn, & Happel, 2002; Stolorow, 1979). While all of us are likely to experience thoughts of death at some point, for some individuals, this may radically diminish their experience of joy or contentment (Yalom, 2008). Furthermore, although many people may develop effective and adaptive strategies to cope with fears of death, such as building relationships and working towards meaningful achievements, others may experience crippling dread, and engage in unhelpful, maladaptive coping strategies, such as avoidance (Menzies, 2012). As a result, death anxiety has been argued to be a transdiagnostic construct, which may underpin and exacerbate a number of different mental health conditions (Iverach et al., 2014).

For instance, death anxiety has been proposed to play a central role in illness anxiety and the somatoform disorders, with frequent medical consultations, reassurance seeking from specialists and checking oneself for signs of illness all having clear associations with death fears (Furer & Walker, 2008; Hiebert, Furer, McPhail, & Walker, 2005). Similarly, the relevance of the dread of death to panic disorder, in which patients may monitor internal symptoms, such as heart rate, or seek medical advice for fear they are having a heart attack, also appears clear (Randall, 2001; Starcevic, 2007). In obsessive-compulsive disorder (OCD), the most common subtypes (washing and checking) can both be explicitly linked to death anxiety, with patients reporting fears of contamination and contracting illnesses, and worries about household fires or electrocution, respectively (Menzies, Menzies, & Iverach, 2015). Recent empirical research has demonstrated the relationship between death thoughts and OCD behaviours, with reminders of death being shown to double the amount of time spent handwashing among compulsive washers (Menzies & Dar-Nimrod, 2017).

In addition, almost one century ago, Kingman (1928) argued that death anxiety is central to the majority of phobias, and recent evidence, revealing that reminders of death exacerbate avoidance and perceived threat among spider phobics (Strachan et al., 2007), lends some support to this claim. Significant positive correlations have been demonstrated between symptoms of separation anxiety and death anxiety (Caras, 1995), suggesting the role of death fears in this disorder. Death-related events, such as the loss of a loved one or a physical threat to the self, have been shown to typically precede the onset of agoraphobia (Foa, Steketee, & Young, 1984). Such life-threatening or traumatic events have also been argued to play a central role in post-traumatic stress disorder (PTSD; Chatard et al., 2012), and to increase death anxiety and the risk of PTSD symptoms (Cheung, Dennis, Easthope, Werrett, & Farmer, 2005). In a similar vein, there is evidence to suggest that individuals with high levels of PTSD symptoms appear less able to effectively suppress thoughts of death, relative to those with low levels of such symptoms.

Even among disorders that appear less explicitly related to death fears, such as social anxiety, thoughts of death have been shown to increase anxious behaviour. For example, among participants high in social anxiety, reminders of death lead to increased social avoidance (Strachan et al., 2007). Similarly, not only does correlational research show that death anxiety significantly predicts disordered eating, above and beyond perfectionism and self-esteem (Le Marne & Harris, 2016), but reminders of death lead women to restrict consumption of food (Goldenberg, Arndt, Hart, & Brown, 2005). Lastly, within the depressive disorders, existential concerns such as death anxiety and meaninglessness have also been argued to play an important role (Ghaemi, 2007; Simon, Arndt, Greenberg, Solomon, & Pyszczynski, 1998). This notion is supported by some experimental research, showing that mildly depressed participants respond more strongly to reminders of death, relative to participants who are not depressed (Simon et al., 1998).

One recent study (Menzies, Sharpe, & Dar-Nimrod, 2019) found that, across a transdiagnostic, treatment-seeking clinical sample, death anxiety was a strong predictor of broad markers of psychopathology, including number of lifetime diagnoses, number of medications, depression, anxiety, stress and a clinician's judgement of

distress and impairment. Furthermore, across 12 disorders, including depression, social anxiety, alcohol use disorder, generalised anxiety disorder and OCD, death anxiety was significantly associated with the symptom severity of that disorder. Importantly, these relationships remained significant after accounting for neuroticism, suggesting the unique role of the dread of death.

With increasing evidence supporting the claim that death anxiety underpins numerous mental health conditions, important implications for clinical work begin to emerge. Primarily, the failure to address the dread of death may explain the revolving door in mental health services (Iverach et al., 2014). As stated earlier, it is not uncommon for a patient to present to treatment at various points across their lifespan, either after relapse or with a seemingly different disorder and pattern of symptoms. Perhaps, for instance, an individual is diagnosed with and treated for separation anxiety as a child, then returns as an adolescent with panic disorder and, lastly, as an adult presents for treatment with a disorder that appears quite different to their previous experiences, such as a phobia of heights. Indeed, some research has found that the rates of lifetime diagnoses are typically around double those of current diagnoses (Simon et al., 2007). Iverach et al. (2014) argued that the dread of death may be underpinning these separate mental illnesses, and each may be a distinct manifestation of the underling death anxiety. If this is the case, standard treatments that focus on addressing proximal threats, such as the fear of falling or worries about a heart attack, are unlikely to ensure long-term outcomes (Iverach et al., 2014). In fact, the removal of these proximal threats to life (e.g. by challenging threat expectancies through exposure and behavioural experiments) may amount to little more than the provision of reassurance. It is the present author's view that these approaches will do little, if anything, for the sufferer's broad fears of impermanence. It may be necessary to treat 'the worm at the core' if we wish to eliminate the revolving door effect.

Future Directions

If existential anxiety is a universal human phenomenon, we should be able to learn from those individuals who are not prone to mental health problems across their life. How are they successfully responding to death-related issues? How do they manage the angst that typically arises from the knowledge of the certainty of one's death? Many authors argued that terror management theory (TMT) best accounts for the behavioural and emotional reactions displayed by most humans in response to the construct of death (Helm, Duchschere, & Greenberg, 2018; Iverach, 2018; Menzies & Menzies, 2018; Pyszczynski & Thompson, 2018). TMT proposes that broad cultural practices (e.g. seeking academic achievement, attaining professional success, contributing to social causes for the betterment of others and extending the self through children), may serve as defensive mechanisms in the face of the terror of death. Considerable experimental research supports the claim that adherence to strongly held 'cultural world views' may buffer against death

fears. As Helm et al. (2018) showed us, this is partly achieved by building robust self-esteem – a sense of self that provides a virtual immortality in the face of death. In essence, TMT proposes that heightened self-esteem may enable us to deny our animal nature by elevating the self to a higher status than worms, dogs and cats. Further, close adherence to cultural worldviews may be associated with activities that give us a continuance after we die (e.g. being part of a social movement that will be ongoing, producing products that will exist when we die). Mikulincer (2018) expanded the TMT position by showing that attachment security may similarly moderate the typical responses to death priming seen in mortality salience research designs. Attachment security – a sense that the world is generally safe and that one is valuable and lovable – appears to provide a solid psychological basis for reducing death dread and is associated with a raft of psychosocial benefits (Mikulincer, 2018).

The 'cultural worldviews' described by TMT include religious belief. As Pyszczynski and Thompson (2018) pointed out, religion transforms death from an unsolvable problem to a controllable one by providing a pathway to literal immortality. Considerable research supports the claim that strong, inherent religious belief is associated with reduced death anxiety and increased well-being (Pyszczynski & Thompson, 2018). Of course, religious belief is not a solution that all individuals find palatable. Further, the effects of religion are not all positive. Religious belief is associated with disdain and hostility to out-groups, as well as violence towards those with different perspectives (Pyszczynski, Vail, & Motyl, 2010). Fortunately, many of the benefits of involvement in religious communities may be gained through other activities that also involve in-group identification, social networking and support. Chopik (2017) reported that increased social support is associated with reduced death anxiety across time. It is well established that social isolation is associated with a range of poor physical and mental health outcomes, and increasing social connectedness has been associated with improvements in mental and physical health in many reports (Jetten, Haslam, & Haslam, 2012). Dingle, Williams, Sharman, and Jetten (2016) recently demonstrated the benefits of choir singing and creative writing groups for the homeless and disadvantaged. Participants in this study had severe and chronic mental health conditions including schizophrenia, bipolar disorder, recurrent depression and addiction. Twelve months after joining the choir or writing groups, 44% of participants perceived their mental health to have improved and 46% reported their physical health to have improved (Dingle et al., 2016). Given the extreme disability of the sample in this research, the findings are impressive. Similarly encouraging results have been reported by Haslam, Cruwys, Haslam, Dingle, and Chang (2016) with their 'Groups 4 Health' programme (G4H). The programme, emerging out of social psychology, targets the development of social group relationships to treat psychological distress. Reductions on measures of depression, general anxiety, stress, social anxiety and loneliness were found at programme completion and at 6-month follow-up. Self-esteem and life satisfaction improved consistently across the trial. Notably, the treatment effects were mediated by participants' increased identification with their G4H members. Given that identity, isolation and meaning

are three of the 'Big 5′ themes described in the existential literature, the positive effects of the G4H programme should not be surprising.

Feelings of connectedness to others may even be the mediating variable that underpins the positive emotional response associated with Buddhist meditation. While the industry of clinical psychology has been obsessed with the removal of negative affect, other fields have been interested in promoting the experience of positive emotion (Hofmann, 2018). Hofmann, Grossman, and Hinton (2011) reviewed the benefits of the loving-kindness meditation (LKM) in a range of populations. Loving-kindness is derived from Buddhism and refers to a mental state of unselfish and unconditional kindness to all beings. Loving-kindness and compassion are overlapping constructs that are related to the Buddhist notion that all living beings are connected. Together with sympathetic joy and equanimity, loving-kindness and compassion constitute the four *brahma viharas*, which are regarded as states to be cultivated through Buddhist practice (Hofmann et al., 2011). Hofmann et al. (2011) reviewed several studies showing that LKM is associated with (1) an increase in positive affect, (2) a decrease in negative affect, (3) reductions in stress-induced subjective distress and immune response, (4) increased activation of brain areas that are involved in emotional processing and empathy and (5) enhanced outcomes with depressed individuals. Similarly, the meta-analysis of Kirby, Tellegen, and Steindl (2017) reported moderate to large pre- and post-improvements on anxiety, depression and psychological distress following compassion-based interventions.

Concluding Comments

The size of the global mental health problem has far outstripped the capacity of governments to meet the demand. Attempts to scale up treatments in automated, electronic form have generally been rejected by consumers. Further, current psychological treatments seem to offer more than they deliver. The industry of psychology has generally produced treatments that improve functioning in the short term, but are associated with relapse and the emergence of further disorders. Chronic disability from mental health problems is common in the community.

Clinical psychology has become an insular profession, unfortunately moving away from its roots in philosophy. Major theoretical models in other fields, even in subdisciplines of psychology, are rarely cited in our clinical journals. The lessons from the existentialists, stoics, Buddhists and social psychologists are generally ignored in mainstream clinical practice.

Solutions to the global mental health crisis will not be found in one-to-one, in-clinic interventions. Emerging from a complex literature are community-wide needs to promote the formation of secure attachments, participation in social activities to build identity and assuage existential isolation and loneliness, meaning-making, authentic living and, for some, religious practice. In addition, we need to recognise

that mental health is severely impacted by stable housing, employment status and physical health (Mental Health Taskforce, 2016). While the profession of psychology may contribute to some of these enterprises, it is our view that many of the gains in global mental health will need to be made outside of the clinic.

References

Australian Psychological Society (APS). (2018). *APS submission to the MBS review: Better access to psychiatrists, psychologists and general practitioners*. Melbourne, VIC: Australian Psychological Society.

Caras, G. W. (1995). The relationships among psychological separation, the quality of attachment, separation anxiety and death anxiety. *Dissertation Abstracts International, Section B: The Sciences and Engineering, 56*, 3436.

Chatard, A., Pyszczynski, T., Arndt, J., Selimbegovic, L., Konan, P. N., & der Linden, B. (2012). Extent of trauma exposure and PTSD symptom severity as predictors and anxiety-buffer functioning. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 47–55.

Cheung, M. C., Dennis, I., Easthope, Y., Werrett, J., & Farmer, S. (2005). A multiple-indicator multiple-cause model for posttraumatic stress reactions: Personality, coping, and maladjustment. *Psychosomatic Medicine, 67*, 251–259.

Chopik, W. J. (2017). Death across the lifespan: Age-differences in death-related thoughts and anxiety. *Death Studies, 41*, 69–77.

Dingle, G., Williams, E., Sharman, L., & Jetten, J. (2016). *School of hard knocks QLD: Final evaluation report*. School of Psychology, The University of Queensland.

Fairburn, C. G., & Patel, V. (2014). The global dissemination of psychological treatments: A road map for research and practice. *The American Journal of Psychiatry, 171*(5), 495–498.

Fleming, T., Bavin, L., Lucassen, M., Stasiak, K., Hopkins, S., & Merry, S. (2018). Beyond the trial: Systematic review of real-world uptake and engagement with digital self-help interventions for depression, low mood, or anxiety. *Journal of Medical Internet Research, 20*(6), e199.

Foa, E. B., Steketee, G., & Young, M. C. (1984). Agoraphobia: Phenomenological aspects, associated characteristics, and theoretical considerations. *Clinical Psychology Review, 4*, 431–457.

Furer, P., & Walker, J. R. (2008). Death anxiety: A cognitive-behavioral approach. *Journal of Cognitive Psychotherapy, 22*, 167–182.

Ghaemi, S. N. (2007). Feeling and time: The phenomenology of mood disorders, depressive realism, and existential psychotherapy. *Schizophrenia Bulletin, 33*, 122–130.

Goldenberg, J. L., Arndt, J., Hart, J., & Brown, M. (2005). Dying to be thin: The effects of mortality salience and body-mass-index on restricted eating among women. *Personality and Social Psychology Bulletin, 31*, 1400–1412.

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M. (2016). Groups 4 health: Evidence that a social identity intervention that builds and strengthens social group memberships improves mental health. *Journal of Affective Disorders, 194*, 188–195.

Hayes, S. C., & Smith, S. (2005). *Get out of your mind and into your life*. Oakland, CA: New Harbinger Publications.

Helm, P. J., Duchschere, J. E., & Greenberg, J. (2018). Treating low self-esteem: Cognitive behavioural therapies and terror management theory. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice*. Brisbane, QLD: Australian Academic Press.

Herodotus, V. I. (1996). *The histories* (trans: De Sélincourt, A.). London, UK: Penguin.

Hiebert, C., Furer, P., McPhail, C., & Walker, J. (2005). Death anxiety: A central feature of hypochondriasis. *Depression and Anxiety, 22*, 215–216.

Hofmann, S. G. (2018). Emotion-based strategies. *Keynote address presented at the 39th National Conference of the Australian Association for Cognitive and Behaviour Therapy, Queensland, October 2018.*

Hofmann, S., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31*, 1126–1132.

Iverach, L. (2018). Death anxiety and psychopathology. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice* (pp. 3–21). Brisbane, VIC: Australian Academic Press.

Iverach, L., Menzies, R. G., & Menzies, R. E. (2014). Death anxiety and its role in psychopathology: Reviewing the status of a transdiagnostic construct. *Clinical Psychology Review, 34*, 580–593.

James, W. (1985). *The varieties of religious experience*. Cambridge, MA: Harvard University Press. (Original work published 1902).

Jetten, J., Haslam, C., & Haslam, S. A. (Eds.). (2012). *The social cure: Identity, health and wellbeing*. Hove, UK: Psychology Press.

Kendall, P. C. (1998). Empirically supported psychological therapies. *Journal of consulting and clinical psychology, 66*, 3–6.

Kingman, R. (1928). Fears and phobias: Part II. *Welfare Magazine, 19*, 303–308.

Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of compassion based interventions: Current state of knowledge and future directions. *Behavior Therapy, 48*, 778–792.

Le Marne, K. M., & Harris, L. M. (2016). Death anxiety, perfectionism and disordered eating. *Behaviour Change, 33*, 193–211.

Loucas, C. E., Fairburn, C. G., Whittington, C., Pennant, M. E., Stockton, S., & Kendall, T. (2014). E-therapy in the treatment and prevention of eating disorders: A systematic review and meta-analysis. *Behavior Research and Therapy, 63*, 122–131.

Mental Health Taskforce. (2016). *The five year forward view for mental health*. London, UK: Mental Health Taskforce, National Health Service.

Menzies, R. E. (2018). Impermanence and the human dilemma: Observations across the ages. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice* (pp. 3–21). Brisbane, VIC: Australian Academic Press.

Menzies, R. E., & Dar-Nimrod, I. (2017). Death anxiety and its relationship with obsessive compulsive disorder. *Journal of Abnormal Psychology, 126*, 367–377.

Menzies, R. E., Sharpe, L., & Dar-Nimrod, I. (2019). The relationship between death anxiety and severity of mental illnesses. *British Journal of Clinical Psychology, 58*, 452–467.

Menzies, R. G. (2012). The dread of death and its role in psychopathology. *Keynote Address presented at the 35th National Conference of the Australian Association for Cognitive and Behaviour Therapy, Queensland, October 2012.*

Menzies, R. G. (2018). The dread of death: Updating the status of a transdiagnostic construct. *Invited address presented at the 39th National Conference of the Australian Association for Cognitive and Behaviour Therapy, Queensland, October 2018.*

Menzies, R. G., & Menzies, R. E. (2018). Fear of death: Nature, development and moderating factors. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice* (pp. 22–39). Brisbane, VIC: Australian Academic Press.

Menzies, R. G., Menzies, R. E., & Iverach, L. (2015). The role of death fears in obsessive compulsive disorder. *Australian Clinical Psychologist, 1*, 6–11.

Mikulincer, M. (2018). Love, death and the quest for meaning. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice* (pp. 57–81). Brisbane, VIC: Australian Academic Press.

Noyes, R., Stuart, S., Longley, S. L., Langbehn, D. R., & Happel, R. L. (2002). Hypochondriasis and fear of death. *The Journal of Nervous and Mental Disease, 190*, 503–509.

Pyszczynski, T., & Thompson, S. (2018). An intelligent design theory of the origins, evolution and function of religion: Toward an integration of existential and evolutionary perspectives. In R. E. Menzies, R. G. Menzies, & L. Iverach (Eds.), *Curing the dread of death: Theory research and practice* (pp. 103–120). Brisbane, VIC: Australian Academic Press.

Pyszczynski, T., Vail, K. E., & Motyl, M. S. (2010). The cycle of righteous killing: Psychological forces in the prevention and promotion of peace. In T. Pick, A. Speckhard, & B. Jacuch (Eds.), *Homegrown terrorism: NATO science for peace and security series — E: Human and societal dynamics* (pp. 227–243). Amsterdam, The Netherlands: IOS Press.

Randall, E. (2001). Existential therapy of panic disorder: A single system study. *Clinical Social Work Journal, 29*, 259–267.

Simon, L., Arndt, J., Greenberg, J., Solomon, S., & Pyszczynski, T. (1998). Terror management and meaning: Evidence that the opportunity to defend the worldview in response to mortality salience increases the meaningfulness of life in the mildly depressed. *Journal of Personality, 66*, 359–382.

Simon, N. M., Zalta, A. K., Otto, M. W., Ostacher, M. J., Fischmann, D., Chow, C. W., & Pollack, M. H. (2007). The association of comorbid anxiety disorders with suicide attempts and suicidal ideation in outpatients with bipolar disorder. *Journal of Psychiatric Research, 41*, 255–264.

Soares, M. C., Mondin, T. C., da Silva, G. D. G., Barbosa, L. P., Molina, M. L., Jansen, K., … da Silva, R. A. (2018). Comparison of clinical significance of cognitive behavioural therapy and psychodynamic therapy for major depressive disorder. *The Journal of Nervous and Mental Disease, 206*, 686–693.

Stolorow, R. D. (1979). Defensive and arrested developmental aspects of death anxiety, hypochondriasis and depersonalization. *The International Journal of Psychoanalysis, 60*, 201–213.

Starcevic, V. (2007). Body as the source of threat and fear of death in hypochondriasis and panic disorder. *Psihijatrija Danas, 37*, 73–82.

Strachan, E., Schimel, J., Arndt, J., Williams, T., Solomon, S., Pyszczynski, T., & Greenberg, J. (2007). Terror mismanagement: Evidence that mortality salience exacerbates phobic and compulsive behaviors. *Personality and Social Psychology Bulletin, 33*, 1137–1151.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 69*, 875–899.

Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death*. San Francisco, CA: Jossey Bass.