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Rachel E. Menzies
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# Existential Concerns and Cognitive-Behavioral Procedures

## An Integrative Approach to Mental Health

Springer

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*For Helen and Colin, my mother and father, who gave me the finest chance to build a life. – RGM*
*For Lachlan, who has filled my life with joy. – REM*
*For my parents Nan and John who taught me the value of education and about difficult choices in life. – GAD*

# About This Book

Clients enter therapy with a range of problems of living. They don't speak in diagnostic terms, but instead focus on the everyday difficulties that confront them. These difficulties may include isolation, loneliness, anxiety and sadness, guilt and regret, and problems making decisions in a world that offers seemingly endless choice. In contrast, the cognitive-behavior therapist is trained in the language of conditioning and extinction, avoidance and safety behaviors, behavioral activation, and attentional biases. This book explores the ideas of the existentialist philosophers as a bridge between the suffering client and technically trained clinician. The volume is not a rejection of cognitive behavior therapy (CBT) but seeks to place CBT in the broader context of the most popular philosophic tradition of the nineteenth and twentieth centuries.

The existentialists argued that the individual's starting point in confronting life is characterized by a sense of disorientation in the face of an apparently meaningless and absurd world. Further, they proposed that each individual must become solely responsible for giving meaning to life and living it passionately and authentically. Each of us must confront the existential issues of death, isolation, identity, freedom, and meaning and find our solutions to these problems.

The present volume explores each of these existential themes in turn. Each section opens with a theoretical chapter describing the relevant existential dilemma and its impact on human experience. The second chapter in each section explores its relationship to mental health disorders and psychopathology. The third chapter in each section explores the evidence for treating the existential issue from a CBT framework.

Editors

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# About the Editors and Contributors

## Editors

**Ross G. Menzies** completed his undergraduate, master's, and doctoral degrees in psychology at the University of NSW. He is currently Professor of Psychology in the Graduate School of Health, University of Technology Sydney (UTS). In 1991, he was appointed founding director of the Anxiety Disorders Clinic at the University of Sydney, a post which he held for over 20 years. He is the past president of the University of NSW and twice national president of the Australian Association for Cognitive Behaviour Therapy (AACBT). He is the previous editor of Australia's national CBT journal, *Behaviour Change*, and has trained psychologists, psychiatrists, and allied health workers in CBT around the globe. Professor Menzies is an active researcher with nearly three decades of continuous funding from national competitive sources. He currently holds over $AUS7 million in research funding. He has produced 10 books and more than 200 journal papers and book chapters and was the president and convenor of the *8th World Congress of Behavioural and Cognitive Therapies (WCBCT)* in Melbourne in 2016. He has recently been appointed a founding director and treasurer of the newly formed World Confederation of Cognitive and Behavioural Therapies (WCCBT). Ross lives with his wife and three youngest children in the inner west of Sydney.

**Rachel E. Menzies** is a postdoctoral fellow at the University of Sydney, where she completed her honors, master's, and doctoral degrees in psychology. She published her first paper on death fears in *Clinical Psychology Review* as an undergraduate student, and followed this by convening a symposium on the topic at the *8th World Congress of Behavioural and Cognitive Therapies* in Melbourne in 2016. Her experimental work on fear of death and psychopathology has been published in several leading journals, and she can regularly be heard on national and international radio, popular podcasts, and at relevant public events (e.g., *The Festival of Death and Dying, Adelaide Writers Week*). In 2017, she gave her first invited plenary address on death anxiety, and an invited workshop, at the *47th Congress of the*

*European Association of Behavioural and Cognitive Therapies (EABCT)*. Since then, she has published five books on existential issues and completed an invited workshop tour on the dread of death across seven cities for the Australian Association for Cognitive Behaviour Therapy (AACBT). In 2021, she won the national PhD Prize from the Australian Psychological Society for her work of death anxiety and its relationship with mental health. Rachel lives with her husband and runs a private practice in the inner city of Sydney.

**Genevieve A. Dingle** is an associate professor and director of clinical psychology programs at the University of Queensland with a research interest in how groups and communities can influence mental health and well-being. This includes both formal groups (such as cognitive behavior therapy groups, and therapeutic communities for alcohol and other drug treatment) as well as arts-based groups such as choirs and creative writing groups. Genevieve worked for over a decade as a clinical psychologist in hospitals and private practice. She is the editor of the journal *Behaviour Change* and serves on the executive of the *Australian Music and Psychology Society* and the *Arts Health Network (QLD),* and convenes the interdisciplinary *UQ Music, Dance & Health research group.* She is one of five authors of Routledge's text, *The New Psychology of Health: Unlocking the Social Cure,* that was awarded the British Psychological Society Book of the Year Award in 2020. Genevieve lives in Brisbane with her husband and two daughters.

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# Part I
# Introductory Issues

# Existentialism and the Problems of Being


**Gerard Kuperus**

**Abstract** This introductory chapter discusses the philosophical movement of existentialism particularly by looking at the issue of human existence or being. The fact that nothing is given beyond our being, that everything is up to us, is not merely a situation of freedom but in fact, as Sartre (Essays in existentialism. Carol Publication Group, Secaucus, 1999) points out, quite distressing. The chapter discusses mainly Nietzsche, Sartre, Heidegger, and Jaspers while also taking up some important reflection from Tolstoy. Our being is marked by what lies at the peripheries of our existence, such as death as well as others. We are then determined by what we are not, and it is the challenge of existentialism for us to relate to the world in an authentic way.

**Keywords** Nietzsche · Sartre · Heidegger · Jaspers · Tolstoy · Existentialism · Death · Authenticity · Atheism · Truth

## 1 Introduction

This introductory chapter to this volume takes up some of the main theoretical approaches in the philosophical movement that is known as existentialism. Needless to say, this is a selection of thinkers and by no means a complete summary. The purpose of this chapter is to indeed introduce existentialism as it is most relevant for this volume. The focus is existential thinking about the problems around our existence – the problems of being – and how different existentialists have dealt with the ethical, social, and ontological issues around the idea that we are thrown into a world without any absolute meaning, value, or truth besides the one's we humans have created. I take up in particular Nietzsche, Sartre, Heidegger, and Jaspers, supplemented by some reflections on Tolstoy's *The Death of Ivan Ilyich.* In particular,

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I take up the issues around the strong sense of freedom and responsibility our being brings with it, as well as issues at the border of our being, both the limits or our existence and others. Both Heidegger (1962) and Jaspers (1963, 1971) discuss this as being in the world in which the self – as being (or "being there," *Dasein*) – is determined through its relationship to what it is (seemingly) not. In order to grasp this move to understand ourselves through the borders or limits of our being, I will first discuss Nietzsche's discussion of truth and his challenge of dualistic thinking that has determined the tradition of Western philosophy.

## 2 Truth as an Illness

The history of existentialism can arguably start with Arthur Schopenhauer (1788–1860), who had a tremendous influence on Friedrich Nietzsche (1844–1900), most of all through his claim that life has no meaning. To grasp the importance and radical nature of the insight of nihilism, it has to be located historically, both within society and the philosophical tradition of the West. Indeed, that these ideas were radical might be missed if we fail to consider that the history of Western philosophy is one that emphasized and searched for objective truth. From Plato (who famously suggested that the shadows that we take to be reality are cast by a true reality, a divine absolute truth consisting of forms) to Descartes (who found the true foundation for all the sciences in the form of cogito, ergo sum), there has been a dominant story that truth exists and that reason and the control of the intellect can guide us to truth. With both Plato and Descartes, we also find the dualism of mind and body. For Plato, it was the soul (*psyche*) that continues to live after the body dies, while for Descartes, it is the mind that is absolutely independent of the body (see further Lawhead, 2005, and Skirbekk, 2001). With his famous cogito, ergo sum, he first and foremost determined us as a thinking thing. Existentialists were not the first philosophers to challenge this history running roughly from Plato to Descartes. Already in ancient Greece, we can find different voices, such as Heraclitus (see Curd & McKirahan, 2011) who thinks in non-dualistic and often contradictory thoughts: Famously, we find that we can and cannot step in the same river twice. In fact, Nietzsche (1994) argues that the history of philosophy has often suppressed these theories that do not fit into Plato's narrative (see also Swift, 2005). He mentions in this regard in particular the philosophy of Democritus. Dominant philosophers such as Plato ordered his books to be burned, Nietzsche suggests. While his theory in this regard often sounds like a conspiracy, the more important point is that the history of Western philosophy is one that has been seeking truth and does so on the strict basis of dualistic thinking. Dualistic thinking is limited insofar as it creates oppositions such as truth and falsity, good and bad, good and evil, mind and body, and human and animal that are always used in conjunction, one providing meaning to the other.

Against this backdrop of a search for truth and certainty, it is indeed a radical break when Nietzsche (following Schopenhauer) exclaims that there is no truth and that this search for truth is a sign of our weakness and illness. These claims emerge

in a time that can be characterized through a loss of power (political, philosophical, scientific, and ethical) of the church. Nietzsche (2001) writes about "the madman" who still believes in God. Of course, his society was still largely Christian, but at that time, the church had already lost its political power. The church had mostly lost the battle with science (although Darwin in the *Origins of Species* never explicitly mentions humans as descending from apes), while the philosophical and, in particular, the ethical powers were still strong. It is, it turns out then, easier to revolt against political systems and scientific beliefs than it is to revolt against philosophical ideas and moral values. It is the latter two that are utterly personal as they get to the core of who we are and what we should and should not do.

Yet Nietzsche (2001) wanted to dismantle these last strongholds of the church. We are living a herdlike existence, he argued, failing to think for ourselves, failing to think about values, let alone create our own values. This is not easy since we feel that we need purpose and meaning in the world. Thus, he argues, we utilize truth and values as a crutch. And that is exactly our problem. Within this context, Nietzsche makes this remarkable statement about philosophy: "all philosophizing up to now was not about 'truth' but about something else, let us say about health, future, growth, power, life" (Nietzsche, 2001, p. 2). Philosophers may have seemed to have argued and written about truth, but in fact, it was all about them. They expressed themselves and used their writing as a means to generate some truth to support themselves, as some medication against their inability to accept there is no truth. Nietzsche explicitly does not want to create truths, and instead, he writes in a personal way to express the idea that all truth is a personal perspective, a meaning.

What is particularly interesting is that while for many the discovery of a loss of purpose and meaning can present a crisis, Nietzsche argues that the believe in a God and in purpose, value, and truth is the true crisis. Nietzsche writes from a perspective in which he regards himself as a philosophical doctor examining the human race. His self-imposed nickname, "the philosopher with the hammer," does in that regard not only refer to a destructive move but also to the medical instrument. Nietzsche, however, does not provide a cure but rather a diagnosis of the problem that plagues humanity. By confronting the issue of depending upon objective truths, Nietzsche directs us to separate from the herd and famously "to become who you are" (cp. Nietzsche, 2001).

In short, Nietzsche (2001) tells us we are sick, he provides us with a diagnosis, and then he tells us to cure ourselves by becoming who we are. With the latter, he indicates the need to escape from the herd mentality, in which we are not ourselves. Nevertheless, as mentioned above, Nietzsche's thought emerges in a period of time when religion was challenged. Today, we can relate the herd mentality to our mass behavior in terms of consumption, fashion, politics, and mass culture. For Nietzsche, it mostly relates to the Christian morality, a morality that is not our own, but provided to us through a long history in which concepts such as good and evil were generated in reactionary processes. As argued in *On the Genealogy of Morality,* the term "bad" was initially used for the poor, unschooled, and uncultured (Nietzsche, 1968). To be "good" meant to be wealthy, educated, cultured, "clean," and powerful. The term "evil" was introduced by the Jews who used the term for their oppressors.

To be "good" as opposed to evil was now determined as being oppressed and not having power.

It is certainly easy to misinterpret Nietzsche (1968) here, as it has invited anti-Semitic readings, but his point is really that what it means to be good has changed historically and is by no means absolute. Moreover, he wants us to question the very idea that being good is associated with being in a position of oppression and powerlessness. Both the morals of "good and bad" and "good and evil" lack authenticity. What it means to be good is in both cases determined through its opposite. Both are reactionary. Although one might argue that Nietzsche here appears to emphasize power and thus open the door to tyranny and oppression, such interpretations would again miss the point. Seeing weakness itself as an indication of one's goodness leads to subordination while we should overcome oppression. We can only do so by overcoming ourselves, i.e., the selves that are not truly selves.

There is, Nietzsche (1968) implies, something very comforting about being in a position of oppression. In a sense, we seem to be afraid of our power. This is exactly the point Jean-Paul Sartre makes when he suggests that we are afraid of our own freedom. Everything we do and who we become is entirely up to us, he argues (Sartre, 1999). The only thing we did not choose is the fact that we exist. Sartre's partner, Simone de Beauvoir, provides a somewhat critical note to this as women (or woman) find themselves in a situation that is not as free as that of their male counterparts. She is already determined as "the other" and her place, especially in 1949 when she published the *Second Sex,* is that of the housewife and mother. Nevertheless, De Beauvoir (1968) embraces Sartre's existentialist ethics that suggests we are responsible for who we are. She herself lived this ethics by not following the norms already given by society. She did become herself by not marrying, by not having children, and by pursuing a career as a writer. With that, she not only created herself, but she also challenged the gender norms that constrained women during this time and created a new model that others could follow.

Sartre (1999) emphasizes that freedom is not necessarily a gift. We are actually constantly afraid of our own freedom and the need to make choices. We do, generally speaking, not like to make choices since each time we do, we are responsible for the consequences. Many of my students experience anxiety over their careers and the multiple choices they are faced with. Especially in their senior year, students are confronted with this as the choices seem unlimited. In the university, they could choose from a limited number of majors and courses offered that had to fit their schedule. After college, anything seems possible.

Sartre not only emphasizes that we are responsible for ourselves but also for everyone else as he writes, "If I want to marry, to have children; even if this marriage depends solely on my own circumstances or passion or wish, I am involving all of humanity in monogamy and not merely myself" (Sartre, 1999, p. 294). If I choose to marry, I am choosing the institution of marriage and am responsible for the implications that are part of that institution. Sartre continues: "I am responsible for myself and everyone else. I am creating a certain image of man of my own choosing. In choosing myself, I chose man" (ibid). I am not just making a personal choice; I am choosing what humanity should look like. This might sound rather

radical in today's world in which freedom is often determined as having virtually no limitations, with the only exception that one's actions should not harm others, at least directly. The language of "rights" addresses this. Sartre chooses a very different approach, largely influenced by Immanuel Kant, in suggesting that in choosing myself, I choose everyone else. My course of action should be the most desirable action in this particular situation. If I as a heterosexual male fall in love with a woman and I decide to marry, I should wish everyone else did exactly the same. Here, we find the power of Sartre's philosophy: I am free, and thus I can choose not to marry for a variety of reasons. Maybe I don't want to reinforce certain structures, such as those that limit marriage to heterosexual couples. Maybe I take issue with marriage creating certain expectations, such as reproduction or gender roles. Or maybe I wish to seek other forms of living that are not determined by forces external to me.

Here, we thus see the difficulties and the pressure that existentialist freedom creates. As Sartre states, it is "very distressing that God does not exist" (ibid. 296). Following a pattern that already lays out what man is – or should be – is comforting. Instead, as commanded by Nietzsche (2001), we are told to not follow the herd and to create our own existence. Thus, we are "condemned to be free" (ibid.). Even more, Sartre's notion of freedom as responsibility is a reaction to the violence that occurred in the Second World War. It is also within this context that he states that I am responsible for the actions of others, including the violence that occurs around me. While there was some resistance, people in France and the rest of Europe were largely standing by as violence occurred around them. In a world without absolute values, anything is possible, yet that does not mean we should let it happen. In today's society, that means that if we do not stop the deportation of undocumented people, the separation of children from their parents at the border, the lack of health care, or even homes for people, we are also responsible. There is an obvious truth to this also in a democracy: We should not blame so much the right-wing xenophobic politicians but rather those who vote for these leaders and those that enable them to perpetuate unjust structures. Yet Sartre's claim lies beyond that: We should not let violence and injustice occur around us. We have a responsibility to stop it and protect the victims even if it means we would have to pay with our own lives.

If we think we are powerless, Sartre (1999) would accuse us of bad faith and quietism. The latter is "the attitude of people who say 'let others do what I can't do.' The doctrine I am presenting is the very opposite of quietism since it declares 'there is no reality except in action'" (ibid. 300). Indeed, Sartre's philosophy can be seen as a philosophy of action in which I should act instead of making up excuses. As De Beauvoir points out, our situation might seem as one that lacks power, yet that does not release us from the duty to fight that very situation. Thus, our existence, or being, is determined entirely by ourselves: Power lies in how we choose to live our lives. There is no blueprint, no design, except for what I make of myself. Thus, Sartre argues that the human being is entirely what one makes of oneself. In order to do so, we need to lead a life of involvement and not just let things happen.

## 3 Being-in-the-World

As Sartre (1999) notes, the only thing we did not choose about our existence is the very fact that we exist. Martin Heidegger (1962) phrases this as being thrown into the world or, in "Heideggerian," "thrownness." Different than Sartre, he emphasizes time or temporality. The meaning of being, for Heidegger, is time, i.e., we are temporarily here. Based on Kierkegaard's description of dread, he provides a description of the experience of anxiety (*Angst*), which is, as he writes, not a fear for something in particular but rather the confrontation with nothing or the nothingness that lies beyond our existence.[1] We are born, we live, and then we die. Without the promise of an afterlife, this "being-toward-death" is a confrontation with our finitude and an experience of anxiety. It is, even more, a fundamental experience or rather a "fundamental attunement" (*Grundstimmung*). We are, so to speak, getting in tune here with our ground, and that ground is nothing. In other words, the confrontation with the lack of a beyond attunes us to our being as temporal.

Human beings engage in all kinds of ways that keep us from this confrontation. We are entertained or entertain ourselves with our gadgets, television, adventures, travel, and so forth. Heidegger describes, in fact, how the experience of boredom can lead us to a fundamental attunement similar to the experience of our mortality. In 1992, the Disposable Heroes of Hiphoprisy sang "Television, The Drug of the Nation." Today, our smartphones and computers connected to streams of social media and (mis)information have become part of our being and body. We have become a hybrid of human and technology. The latter is, indeed, increasingly determining our being. If these are indeed drugs, we have to ask the question: What illness are these drugs used against? Of course, drugs and relying on them can themselves become a disease, but why are we attracted to drugs in the first place? We all know that a walk through a city or a hike in the forest is going to be a much more positive experience than flipping through screen after screen on Facebook, Instagram, or Twitter. Yet the fact that we chose the latter is an indication of a problem. In fact, almost a century ago, Heidegger (1962) saw similar issues in the way urban lives, driven by technology, constituted a new form of living in which gossiping and a general business are determining our relationship to the world. We are not ourselves; we are inauthentic beings, Heidegger suggests. Only in certain moments, such as in the attunement of being-toward-death and boredom, do we experience ourselves, our being. Technology, one could say, assures that we never find a moment of boredom in which we are forced to reflect on our being. The choices we have to make are easy ones and often binary: watching show x or y, clicking "like"

[1] It might seem that Søren Kierkegaard (1813–1855) would also have influenced Nietzsche, but no evidence exists that Nietzsche read his work (which was not translated into German at the time). Because of this language barrier, the influence of Kierkegaard is only occurring much later through thinkers such as Heidegger. Kierkegaard also represents a break with many of the other existentialists since he still held on to a Christian faith.

or "dislike," and "thumps up" or "thumps down." In fact, it keeps us from becoming who we are.

Fundamental attunements can be intimidating. The realization that I am going to die is not a fact I want to think about nonstop. It seems that today, as in Heidegger's time, we are entertained nonstop in order to distract ourselves from ourselves, i.e., from our being. We are fleeing away from ourselves, from boredom or the anxiety over our finitude, in which we are confronted with our very being as a being that is free. This is, thus, a way to think about the attraction to television, social media, gossip about celebrities (or our neighbors), and endless streams of (mis)information.

Yet ultimately, it is not death but living that provides the biggest challenge. As we have already seen, Jean-Paul Sartre (1999) emphasizes responsibility as the ultimate consequence of freedom and the idea that anything is possible. For Sartre, following Nietzsche, no absolute values exist. We can and have to create our own values, Nietzsche tells, followed by Sartre's exclamation that we are fully responsible for ourselves and everyone else. Now, that is more intimidating than the knowledge that I am going to die. We like to blame others, the government, men or women, millennials, etc. When it comes to ourselves, we blame our circumstances and situation. Although it is important to recognize that we do not all have equal opportunities, it is a tricky issue since we can easily fall into bad faith. Not falling into bad faith is a true challenge; however, since without anything or anyone to blame now, everything is our own responsibility. Thus, when Nietzsche (2001) tells us to live our life as if we want to live it over and over again, or when Heidegger (1962) says that through a fundamental attunement we can recognize the significance of our being and thus make the most out of it, or when Sartre says you are fully responsible, this is where we find the true demand of existentialism. There is no greater meaning to being than what we make of it.

For existentialism, the challenge becomes to live a life that is authentic or one's own. It would, however, be a mistake to exclude external forces. According to Heidegger, we are "being-in-the-world." The dashes have a significant meaning here: for a human being to be means to be in the world. "World" is my world insofar as it is constituted by all the entities that I encounter. Yet those entities and the others I encounter in the world also constitute an otherness or something alien.

This encounter with an alien part of my being is provided particular attention by Karl Jaspers, an existential thinker who started out as a psychiatrist and turned to philosophy. As such, he provides an existential understanding of psychotherapy (see Schlimme, 2013, p. 150). As a philosopher, I will stay away from any clinical implications and focus on the philosophical concepts. Nevertheless, as should be clear throughout this chapter, the implications of existentialism can have severe impacts on mental health, both in a positive and negative way.

One thought that is consistently expressed by Jaspers is that while psychiatry as a science works with larger structures, it is important to see the patient as a person, a unique individual, formed by a certain constitution (*Anlage*) and one's environment or milieu (cp. Jaspers, 1963). Yet he also emphasizes that we are free beings: When speaking about one's worldview (*Weltanschauung*), he is particularly thinking about our religious and/or philosophical ideas. Even while we often think those

are fixed, it can be in constant flux (cp. Schlimme, 2013, p. 157). Indeed, as such, we are much more free than we assume, or as Sartre would say, we are much more free than we are willing to accept.

About truth, Jaspers writes that "even the existence of truth in itself can become doubtful" (Jaspers, 1963, p. 42). We encounter different conflicting truths, we have rejected absolute truths and possibly even all truth, and we can even speak of "pseudo truths." Thus, "the question of truth is one of the dizzying questions of philosophizing" (Jaspers, 1963, p. 43). Specifically within the context of existentialism, Jaspers defines the issue of truth then in terms of boundaries (a "border situation" or *Grenzsituation*), where my existence and some other existence can come into conflict. One of those potential conflicts is our relationship to death – a conflict between our existence and nonexistence. Death is a part or our being, yet it is difficult to accept it as such. The same is true for other aspects of our own being that we tend to place at the border of our existence, for example, suffering, fight, contingency, and guilt. As all existentialists, Jaspers (1971) emphasizes the limit of our existence as a defining moment of it. Accepting these situations at the limits as part of our being is one of the major challenges we are facing as individuals.

In *Philosophy of Existence,* Jaspers defines the central issue of existentialism, paraphrasing Kierkegaard, as follows: "everything essentially real is for me only by virtue of the fact that I am I myself. We do not merely exist; rather, our existence is entrusted to us as the arena and the body for the realization of our origin" (Jaspers, 1971, p. 22). Existence is a given and that is not the issue, to realize it in the best possible way, in a world that provides no absolute truths; this is indeed the challenge. For Jaspers, one can either fall into nothingness, "the bottomlessness of the infinite (Jaspers, 1963, p. 39), or I can give myself to myself and "sense the fullness of the encompassing" (ibid. 40). The term "the encompassing" refers to being itself, this eluding entity that "always seems to recede from us, in the very manifestation of all the appearances we encounter […] it is the source from which all new horizons emerge, without itself ever being visible, even as a horizon" (ibid. 1963, p. 40). Being or "the encompassing" is what has to accompany all that exists, including us. It is our origin yet invisible and ungraspable. Thus, what I am "always remains a question" (Ibid. 45).

Although the influence between Heidegger and Jaspers is a lot more complex than I can even start to discuss in these pages, we can find similarities in the sense that both thinkers emphasize being as elusive and both regard mortality as a constitutive aspect of our being. Heidegger (1962) ultimately suggests that the meaning of being is temporality. We have a beginning and end, and it is that end, death, which is essential to our being. Both Jaspers (1963, 1971) and Heidegger (1962) emphasize the difficulty to accept death as a part of ourselves. Heidegger describes how we are fleeing away in "the they" and describes the experience of our finitude in terms of anxiety. Jaspers discusses the difficulty to accept death as part of our being within the context of psychiatry. As one of the "border situations," death is at the limit of my being, some other existence, or rather nonexistence.

## 4 Conclusion

Our existence, or to be as a human being, is full of challenges and relationships with otherness and alien forces. One of the central ways in which I have approached that issue has been through an engagement with the question, What death means in an existential way? A good illustration can be found in Tolstoy's novella *The Death of Ivan Ilyich.* After falling while hanging curtains in his new home, the main character first experiences some discomfort, then falls ill, and eventually dies. The process is an extended and painful one. Ilyich cannot tolerate his family or other people, except for Gerasim, the family's young butler, who shows compassion and does not fear death. As it becomes clear that he is dying and Ilyich is confronted with his mortality, the pain and agony eventually subside.

With, on the one hand, the agony of Ilyich and, on the other hand, the calmness of Gerasim, it becomes clear to the reader that it is not a physical illness that is tormenting Ilyich. It is regret about his life: the psychological burden of not having lived the life that he would have wanted. His death is a confrontation with the fact that he has not truly lived: He has waisted away his life in a loveless marriage, and he has worked his way up the social ladder. He has not lived his own life; he has lived a life determined by external forces. Life and work might be without meaning, but he has failed to create a life of his own, an authentic life. A famous line from the book sums it up perfectly: Ilyich's life has been "most simple and most ordinary and therefore most terrible" (Tolstoy, 2004, p. 43). When one is facing death, the most terrifying aspect is not death but life. The realization that one has not lived an extraordinary life comes when it is too late, when he cannot do anything about it.

Tolstoy, Nietzsche, Heidegger, Jaspers, and Sartre all provide important insight regarding the responsibility we face as humans to create our own lives. It is easy to not choose, to let things happen, as is the case with Ilyich. Heidegger (1962) and Jaspers (1963) suggest that we have to let a confrontation with our mortality occur, not at the end but earlier in life. This can guide us in living our lives fully. In a slightly different way, Sartre (1999) emphasizes that we are fully responsible for all our choices. We cannot blame others or find other excuses to not act. Nietzsche (2001) even sees our whole society as a construction in which we are herd animals and in which a slave morality actually encourages us to be in a position of the oppressed, a victim of powerful circumstances. In the ethics of "good and evil," good is determined exactly as being subordinate, and this kind of ethics has, according to Nietzsche, let to the demise and sickness of our society.

What Nietzsche, as an atheist, saw coming is that with the death of God, people will have to confront the reality that this life is all there. By giving up on the promise of a reward in the afterlife, all attention turns to living or life itself.

When the attention turns to life itself in which anything is possible, we are presented with absolute freedom. This is what we should want, yet we flee away from it. We try to be like someone else, perhaps some celebrity, and we all end up being like everyone else. Nietzsche (2001) describes this as the herd mentality and Heidegger (1962) as "the they" (*das Man*), and Sartre (1999) emphasizes that we

are afraid of our own freedom as we fall into patterns of "bad faith." We try to convince ourselves that things are not up to us even while we deep down know better. We can change our lives but, as Ivan Ilyich discovers, not at the very end when it is too late.

To be, to exist in an existential sense means to be free and thus to be responsible for my being as well as that of others. We exist as "being-in-the-world," and we constantly encounter border situations in which some apparent alien force turns out to be a part of our existence. It is in these encounters with other human beings, the world, or death that we have to find a way toward an authentic existence. This is the challenge existentialism presents to us.

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# Existentialism and Its Place in Contemporary Cognitive Behaviour Therapy


**Michael Worrell**

**Abstract** This chapter explores the place that 'existential thinking' may hold in contemporary Cognitive Behaviour Therapy (CBT). It is proposed that a wide range of CBT models can usefully explore a range of existential themes such as death, meaninglessness, isolation and freedom. At the same time, it is suggested that a more in-depth consideration of central propositions of existential phenomenology challenges many of the assumptions and therapeutic practices of CBT. Central to this is the existential-phenomenological emphasis on 'relatedness', which puts into question the unclarified Cartesian philosophy implicit in much CBT. The chapter also discusses how key insights of existential phenomenology may be explored in the training of CBT therapists via phenomenologically based experiential exercises.

**Keywords** Existential phenomenology · Existential givens · Phenomenology · CBT · 'Relatedness'

> *In anxiety one feels 'uncanny' Here the peculiar indefiniteness of that which Dasein finds itself alongside in anxiety, comes proximally to expression 'the nothing and the nowhere'. But here 'uncanniness' also means 'not-being-at-home'.* (Heidegger, 1962, p. 233)

## 1 CBT and Existentialism: An Uncanny Relationship?

Can existentialism, or existential thinking (a broader term I use to encompass existential philosophy as well as existential therapy), be said to have a 'home' in contemporary CBT? Or is it more accurate to suggest that CBT has, as one of its original homes, existential philosophy? For some, the juxtaposition of CBT and existential thinking may itself appear 'uncanny' and disorienting as they represent fundamentally different and opposed ways of understanding human experience and psychological distress. Much of course depends upon how one defines and delineates the nature of 'existentialism' and 'CBT'. Both of these terms are in their own ways

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contested and unclear. Can it be said that CBT exists? It is often noted that CBT is in fact not a unitary school unless a stance is taken to limit the definition of CBT to include only a set range of perspectives, research projects, commitments and practices.

Salkovskis (2002), surveying the development of the field, defined CBT as 'a set of empirically grounded interventions'. This definition would initially seem to imply that CBT is essentially a set of 'tools' that are ready to hand and are primarily to be thought about in terms of whether they are good tools, appropriate for some tasks and not others, depending also on the skilfulness of the person wielding the tool. This would also seem to indicate that the foundation stone for CBT therapists is the empirical method itself (which is of course also in need of clarification and by no means anywhere a settled issue). So, for example, even if CBT therapists may adopt different positions regarding the direct causal role of cognition in psychopathology, they would nevertheless agree on how such questions should be approached through the experimental method. However, CBT as a whole does not endorse the idea that it can be defined principally in terms of techniques and the extent to which they are empirically supported. Beck et al. (1979), Clark (1995) and Salkovskis (2002) have strongly argued that it is not possible to define Cognitive Behavioural Therapy simply in terms of its technical interventions. Rather, a wide range of interventions can be employed to the extent that these interventions make sense in terms of the CBT model. That is, it is the conceptual and theoretical aspects of the cognitive behavioural model, which remain contested and subject to debate, that define it. It follows from this that any consideration of the relationship between existentialism and CBT cannot simply be at the level of techniques, as in 'are there technical procedures that may be employed to address existential issues in CBT' (although this is of course not irrelevant). The relationship between CBT and existentialism must also be explored at a conceptual, theoretical and indeed philosophical level.

And what of existential philosophy and existential psychotherapy? As the previous chapter demonstrated, while 'existentialism' is clearly identifiable as one of the most important and influential philosophical movements of the twentieth century, its defining features and key arguments have always been subject to heated division, debate and revision (Cooper, 1999). Indeed, if one were to imagine all the key existential thinkers were able to meet together in one place, a café perhaps, to discuss their thinking, most likely, the one thing that they would each agree on is that all the others present in the room have substantially misunderstood and misrepresented the views being presented.

CBT therapists, seeking to gain inspiration or guidance from existential philosophy, also need to contend with the fact that there are already a substantial number of 'existential psychotherapies' (Cooper, 2003). These have ranged from approaches that have worked out the therapeutic implications arising from the work of a single philosopher, such as the work of Medard Boss who developed 'Daseinsanalysis' with the direct collaboration of Martin Heidegger (Boss, 1963) to those approaches that draw inspiration from a diverse range of existential philosophers (see, for example, van Deurzen et al., 2019). It is also the case that existential philosophy has had considerable impact across a diverse range of psychotherapies. This includes a

wide range of humanistic psychotherapies and existential-humanistic psychotherapies (Schneider, 2008), as well as forms of psychoanalysis that have attempted to rework fundamental psychoanalytic ideas such as the unconscious and transference through the lens of existential philosophy (Stolorow et al., 2002). All of these forms of inspiration and integration are themselves subject to controversy and critique. Currently, there exists no widely held agreement as to what constitutes an appropriate or indeed 'authentic' application, or thinking through of the implications, of existential philosophy for therapeutic practice.

## 2 Existential Issues Versus Existential-Phenomenological Thinking

The most straightforward and accessible discussion of existential philosophy and its relevance to and place in CBT would be one that highlights a range of 'existential issues' and topics and explores how CBT therapists, and CBT as a model, might incorporate or address these issues. In this regard, the work of Yalom (1980) is highly useful in that he has identified four such 'fundamental existential concerns' and clearly demonstrates how a wide range of clinical and experimental evidence supports the role of these concerns in different forms of psychological distress as well as the practice of therapy. The four existential issues that Yalom identifies are death, meaninglessness, isolation and freedom. Each of these themes and concerns can indeed be found in a range of existential philosophies. Equally, as potential 'transdiagnostic' issues, each of these themes lends themselves quite readily to a range of CBT conceptualisations and interventions. 'Death', for example, or at least 'fear of death' and 'death anxiety' can be a legitimate focus for CBT and may substantially enrich CBT practice. There is in fact a very substantial range of empirical literature to support the notion that concerns around death feature very heavily in differing forms of psychopathology and that there may be CBT-specific forms of intervention that can usefully address this (see Menzies et al., 2018, as well as chapters in the present volume). Equally of course, these concerns lend themselves to forms of analysis and interventions arising from a wide range of different theoretical perspectives including the humanistic and psychoanalytic. Issues around death, and indeed the hypothesis of a 'death drive', are featured prominently in Psychoanalysis (Freud, 1920/2003).

Arguably, taking such a 'thematic' focus to existential issues, while legitimate and potentially highly productive, constitutes only the most superficial engagement with existential thinking. Why might this be so? While Yalom's (1980) discussion is original, engaging and useful, it remains the case that there are a wide range of other existential issues and concerns that can be presented as equally primary but have somehow not made it onto this list of 'the big four'. To identify an issue or concern as being 'existential' is to suggest that this issue is in some way rooted in, and an expression of, some fundamental 'given' aspect of what it means to be human. The

issue is somehow essential, unavoidable and constitutive of human existence itself. Without it, human existence would not be what it is. Additionally, and unfashionably, to identify an issue or factor as existential is to argue that this is in some way universal and that it finds expression and can be discerned cross-culturally and across time.

## 3 Identifying the 'Existentials'

The range of relevant existential 'givens' can in fact be seen to be quite wide, and what should and should not be included in any such description is a subject for debate. Medard Boss (1963), for example, based upon the work of Martin Heidegger, has argued that our '*dreaming existence*' is a fundamental aspect of what it is to be a human being. In a manner that CBT therapists may initially find difficult to appreciate, Boss describes our experience of dreaming as in a sense 'equal' to, although different from, our waking existence. To be human, for Boss, is to live in dreaming and to be in the world through and as dreaming. Additionally, Boss (1963) discusses how human existence is always fundamentally an *embodied existence*. Embodiment, existence through 'being-a-body', is so fundamental that it is difficult to appreciate the emphasis on death awareness and death anxiety other than through an appreciation of the fundamentally embodied nature of human existence. In addition, drawing on Heidegger, Boss argues that human existence is always characterised by some '*mood*'. Human beings are said to be 'attuned' to the world via mood as an 'atmosphere' that, rather than being seen as simply the outcome of cognitive processing, is fundamental to the way human existence reveals the world itself. The most fundamental of moods for existential philosophers is that of anxiety. Existential anxiety is in this sense basic to human existence, and we *are* anxiety. Existential anxiety reveals human existence as always 'open', 'unfinished' and as always a being-towards-death (Heidegger, 1962). Additionally, human existence is seen as inevitably always 'guilty'. Rather than this indicating some form of moral lapse or sin, *existential guilt* refers to the fact that, as limited beings, we are always already 'behind' our possibilities for being. Any choice we make, and we are always inevitably making such choices, involves an implicit or explicit 'no' and letting go of other known and unknown possibilities for being.

A further addition to this list of 'existential givens' is suggested by the existential therapist Hans Cohn (2002) who has convincingly argued that *sexuality* is fundamental to human existence. Sexuality is existential in the sense that each human being responds to and takes up a stance towards the 'possibilities of being sexual' and that this stance is an expression of their manner of relating to self, others and world. Existential sexuality is a primary means of relating to and revealing a world.

## 4 Existential Uncertainty

Spinelli (2015), in his original take on existential psychotherapy, has suggested that one of the most central existential concerns, or rather 'principles' to arise from existential-phenomenological philosophy, is that of '*uncertainty*'. This emphasis on 'principles' is important as it suggests that many of the themes and dimensions discussed above will also be seen to be expressions of and to include a 'reference to' such principles. Existential guilt, for example, can only be fully understood to the extent that this expresses a response to, and is revealing of, existential uncertainty. According to Spinelli (2015), the principle of existential uncertainty asserts that:

> I can never fully determine with complete and final certainty or control not only *what* will present itself as a stimulus to my experience, but also *how* I will experience and respond to stimuli. An immediate consequence of this stance is that even how I will experience myself under differing stimulus conditions cannot be predetermined. (2015, p. 22, emphasis in original)

At the same time, the principle of uncertainty is also contextualised by the fact that human existence is always, using Heidegger's language '*thrown*', that is, that human beings 'always already' find themselves in a context and situations over which they exert little control and yet must in some way respond to. Such contextual givens such as racism, inequality and the vagaries of a global pandemic provide the background conditions from within which the principle of uncertainty arises. The principle of uncertainty in existential phenomenology also reveals itself to be paradoxical in that any statement such as 'all is uncertain' reveals itself as a statement of certainty (Spinelli, 2015). Thus, rather than a fixed position of the certainty of uncertainty, existential phenomenology challenges us to consider the uncertainty of certainty and the uncertainty of uncertainty. In regard to the latter possibility, this would, for example, encourage a CBT therapist to consider each new instance of 'a client presenting with panic attacks and thus appropriate for treatment X with manual Y' as potentially novel, unpredictable and uncertain. The manual need not necessarily be thrown away as an inauthentic expression of certainty, but rather, the question becomes, What new uncertainties may be revealed by the attempt to understand how the manual and model both throws light upon and obscures the client's experience of problems in living that have been described as 'panic attacks'?

Recently, CBT therapists who have turned their attention to the task of identifying 'transdiagnostic factors' have argued that 'intolerance for uncertainty' is potentially one of the most significant factors implicated in a range of different forms of psychological distress. McEvoy and Erceg-Hurn (2016) have argued that intolerance for uncertainty may constitute both an important transdiagnostic factor and a 'trans-therapy' factor. That is, intolerance for uncertainty may be a key factor that is altered by a range of differing therapies even when this is not an explicit target of those therapies. As such, they consider it to be a potential 'universal process'.

## 5 Existential Relatedness

As Spinelli (2015) has argued, possibly the most foundational principle of existential phenomenology is the principle of '*existential relatedness*'. This is also, unfortunately, the principle that is the most difficult to grasp and keep hold of due to the extent to which it challenges typical Western assumptions that can most certainly be seen to be present in most forms of psychological practice including CBT. Martin Heidegger's (1962) expression 'being-in-the-world' attempted to express this fundamental relational nature of human existence. This is also elaborated as 'Dasein', which describes the nature of human being as 'being-there' or alternatively 'the "there" where being reveals itself'. Unfortunately, despite the use of hyphens that are intended to express the extent to which being and world are a unitary phenomenon, it can be so easy to read this expression as indicating the existence of two separate aspects 'being' and 'world' that somehow enter into or create a relationship.

In much psychology, based as it is on a 'Cartesian' perspective that separates subject from object and 'inner' from 'outer', and certainly in much CBT, there are a range of apparent 'splits'. Consider the distinctions between cognition and behaviour or cognition and emotion or indeed between 'situation' and 'response'. Related distinctions can be identified in terms of body and mind, self and other, and 'cognitive representation' and 'outer reality'. The existential-phenomenological principle of relatedness can be seen to challenge each of these apparent separatist distinctions and to instead propose that while we may indeed experience and report upon seemingly more isolated phenomena such as 'my self', 'my freedom', 'my body' and so forth, each of these more subjectively grounded descriptions in fact emerge from a more foundational relatedness. It is more existentially adequate to speak of 'body-mind' and 'lifeworld'. Thus, issues and dilemmas such as 'freedom' and 'choice' cannot be adequately considered from the more typical individualistic and separatist position or must at least be considered as highly limiting.

A typical misunderstanding of existential thinking is that it emphasises the primacy of the 'lone individual', isolated in their own inner emotional experience, condemned to create their own individual and unique life project in the face of the absurdities of existence. Such a view can of course be found but must be contextualised within a more thoroughly relational perspective. In such a perspective, the experience of an individual unique self is seen as an outcome of relatedness, and each existential choice can be seen as implicating others and the world and as having unpredictable and uncertain consequences for others and the world. Thus Yalom's (1980) emphasis on isolation could be more adequately understood as a polarity with 'being-with-others' on one end and 'isolation' on the other. The following quote from Merleau-Ponty serves well to express this central principle of relatedness:

> True reflection presents me to myself not as idle and inaccessible subjectivity, but as identical with my presence in the world as to others, as I am now realising it: I am all that I see, I am an intersubjective field, not despite my body and historical situation, but, on the contrary, by being this body and this situation, and through them, all the rest. (As quoted in Friedman, 1964, p. 201)

The principle of existential relatedness can be seen as having many radical consequences for the practice of therapy, and any consideration of the place of existential thinking in CBT needs to grapple with such consequences. Existential thinking, therefore, is not identifiable by its specific focus on themes such as death, meaning, isolation and freedom, but rather, that such concerns are explored in terms of their grounding in relatedness.

## 6 The 'Way' of Existential Thinking: Phenomenology

In the sections above, I have attempted to show that while it is a valid undertaking to identify and explore a range of existential issues such as death, meaninglessness, isolation and freedom, there is nothing uniquely existential about any exploration that considers these themes. I have also briefly shown that each of these themes needs to be more thoroughly contextualised within the existential-phenomenological notions of relatedness and uncertainty. Prior to considering what place such ideas might have in CBT, it is also necessary to briefly consider the particular method and stance that existential thinkers such as Heidegger, Sartre and Merleau-Ponty adopted in order to approach such issues. This concerns the philosophy and method of 'phenomenology'.

Phenomenology can be considered primarily as a way of doing philosophy rather than a set and agreed-upon philosophical system. It is a practice and a way of exploring and describing experience. The term 'phenomena' is understood as 'that which appears', and as such, phenomenology becomes the exploration and description of 'what appears in the way that it appears' (Moran, 2000).

Spinelli (2015) has described the phenomenological method in terms of three overlapping and interdependent phases or steps. A phenomenological investigation of any phenomena, such as the experience of 'being anxious', or 'being depressed about the economy', involves the following interdependent overlapping steps:

1. **The phenomenological reduction**: Here, the researcher, philosopher or therapist is required to identify and to make an attempt to set aside any preconceptions, personal biases or theoretically based views regarding the nature of the phenomena under investigation. This includes hypotheses about causal factors involved in its generation or maintenance. This step is often regarded as the most challenging aspect of the method as frequently, assumptions and preconceptions remain unreflected upon. The task of the reduction remains an attempt at introducing an unusual degree of experiential openness to whatever arises, not unlike some descriptions of mindfulness. In therapy, this step requires of the therapist a willingness to set aside any notions of being a 'change agent' or 'educator' in favour of a stance that attempts to 'stay with' the lived experience of the client as it reveals itself in the immediacy of the therapeutic conversation. If there is something that can be said to express a degree of 'competence' here, it is this very willingness and ability to stay present and open to the client's experience as

well as the experience of the therapist as they attempt this unusual form of intense listening, seeing and sensing.
2. **The rule of description**: The second step can be summarised as 'describe don't explain'. The therapist or investigator is encouraged to attempt a descriptive clarification of the phenomena under investigation: How is 'being anxious' experienced? What does it entail? How is this experienced bodily and within the world? Again, these descriptions should be as free of 'causal scientific hypotheses' as possible.
3. **The rule of 'equalisation'**: In this final step, the investigator or therapist is required to avoid placing any 'hierarchies of significance' on the descriptions that were obtained. Thus, a client's reports of a sense of 'feeling small and insignificant' or 'like my heart will explode' or that 'the space between my door and the stairs seems infinite and uncrossable' are each regarded as potentially equal in their meaningfulness and relationship to the phenomena of being anxious.

The descriptive phenomenological method presents itself as a clear alternative to the typical hypothesis testing approach of CBT whose intent is often to construct a causal model to explain the development and maintenance of a psychological problem. Nevertheless, a number of CBT-oriented researchers have seen in the phenomenological method a useful tool that has potential in the training of CBT therapists, particularly in regard to all frequent temptation to 'jump to conclusions' regarding the nature of a client's difficulties (O'Conner, 2015).

In summary, it has been argued above that existential thinking and existential phenomenology present CBT therapists with a significantly expanded and deepened description of 'what it means to be human'. It raises issues such as death, meaninglessness, isolation and freedom but does so in a novel way that seeks to highlight the irreducibly relational and contextual basis of human experience and existence. Existential thinkers have argued that such issues are best approached from a phenomenological perspective, and this perspective is one that makes unique demands on the therapist or investigator, which in large part rest upon the willingness to 'let go of' much of the theoretically derived assumptions regarding 'what it means to be a therapist'. In what way can these ideas and perspectives have any place within a CBT that presents itself as the project of developing a scientific understanding of human distress and the practice of therapy? In the sections that follow, I outline a variety of ways in which different versions of CBT have both points of contact as well as points of divergence with some of the existential principles and methods described above.

## 7 Standard 'Beckian' CBT and Existential Thinking

One does not need to dig too deep in order to find clear evidence of a place for existential thinking in what might be regarded as 'standard' Beckian CBT. In what might be regarded as the foundational CBT text, Beck and his colleagues

acknowledge the influence of the existential and phenomenological philosophies of Heidegger and Husserl as well as the contributions of the phenomenological studies of Jaspers, Binswanger and Strauss (Beck et al., 1979). More recently, Clark et al. (1999) have stated that the philosophical perspective that most clearly is in tune with and captures the central concerns of CBT is existential phenomenology. Moss (1992), writing from a more traditional existential therapy perspective, has argued that Beck and other cognitive therapists have effectively given a greater degree of respectability and legitimacy to existential ideas and have succeeded in 'smuggling' insights from existential phenomenology into the respectable halls of academia via the 'back door'.

A strong case can be made that Beck and his colleagues are correct when they seek to characterise CBT as being consistent with existential phenomenology. The focus on forms of meaning that are in principle directly accessible by the therapist and client alike, as opposed to an emphasis upon the role of the therapist as 'interpreter' of the client's statements in terms of hypothesised 'underlying' or 'unconscious' factors, provides a clear point of contact between CBT and existential psychology. Beck's description of a cognitive triad of self-world-future also seems consistent with a range of existentially derived analyses regarding the centrality of meaning. Beck's description of the process of 'guided discovery' could also be interpreted as a form of structured phenomenological exploration. Therapist questions that arise from a guided discovery standpoint are those that 'stay close' to the client's experience but may direct their attention to aspects of this experience that they are not currently attending to in order to widen the client's perspective. If Beck's cognitive therapy is presented as a framework for the therapeutic exploration of meaning, it could also be easily argued that many of the thematic focus points of existential phenomenology, death, isolation, freedom, choice and meaning, are a legitimate topic for CBT therapists to the extent that these themes present themselves in clinical work. Indeed, the recent contributions of 'experimental existential psychology' (Greenberg et al., 2004) that have presented quantitative data that support the hypothesised role of 'death anxiety and defences', for example, may provide substantial support for CBT therapists to consider the role of these existential themes.

In addition, the so-called 'disorder-specific' models of CBT that have focussed on identifying the specific cognitive content and processes maintaining specific difficulties can also be read as highly informative, phenomenologically rich and clinically helpful analyses of the manner in which the clients presenting problems are in fact best thought of as their 'attempted solutions' to universally experienced aspects of existence such as anxiety.

The work of Robert Leahy (2015), which represents a further elaboration of an essentially Beckian CBT perspective, has drawn explicitly on existential philosophy and has sought to highlight the more 'tragic' aspects of existence as well as the need for competent CBT therapists to develop the capacity to 'stay with' expressions of distress that arise from encounters with inevitable aspects of existence, such as death and loss, rather than attempting to 'reconstruct' the client's cognitions.

Drawing directly on the philosophies of Heidegger and Sartre, Leahy suggests that:

> individuals struggle with their freedom of choice, often having difficulty with the "given" that is arbitrarily part of their everyday lives, while recognising that the choices people face often involve dilemmas or tradeoffs that are emotionally difficult. Choice, freedom, regret, and even dread, are viewed as essential components of life in this model, and these "realities" cannot simply be eliminated by cost-benefit analysis, rationalization, or pragmatism. (2015, p. 10)

At the same time, however, there remain significant points of difference and potential conflict. Most significant is the reliance of standard Beckian CBT that can be described as a 'correspondence theory of truth' based upon assumptions of the separateness of cognition, emotion, behaviour and world (no matter how closely entwined and interactional these elements are regarded as being). The correspondence theory of truth holds that the truth of a client's cognitive representations, which are in some way 'internal' and separate from the world, can be evaluated in terms of the degree to which they correspond with the way the world 'really is'. That CBT, in its standard version, can be seen to embrace both a 'rationalist' stance, and a correspondence theory of truth can be clearly seen in the following quote that is from an article whose explicit purpose is to clarify perceived misconceptions regarding the CBT model:

> Standard cognitive therapy is a structured, time-limited, problem-oriented psychotherapy aimed at modifying the faulty information processing activities evident in psychological disorders like depression... The therapist and patient collaborate to identify distorted cognitions, which are derived from maladaptive beliefs or assumptions. These cognitions and beliefs are subjected to logical analysis and empirical hypothesis testing which leads individuals to realign their thinking with reality. (Clark, 1995, p. 155)

Existential phenomenology, with its emphasis on the inherently relational nature of human existence, challenges the model of truth implicit in the above quotation. With it, the possibility of a therapist identifying and challenging distortions or errors in thinking is challenged as is the assumption that therapeutic encounters are primarily to be seen as forms of 'treatment' for identified psychological 'disorders'. As noted above, the phenomenologically based perspective of existential thought suggests that therapists are more likely to gain a more adequate understanding of a client's experience to the extent that they are able, initially at least, to 'set aside' notions of treatment or psychoeducation.

## 8 Schema Therapy: Working with the 'Depths' of Meaning

While the concept of 'schema' features clearly in standard CBT, the use of this concept has been considerably expanded by Young et al. (2003) and others who have developed 'schema-focussed' approaches that seek to understand client distress and change in terms of 'deep' cognitive structures that are often, in their content, clearly related to and expressive of fundamental existential issues.

Young et al. (2003) argues that traditional CBT assumes that clients will be able to directly change distorted cognitions and unhelpful behaviour through rational-logical strategies such as empirical analysis, logical discourse, gradual behavioural exposure tasks and experimentation. Young et al. (2003) argue that for many clients, this is not the case and that their distorted cognitions and behavioural patterns are highly resistant to change even after months of sustained intervention. Young et al. argue that for many such clients, their distorted cognitions and unhelpful behaviours are ego-syntonic, that is, they are experienced as central to the client's identity and that 'to give them up can seem like a form of death- a death of part of the self' (2003, p. 4). This understanding of the uncertainty and potential losses associated with meaningful cognitive change is very much in tune with the perspective of existential phenomenology where individual's 'world views', their beliefs, explicit and implicit are seen as in many ways expressive of efforts to cope with the given existence and to provide a degree of predictability and certainty in the face of inevitable uncertainty.

Young et al. (2003) has also suggested that the origin of schemas lies in the frustration of a number of core emotional needs in childhood. Such needs are seen by Young et al. (2003) as 'universal' aspects of human experience and development. These needs include:

1. Secure relationship attachments that provide safety, stability, nurturance and acceptance
2. Autonomy and sense of competence and individual identity
3. Freedom to express valid needs and emotions
4. Spontaneity and play
5. Realistic limits and self-control

Young et al. (2003) regard 'schema healing' as the ultimate goal of schema therapy. The process of schema healing, however, is seen as long and often arduous. They argue that individual will often resist the process of schema change as:

> Patients resist giving up schemas because the schemas are central to their sense of identity. It is disruptive to give up a schema. The whole world tilts. In this light, resistance to therapy is a form of self-presentation, an attempt to hold onto a sense of control and inner coherence. To give up a schema is to relinquish knowledge of who one is and what the world is like. (2003, p. 32)

A number of features of the schema approaches seem to allow for a greater degree of appreciation for existential issues in a broadly CBT perspective. The focus on 'deeper' levels of meaning would appear to open up the possibility of working with more existential aspects of meaning and experience. Ottens and Hanna (1998) have argued for an integration of cognitive and existential perspectives on the basis of this shared, focused-upon meaning at a schematic level. These authors argue that many of the schemas identified by CBT theorists are inherently 'existentially constituted' as they refer to basic fundamental aspects of a client's identity, essence and validity in the world. Indeed, it may be possible to identify explicitly existential schemas such as 'my existence is wrong or should not be', 'my existence is a burden

and is damaging to others' and 'my existence is vulnerable and not real'. Schema therapy also seems to express a greater appreciation for the dilemmas and challenges of change that is in tune with existential thinking. Any potential movement towards changing a schema, while it may open up greater and more positive possibilities, is also unpredictable in its implications. This perspective on change, that change is often a question of trade-offs and 'workability' rather than 'rational correspondence with reality', is also of central concern to those versions of CBT that have described themselves as 'constructivist'.

## 9 Constructivist and 'Post-rational' CBT

A key concern for a range of 'constructivist' approaches is the question of 'epistemology' that is 'how we come to know what we know'. These approaches have tended to contrast themselves with what they regard as the more 'objectivist' and 'rationalist' approach of standard CBT. In the so-called objectivist approach, knowledge is regarded as 'representation' of an external world and where such representations can be tested as to their degree of accuracy. By contrast, the constructivist sees knowledge as a product of social construction, negotiation and co-construction. Lincoln and Hoffman (2018) have suggested that existential phenomenology and constructivism converge on taking seriously the philosophical and epistemological basis of therapy and psychological theory. Additionally, they can both be understood as challenges to the limits of modernism in psychological theory and practice and emphasise multiple 'ways of knowing' and the extent to which personal and cultural assumptions may condition and constrain knowing and action.

A diverse range of 'narrative', 'constructivist' and postmodern approaches to CBT have been proposed that on the whole have not greatly influenced the mainstream of CBT practitioners but that nevertheless represent important developments. Social constructivism as a philosophy has had a wide-ranging influence over differing psychotherapies and academic disciplines. In some respects, it represents a development of certain strands of existential phenomenology. Important theorists who have attempted to develop a more constructivist version of CBT include Guidano (1991) and Mahoney (2003).

Guidano (1991) explicitly contrasts what he regards as a 'post-rationalist' cognitive therapy with rationalist (standard) CBT that he positions as inevitably being focussed upon 'control':

> the therapeutic relationship established in rationalist and objectivist psychotherapy cannot become other than an instrument- a more or less authoritarian instrument- for the reestablishment of a rational, realistic, and otherwise socially dictated order. (Guidano, 1991, p. 100)

Guidano argues that for the constructivist, rationality is inherently relativistic. There is no 'God's-eye view' from which a therapist is in a position to judge the irrationality or otherwise of a client's thoughts. Guidano's post-rationalist cognitive therapy

focusses upon the gaps and incongruities that inevitably exist between the individual's ongoing, embedded, acting, experiencing 'I' and their sense of self that continually emerges from abstractly self-referencing this ongoing experience—the observing and appraising 'me' (alternatively phrased as the self as subject 'I' versus the self as object 'me'). Guidano emphasises that the experiencing I is always ahead of and not equivalent to the reflecting Me. Guidano draws upon attachment theory as a resource to help theorise the difficulties and distortions that arise in the ability of the reflecting Me to adequately capture the experiencing I. 'Normal functioning' is regarded as being equivalent to a personal meaning organisation that is capable of evolving towards greater complexity via assimilation of contradictions in experience and construction. In psychotherapy, the experience of emotion is regarded as central in promoting reorganisation of self-constructs and emotion schemas.

Key to Guidano's (1991) constructivist perspective is an understanding of the nature of resistance to change as being essentially about the inherent need for individuals to maintain the coherence and stability of their current meaning constructions. Those constructions that are more 'core' to the sense of self are highly resistant to change, and as such, resistance is seen as essentially expressive, self-protective efforts at maintaining coherence and identity rather than expressing poor motivation or non-compliance.

Mahoney's (2003) version of constructivist psychotherapy also focusses on 'deep' tacit core-organising principles and uses a wide range of strategies to assist clients in increasing their awareness of these. He describes strategies such as the 'life review' that focuses on the elaboration of a life narrative as well as 'mirror time', which is a mindfulness-based intervention involving the client being able to become aware of and stay with emotions, memories and thoughts that arise as they view their own face in a mirror for a specified period of time.

Key to the therapeutic application of these constructivist principles is a preference for a more unstructured therapeutic process, a lessened focus on highly specified treatment targets and a focus on the therapeutic relationship and the accessing and exploration of emotional embodied experience as key processes of change (Mahoney, 2003). Additionally, in contrast to an attempt at the identification and 'correction' of cognitive distortions, these approaches advance what they refer to as an 'almost reverential' appreciation for clients' meaning-making processes.

As with many apparent polarities, the contrast between so-called objectivist and rationalist CBT and constructivist CBT may be much less stark as many have proposed. In fact, standard CBT appears to contain many elements that fit more easily within a constructivist perspective than a rationalist one. Consider, for example, strategies to alter 'rules for living'. Seldom is this done via appeal to logic alone. Most often, this is addressed through an open dialogue regarding the possibilities and limitations of any change in such ways of being. This consideration of the pros and cons of change and the recognition that change may at times lead to unexpected, unpredicted consequences is a feature embraced by both standard CBT as well as existential and constructivist thinking. The constructivist strand of CBT has on the whole had a limited impact, and the most recent elaboration of the standard CBT model by Beck and Haigh (2014) has incorporated a much greater focus on

constructivist aspects while still maintaining an overall rationalist perspectives. It appears that the pragmatic and clinically focussed CBT is capable of embracing and living with the apparent contradiction between these two philosophical polarities. By far the most interesting development, in terms of potential for contact with existential themes, within the family of CBT therapies has been the development of a range of 'third-wave' CBT therapies. These approaches are often characterised by a renewed interest in the philosophical underpinnings of the approach. Possibly the most important of these approaches, in terms of existential issues, is Acceptance and Commitment Therapy or ACT, to which we now turn.

## 10 Acceptance and Commitment Therapy: An Existential CBT?

Of all approaches, ACT possibly comes closest to constituting an 'existential CBT'. At the same time, as will be discussed below, there remain significant points of disagreement and difference that should not be glossed over or ignored.

According to Yalom (1980), existential psychotherapy may not constitute a specific school of therapy at all and that what it represents is more of an attitude or position towards the nature of psychological suffering and the process of therapy. This basic existential attitude contends that human difficulties are expressions of individuals attempt at responding to the nature of existence itself. Hence, psychological disturbance and distress is to some degree inevitable and unavoidable. Most human difficulties are thus issues 'to be lived' as opposed to 'problems to be solved' in any final sense. Existential thinking can be said to embrace what the philosopher Miguel De Unamuno (1954) has referred to as a 'tragic sense of life'. This contrasts clearly with the apparent optimism of much CBT that sees the possibility of 'a CBT' *for* most human difficulties. ACT, on the other hand, appears to embrace a much more existentially attuned tragic sense of life. Hayes et al. (1999), in their original presentation of ACT, distinguish between what they refer to as the 'assumption of healthy normality' and the assumption of 'destructive normality'. Hayes et al. (1999) argue that the 'psychological mainstream' (including CBT) has adopted the assumption that the natural state of human existence is one of health and that, by corollary, the experience of abnormality, in the form of psychological distress, is a form of disease. That is, the common assumption amongst clients as well as therapists is 'I am meant to be happy, and if not, there is something wrong that can and should be fixed'. ACT, by contrast, asserts that psychological distress and difficulty are inevitable aspects of human existence principally due to the manner in which language works and the extent to which we become 'entangled' with language.

While the connection between ACT and existential phenomenology may seem to be most obvious in regard to the ACT emphasis on issues of mindful acceptance and 'values', the connection actually runs much deeper and ultimately arises from the fact that ACT represents an evolution of a radical behavioural approach that can be traced to the work of Skinner.

Numerous authors have highlighted points of convergence between Skinner's version of behaviourism and existential phenomenology. Principally, this is due to the fact that Skinner proposed a more contextual and less mechanistic science of behaviour. Kvale and Greness (1990), for example, have pointed to some surprising points of convergence between the psychology of Skinner and the existential philosophy of Sartre. This convergence rests upon the rejection of the Cartesian notion of the a 'dual world'—an inner world of thoughts and emotions versus an outer world consisting of environmental stimuli. Two quotes from the respective authors seem to point towards an essential agreement on the notion that behaviour should be understood only in terms of acting-within-context and without recourse to notions of 'inner states' or cognitive representations:

> Our "perception" of the world- our "knowledge" of it- is our behaviour with respect to the world. (Skinner, 1953, p. 90)

> The point of view of pure knowledge is contradictory; there is only the point of view of engaged knowledge. This amounts to saying that knowledge and action are only two abstract aspects of an original, concrete relation. (Sartre, 1956, p. 30)

Hayes et al. (1999) describe the philosophy of functional contextualism as deriving from the pragmatism of William James as well as other influences. In contextualism, the basic unit of analysis becomes the 'act-in-context' with the hyphens serving to emphasise that this must be understood in terms of a 'whole event' including its historical and situational context. Parts or elements (such as a specific behaviour of an individual) are only abstracted in accord with a specific purpose or goal of analysis. Thus, contextual analyses are viewed as being inherently relational.

Within ACT, 'truth' is a matter of pragmatism, and a psychotherapeutic theory is true to the extent that it is effective in supporting the attainment of its specified goals. Hayes (2016) asserts that the goals that are chosen by a researcher or a therapist and client together can only be stated and 'owned' and that the results of any particular analysis or therapeutic intervention do not in themselves justify the choice of that goal. Following Skinner, the stated goal of contextual behavioural science, of which ACT is an expression, is 'the prediction and influence of behaviour with precision scope and depth' (2016, p. 20). Hayes (2016) acknowledges that ACT, as a form of functional contextualism, overlaps with other forms of contextualism that he labels as 'descriptive contextualisms'. Existential phenomenology is a clear example of a descriptive contextualism. Descriptive contextualism, while sharing many core assumptions of functional contextualism, starts from a different goal. The goal of descriptive contextualism has been stated in terms of the search for 'understanding' as opposed to the search for the means to exert influence or achieve predictive precision.

In the application of a contextual behavioural science approach to psychological therapy, many further points of contact with existential approaches to therapy can be seen. ACT proposes that therapy should not principally be focussed on the attempt at controlling or eliminating unwanted psychological phenomena such as anxiety or depression. Rather, such efforts at control are seen as themselves as constituting the

main difficulty. ACT suggests that therapy can more effectively be reconfigured to support clients in clarifying for themselves key values, that is, 'What do you want to stand for? What do you want your life to "be about" regardless of whether or not you continue to experience these distressing phenomena?' The central aim of ACT is also described as the effort to support 'psychological flexibility', which has been defined as contacting the present moment fully as a conscious human being and, based on what the situation affords, changing or persisting in behaviour in the service of chosen values (Hayes et al., 1999).

ACT has the potential to renew an interest within CBT regarding issues that are in essence philosophical. Hayes et al. (1999) argue strongly that it is important for therapists to be clear on the philosophical assumptions that they are embracing. As noted above, Hayes (2016) has suggested that such assumptions can be clarified and owned. Existential phenomenologists, on the other hand, might present the challenge that such assumptions can also be questioned. From an existential perspective, the chosen value of moving towards the possibility of 'prediction and control' remains problematic to the extent that this value may serve to introduce a significant degree of bias and distortion in terms of a therapist's ability to 'stay with' phenomena as they reveal themselves. In the conduct of therapy, this may express itself in terms of a therapists' attempt to 'shape' a client, even if this is done in a flexible and paradoxical manner, towards a predefined ideal of psychological flexibility. Contrast the emphasis on prediction and control, in essence a desire to move towards certainty, with the existential-phenomenological embrace of uncertain certainties and uncertain uncertainties. The ACT therapist's frequent use of experiential techniques of defusion, mindfulness and committed action may run the risk, from an existential-phenomenological point of view, of detracting from the therapist's and client's ability and willingness to 'stay with' phenomena as and how they reveal themselves in the therapeutic conversation.

## 11 Summary: Finding a Place for Existential Thinking in CBT

The above, admittedly superficial and incomplete, exploration of where existential thinking may have points of contact and divergence with various forms of CBT has hopefully demonstrated that there may be interesting and productive points of dialogue and debate between these differing perspectives. From an existential perspective, committed as it is to the embracing of a phenomenological stance, there is a grave risk that CBT therapists may seek to 'technologise' existential issues. Thus, 'death anxiety', 'meaninglessness', 'existential choice and responsibility' and, even worse, 'relatedness' could become just additional variables or factors in an increasing 'set' of 'transdiagnostic issues' that will attract researchers into devising specific interventions for their 'overcoming', resulting in that most despair and angst inducing eventuality of the development of 'yet another manual'. There is of course

nothing inherently wrong with attempting to explore such existential issues from a more empirical standpoint. However, the risk is that in doing so, some of the more disturbing, challenging and demanding aspects of existential thinking is lost.

Cohn (2002) has emphasised a very useful distinction that CBT therapists could keep in mind. This is the difference and relationship between what has been referred to as the 'ontological' and the 'ontic'. The ontological refers to aspects of being itself, essential and fundamental givens of existence. The ontic, on the other hand, refers to our everyday experience of existing. Cohn, drawing off the work of Heidegger, emphasises that the ontological can be seen as being included in the ontic. It does not need to be seen as somehow behind the ontic or causal of the ontic. Thus, a client who presents with a phobia of snakes, for example, need not be principally approached in terms of this 'all being about the fear of death'. Similarly, a client presenting with OCD that expresses great difficulties with the issue of responsibility need not be seen as principally struggling with a case of 'excessive existential responsibility and guilt'. These clinical presentations should not be seen as being principally *caused* by these existential concerns with the notion that delineating, formulating and designing interventions to more effectively target these existential dimensions will lead to a better therapeutic result. Instead, if these existential dimensions are in fact ontological, aspects of existence itself, then they are present at all times and in all situations. Thus, my writing this paper is itself expressive of my attempts at responding to both my 'being-towards-death'—there is a 'deadline' for its completion, which I have now missed, and my choice to attempt its completion also contains within it my stance towards 'existential responsibility and guilt'; my choice necessarily entails saying no to other possibilities of being. My award-winning novel remains, alas, unwritten.

Existential dimensions of existence cannot be seen as being either pathological or healthy, and therapists are encouraged instead to remain at an ontic level but with the possibility of developing ears that are able to discern the presence of existential dimensions in many clinical presentations, as well as in their own experience as a thread that at times may be useful to clarify and explore. How might this 'existential competence' be developed? I would suggest that in the training of CBT therapists, other than didactic explorations of existential literature, principally, this can be supported by experiential practice exercises that focus on the capacity for 'deep listening' and 'staying with phenomena as and how they reveal themselves'. Below, I have outlined several of these exercises in the hope that some may prove enticing and productive for reflection.

## 12 Exercises in Phenomenological Listening

The following exercises are offered as possibilities for CBT therapists in training regardless of their preferred version of CBT. The intention is not to practice these exercises as forms of 'skill' that relate directly to CBT interventions. They are not opportunities for 'role play', and they are not intended as practice runs for how CBT

therapists should work with their clients. Rather, they are designed to allow the possibility of the therapist in training to 'gain a sense' of what phenomenological listening might be like and what it might be like to allow 'existential issues' to present themselves in the way they present themselves without the need for these to be 'assessed', 'formulated' or 'intervened' with.

In each exercise, there are three 'positions', that of therapist, client and observer. Ideally, each participant takes a time in each role. There is no set time limit for these exercises, but in general, between 10 and 15 minutes per interaction should be sufficient.

**Exercise 1: 'Just' Listening**
In this exercise, the 'client' is asked to describe a recent experience where they had some form of emotional experience, be it positive or negative. The client is simply asked to describe, 'What was this experience like for you?' The task of the 'therapist' is to remain completely silent throughout and to attempt to listen in a way that allows them as full a sense as possible of what this experience was like for the client. No questions or redirections are allowed. At the end of the exercise, each participant is asked to describe what this experience was like—was it interesting, frustrating, enjoyable, anxiety provoking, etc.

**Exercise 2: Listening to Myself Listening to You**
In this exercise, the 'client' is again asked to describe in detail a recent experience where they felt a strong emotion. The 'therapist' is again asked to remain silent and to focus on listening in depth to the client. However, on this occasion, the therapist is also asked to listen intently to their own experience of attempting to listen to the client: 'What is it like to attempt to enter into the experience of the client in the manner that the client has this experience. What images, memories, emotions, body sensations, etc., arise when this attempt is made?' Again, after each exercise, each participant is asked to describe what occurred for them and their reflections about this.

**Exercise 3: Clarification of Embodied Emotional Experience**
In this exercise, the therapist is at last allowed to speak! However, their task is to remain one of attempting to gain as adequate as possible understanding of the client's experience as and how it presents itself. In this exercise, the therapist is permitted to ask for clarifications and further description; however, such clarificatory questions should be limited to questions that are attempts to gain further descriptions of the clients' 'embodied emotional experience'. There should be no attempts made to identify and separate 'key cognitions', nor should there be any attempts to steer the conversation towards problem solving or towards alternatives that the client has not already engaged with. Again, reflection and discussion are invited after each exercise.

**Exercise 4: Existential Observations**
This exercise is principally focussed upon the 'observer' position. In this exercise, the therapist and client proceed as above for Exercise 3 (there is a second run of Exercise 3 with these additional instructions). The observer is asked to listen intently

to both the therapist and client as they are engaged with each other and to also note their own experience while doing so. In addition, the observer is asked to see if they can discern the presence of any 'existential dimensions' that arise within the dialogue. What is it like to simply note the presence of these dimensions in the manner in which they present without these necessarily being 'targeted'? Again, reflection and discussion are invited following the completion of the exercise.

## 13 Conclusion

This chapter has endeavoured to show how existential thinking and existential issues 'show up' in a variety of forms of CBT. There is no doubt that existential thinking is fundamentally a different form of human enquiry than the scientific, evidence-based methodologies favoured by CBT theorists and therapists. Nevertheless, there are significant points of contact and convergence that are worthy of further dialogue and debate. It is possible that for CBT to maintain its commitment to an empirical hypothesis testing, problem-solving perspective, the existential thinking will remain primarily at the level of suggesting a range of themes that may lead to the identification of important 'transdiagnostic factors'. Where existential thinking is engaged with more fully, including an engagement with phenomenological methods as well as the conclusions and findings of phenomenological investigations, it remains the case that CBT therapists and theorists are presented with a rage of highly significant challenges that again raise the old as yet still open and unresolved question regarding the best way to understand the relationships between cognition, emotion, behaviour, other 'selves' and world.

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# Part II
# Death

# Death Awareness and Terror Management Theory


**Ilan Dar-Nimrod**

**Abstract** Terror Management Theory (TMT) is the dominant social psychological theory examining the relationship between death awareness and human behaviour. According to TMT, cultural worldviews and self-esteem are thought to serve an important anxiety-buffering function in order to manage (or 'tranquilise') existential fear of death. This chapter reviews the evidence for TMT in a wide array of settings, evaluating empirical support of the fundamental principles of the theory and for more recent theoretical extensions of the ORIGINAL account. These review addresses empirical findings that examine cognitive, attitudinal, affective, and behavioural consequences of the awareness of our own death. It also examines moderators proposed and the potential role of death anxiety in psychopathology. Lastly, competing theoretical accounts offering alternative explanations for the empirical findings of the role of death awareness on human behaviour are briefly introduced.

**Keywords** Death · Terror Management Theory · Death anxiety · Death awareness · Mortality salience · Existential psychology · Existentialism · Self-esteem · Worldview defence · Psychopathology · Mental illness · Attachment · Materialism

> *The most painful state of being is remembering the future, particularly the one you'll never have*. (Søren Kierkegaard)

There are very few recurrent themes among human beings, which emerge seemingly in every known culture and group, as the concerns about our mortality does. These concerns have been recorded in numerous modes of expression. They are visible in ancient forms of arts, such as cave drawings from the Neolithic period, just as they are on full display in the modern versions of visual arts, such as paintings, photography, and movies. They appear in some of the earliest samples of human writings, just as they still do in the current literature and poetry. They seem to be a central element of worry and reflection among peoples of antiquity, just as they are in

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contemporary Western and non-Western societies. Such longevity and endurance suggest that death is a phenomenon that is of grave centrality to the human experience.

Death, of course, is not a uniquely human phenomenon. All biological life forms, from the lowliest of single-cell organisms, through the different forms of plants and flora, to the animal kingdom in its various, glorious manifestations, share the experience of arriving into this world with a (mostly undetermined) expiry date. These biological life forms all seem to share a basic tendency – to keep death at bay for as long as possible – commonly referred to as a survival instinct.

One of the main differences between the human experience of death and (to the best of our understanding) the experience of other earthly life forms revolves around our ability to think abstractly. As Kierkegaard darkly quips in the quote that leads this chapter, just as we are able to reflect on our past, we are capable of imagining our future, and as a part of the inevitable things to come, we are faced with inevitability of our own mortal demise. As such, the combination of the common-to-all-life forms biologic instinct to protect our continuous existence, on the one hand, and our species' unique ability to realise that we will all fall short in this quest sooner or later, on the other hand, brings about a most pronounced existential angst, which philosophers (Heidegger, 2014; Kierkegaard, 1849; Sartre, 1956), anthropologists (e.g., Becker, 1973), and, more recently, psychologists (e.g., Greenberg et al., 1986; Yalom, 1980) have been attempting to unpack and reflect upon.

## 1 The Denial of Death

Ernest Becker, a cultural anthropologist, has penned an influential, Pulitzer Prize-winning book, which attempts to capture the processes involved in the human realisation that our most basic life goal will eventually be thwarted by the unassailable fact of the ultimate failing of the flesh. *The Denial of Death* poetically and painfully captures the tension between our organismic drive for survival and our abstraction capabilities, stating:

> This is the paradox: he is out of nature and hopelessly in it; he is dual, up in the stars and yet housed in a heart-pumping, breath-gasping body that once belonged to a fish and still carries the gill-marks to prove it. His body is a material fleshy casing that is alien to him in many ways—the strangest and most repugnant way being that it aches and bleeds and will decay and die. Man is literally split in two: he has an awareness of his own splendid uniqueness in that he sticks out of nature with a towering majesty, and yet he goes back into the ground a few feet in order to blindly and dumbly rot and disappear forever. It is a terrifying dilemma to be in and to have to live with. The lower animals are, of course, spared this painful contradiction, as they lack a symbolic identity and the self-consciousness that goes with it. (Becker, 1973, p. 23)

Becker (1973) does not only identify the dilemma faced by the self-conscious organisms that we are. He also suggests that the same elements that give rise to that agonising paradox of our existential concerns, namely, our high intelligence and

ability to think abstractly, are also the elements that were utilised to device the mechanisms to overcome the seemingly futile quest for eternal existence. He identifies mechanisms that he argues to have evolved to allow us to overcome the paralysis that accompanies the realisation of our mortality, arguing, as many before him did, that religion often offers a portal to transcend the limitations of the flesh. Religion in his view offers one the opportunities to use our abstract thinking to imagine and construct a post-mortem life unbound by the imperative of the temporary biological existence, solving the paradox in its entirety by offering a literal eternal existence. The Ernest Becker Foundation (n.d.) has published accounts that delve more specifically into the interplay between Becker's scholastic syntheses and different religions, such as Buddhism, Protestantism, and Judaism; these interesting accounts may be explored here: http://ernestbecker.org/this-mortal-life/religion/.

However, whereas many scholars (e.g., Chidester, 1990; Kierkegaard, 1849; Norenzayan et al., 2009) agree on the general role of religion in addressing existential concerns, Becker (1973) also identifies additional mechanisms that he argues to have evolved to address these concerns. He postulates that being part of a society with (at least perceived) enduring cultural values, mores, norms, and practices allows one to experience a version of virtual immortality. This process is facilitated by the Cartesian dualistic sense of mind and matter in which the mind, or our immaterial self, is viewed as consisting of those cultural elements, which need not obey biological disintegration imperatives. He goes even further to suggest that culture, which he sees as a collective fabrication of commonly held views about reality, has **evolved in the first place to help us deal with our death awareness** and the anxiety it brings. As such, one may view the endurance of one's culture, even after their own passing, as bringing about symbolic immortality, as they view of their true selves revolving around this shared understanding of reality, rather than through the biological limitations of the flesh.

Becker (1973) also recasts earlier psychoanalytic constructs through his primary focus on our evolved denial of death's inevitability. One construct of focus, which he identifies as an evolved adaptation to thwart the paralysis that accompanies humanity's death awareness, is self-esteem. Becker argues that viewing oneself as a central figure in the universe, a narcissistic quest to create a heroic self-image, is rooted in our quest to deny our own mortality through a grandiose attempt to build a lasting legacy he terms 'an immortality project'.

## 2 Terror Management Theory

Becker's (1973) understanding of death awareness served as the main inspiration for the dominant social psychological theory on how death awareness affects our emotions, beliefs, attitudes, motivation, and, ultimately, behaviours. Three graduate students from the University of Kansas in the late 1970s, Jeff Greenberg, Tom Pyszczynski, and Sheldon Solomon, found Becker's theoretical arguments inspirational and went on a decades-long quest to further extend the conceptual work he

originated and garner empirical evidence for the still-growing expansion of our understanding of the role of death awareness in everyday life.

Terror Management Theory (TMT; e.g., Pyszczynski et al., 1999) offers a dual-process model revolving around people's reactions to death awareness. It draws a vital distinction between conscious and non-conscious mortality cognitions as the responses that follow these different modes of death awareness are fundamentally different (Greenberg et al., 1994; Pyszczynski et al., 1999).

TMT (e.g., Greenberg et al., 1986) follows Becker's (1973) argument that thoughts of one's own death induce an anxiety (i.e., terror) so consuming that it can lead to functional paralysis. According to the theory, the immediate response to these terrifying thoughts is to engender proximal defences. Some of these responses may prove beneficial as in the case of increased survival-related vigilance, such as greater actionable plans-related health threats (e.g., Routledge et al., 2004), and some that are regularly painted in unfavourable light in the psychological literature – responses revolving around suppression of the threatening cognitions (Arndt et al., 1997; Pyszczynski et al., 1999). The motivation behind this active suppression is to overcome the debilitating horror by distancing oneself from death as much as possible through vigilance, denial, or distractions. Pyszczynski et al. (1999) argue that these immediate responses represent a 'rational, threat-focused (reaction)… when thoughts of death are in current focal attention' (p. 835).

In line with this account, and perhaps quite counter to our naïve intuition, there is little evidence to suggest that the response to actively contemplating one's own death (vigilance, denial, and suppression according to TMT accounts) is mediated by conscious affective experiences. At first blush, it seems reasonable to predict that mortality thoughts would lead to overt experience of negative affect, such as anxiety. However, most studies that measure self-reported affect following activation of thoughts about one's own death find no support for such a prediction, instead showing that whether one thinks about one's own death or about their favourite television program, (e.g., Norenzayan et al., 2009), a visit to a dentist (e.g., Menzies & Dar-Nimrod, 2017), or even if they were not asked to think about anything in particular (Rosenblatt et al., 1989), there is no clear indication of different reported affective experiences, providing support for the suppression prediction. However, one may wonder if the findings that participants do not tend to report greater anxiety following an activation of death thoughts may be indicative of a reporting bias rather than actual successful suppression. To address this possibility, Rosenblatt et al. (1989) assessed anxiety or arousal-related physiological responses after activation of death cognitions to avoid the trap of biased reporting. They found that, similar to the self-report results, participants did not significantly differ in their blood pulse rate or skin conductance as a function of thinking about their own death, compared with thinking about eating and food, or if they were not instructed to think about anything specific.

Whereas the common immediate response to consciously thinking about one's death is suppression, once the thoughts about death are supressed, TMT researchers argue that they non-consciously linger. To demonstrate this presence of non-conscious death awareness, TMT experiments often use a non-obtrusive measure of

death thought accessibility, which takes the form of a word completion task (e.g., Dar-Nimrod, 2012; Greenberg et al., 1994). Participants in this task are given a list of words (e.g., 20) with blank spaces representing missing letters, which they are required to add so that they end up with an English word. The partial words they see contain two different intertwined sets: one set that can be completed by either death-related words or non-death-related words and a (larger) filler set that can be completed with only non-death-related words (designed to reduce the chances that this measure itself will activate death cognitions). The accessibility of death thoughts is then assessed by summing up the number of word completions that use death-related words. For example, a person may see the following partial word 'G R A _ E' and complete this task by placing a single letter where one is missing (represented by the '_'). In this case, they may put a 'P' (or 'C' or 'D' or 'T'…) to create the word GRAPE (a non-death-related word), or they may put a 'V' to create the word GRAVE (a death-related word). Indeed, in line with the distinction between proximal (conscious) and distal (non-conscious) death awareness, studies regularly find increased non-conscious death thoughts accessibility following a mortality saliance prime (for a review, see Hayes et al., 2010).

The distal death awareness that lingers once the suppression process kicks into gear has been the focus of the vast majority of the research that has been carried out under the Terror Management theoretical umbrella. In line with Becker's (1973) account, the (original) theory (Greenberg et al., 1986; Pyszczynski et al., 1999) postulates that human beings have evolved to utilise two intertwined psychological mechanisms to ameliorate the detrimental anxiety that follows the suppression of conscious death awareness: self-esteem and cultural worldview defence. These mechanisms provide a buffer against terrifying existential cognitions by eliciting a sense of symbolic immortality for those who perceive themselves to live up to their culturally prescribed standards, and as a result, non-conscious accessibility of death cognitions is reduced.

TMT researchers postulate that self-esteem is 'a sense of personal value that is obtained by believing (a) in the validity of one's cultural worldview and (b) that one is living up to the standards that are part of that worldview' (Pyszczynski et al., 2004, pp. 436–7). Note, unlike Becker's (1973) argument that a narcissistic self-heroism view of oneself is designed to keep death anxiety at bay, TMT offers a more palatable description of this mechanism, but they both converge on the perception that this positive self-view plays a role in attenuating the fears of one's own ultimate demise.

Embedded in the TMT definition of self-esteem, while also being an independent mechanism argued to pacify death anxiety, TMT (e.g., Greenberg et al., 1986; Pyszczynski et al., 1999; Solomon et al., 1991) suggests that cultural worldviews serve an important role in our understanding of the effects of death awareness. Echoing Becker's (1973) focus on the importance of one's culture in providing a sense of symbolic immortality, TMT argues that distal death awareness should lead us to become more protective of our cultural worldviews in order to attach our sense of personal existence to a more enduring construct than our own corporal being, namely, the social structure that surrounds us, with all its glorious (and at times

unsavoury) derivatives, such as its symbols, practices, values, and reputation. By far the most researched element of the theory, different manifestations of the defensive responses following activation of non-conscious death awareness have been demonstrated in many empirical studies, as we will explore in greater depth in the following sections.

As the theory gained traction in the late 1980s and the 1990s, additional researchers have started investigating potential phenomena related to death awareness through the TMT lens. As part of this growing prominence of the theory, in the late 1990s, an additional mechanism, which functions to ameliorate death anxiety, has been proposed – the ability to create meaningful, close personal relationships.

Human beings are a social species whose flourishing is closely related to the evolution of the social skills honed through successive generations for numerous millennia. Many psychological studies and theories have revolved around understanding the different features of our species' sociality, and an entire subdiscipline of psychology (i.e., social psychology), as well as full scientific disciplines (e.g., sociology, anthropology), emerged to address this central feature of our existence. In 1998, a pair of Israeli researchers, Victor Florian and Mario Mikulincer, proposed that one's ability to create and maintain nourishing personal relationships may also serve as a protective mechanism from the terrorising thoughts of our mortality.

One central theory in psychology that focuses on a person's ability to successfully maintain rewarding personal relationships is the Attachment Theory. John Bowlby (1969, 1973), one of the main conceptualisers of Attachment Theory, argued that early interactions with parents (and, at times, other caregivers) shape the orientations that influence impending relational functioning in myriads of manners. One suboptimal orientation encompasses individuals who display anxious attachment, which is characterised by fears of abandonment, rooted in negative views on the person's entitlement to be loved, casting long shadows on these individuals' existing strong desire for closeness and intimacy (Mikulincer & Shaver, 2007). Another presentation of a challenging attachment style is an avoidant attachment. The hallmarks of this orientation revolve around avoidance and self-sufficiency that manifest in common withdrawal from close, intimate relationships (for a review, see Shaver & Hazan, 1993). On the rewarding side of attachment orientations, or styles, people with a secure attachment style allow themselves to rely on close others when they need support, which manifests itself in a sense of security and safety (i.e., 'a sense that the world is generally safe'; Mikulincer & Shaver, 2007, p. 21).

Adult attachment styles were found to relate to the regulation of experiences of distress. Individuals with a secure attachment style regularly report the belief that they are capable of effectively coping with distress and challenging occurrences (e.g., Mikulincer & Florian, 1995; Shaver & Hazan, 1993), often through the use of support from close others. They also tend to avoid protectively twisting their views of the self, the stressful event, or the world around them (Mikulincer, 1997, 1998). On the other hand, insecure (avoidant or anxious-ambivalent) individuals seem to experience heightened levels of distress and lower levels of efficacy beliefs in their ability to cope with those events, often leading to reporting of distortions in their views of the self and the world (for a review, see Mikulincer & Florian, 1998). Thus,

attachment styles are involved in response to a wide array of threats that are unrelated to death. That said, as the foundation of the TMT is that death awareness presents a stressful event that lingers in the unconscienced mind, the distress-ameliorating features of secure attachment style – shown to apply for varied sorts of stressors – have been argued to also reduce defensive reactions identified by the theory, as it does in those other areas (Mikulincer & Florian, 2000).

The availability of the existential anxiety buffering defence mechanisms, according to TMT, allows us to function with relatively ease despite the hypothesised paralysing terror, even if, as we will see in the next sections, they may introduce various personal and societal costs at times. The question that arises, however, is what happens to individuals who are either inapt in their utilisation of these mechanisms or otherwise fail to reduce accessibility of death awareness?

Early TMT researchers (Simon et al., 1996) suggested that depression may arise through individuals' reduced ability to derive sufficient meaning from their cultural worldviews to gain a sense of symbolic immortality. Similarly, failure to successfully counter paralysing death awareness has been suggested to lead to different manifestations of anxiety disorders (Strachan et al., 2007). Strachan et al. (2007) argued that death thought accessibility increases phobic responses among individuals with such tendencies (e.g., heighten anxious reactions to spiders among arachnophobic individuals). They also suggested that a failure to manage death anxiety leads individuals with obsessive-compulsive propensities to experience an increased desire to regain control over their lives, manifesting in exacerbation of their obsessive and/or compulsive tendencies. These arguments also resonate with other researchers who maintained that obsessive-compulsive disorder stems from death anxiety, highlighting the central role death takes in most presentations of the obsessive-compulsive disorder (OCD), such as fear of death due to pathogens that is central to the compulsive washing subtype or the fear of violent home invasions that haunt compulsive checking subtype individuals (Menzies et al., 2015).

A sweeping argument has been made by Iverach et al. (2014) on the role of death awareness in psychopathology. Building on previous research and clinical observations, these researchers postulate that death anxiety is a central transdiagnostic construct underlying mental health pathology in its entirety. This audacious suggestion departs from, and subsumes, the common focus on specific psychopathological manifestations, such as anxiety disorder and depression, as independent phenomena, offering a new conceptualisation of mental illness as a whole. Iverach et al. (2014) highlights the common clinical observation that individuals who present for therapy with a specific disorder (e.g., fear of heights) may receive successful treatment for their condition just to later present with a completely different disorder (e.g., major depression), seemingly unrelated to their first diagnosed condition. Termed the revolving door of psychopathology, Iverach et al. (2014) suggest that death anxiety lies at the heart of the individual's struggle with mental illness, and thus, even successful treatment for specific manifestations in forms of particular disorders is insufficient, as the core underlying struggle – coping with death anxiety – is left unaddressed. This provocative argument may also prove to bring about a significant new direction in reducing the huge personal and societal tolls of mental

illness if true as there are indications that cognitive behavioural therapy can be effective in reducing death anxiety (Menzies et al., 2018b; also, see different voices and perspectives discussing treatments for death anxiety in Menzies et al.'s, 2018a, excellent edited volume).

## 3 Empirical Support for Terror Management Theory

Whereas Becker's (1973) account is theoretical in its approach, investigators who contribute to TMT-related research have focused on deriving testable hypotheses from the theory to assess whether its different tenants stand up to empirical scrutiny. This experimental approach resulted in a diverse set of studies spanning over 30 years and hundreds upon hundreds of experiments. These studies have taken place in a large number of countries and cultures, from North America (e.g., Dar-Nimrod, 2012), through Europe (e.g., Goncalves Portelinha et al., 2012) and the Middle East (e.g., Mikulincer & Florian, 2000), to East Asia (e.g., Heine et al., 2002) and Oceania (e.g., Menzies & Dar-Nimrod, 2017). The results of these studies most often find support for different phenomena explained most clearly through the TMT perspective, suggesting a seemingly universal psychological process in line with the sweeping claims made by the theory.

The experimental approach revolves around activation of death awareness and assessing specific outcomes, processes, moderators, and possible protective or exacerbating elements. However, our society in inundated with direct and vicarious reminders of death. Death is one of the most frequent features in daily activities, such as news consumption and television watching (e.g., DeSpelder & Strickland, 2002), and as such may be viewed as a chronically accessible theme, rendering any experimental activation superfluous, as one needs not make accessible what is readily accessible all of the time. However, TMT does not focus on the death construct in general; instead, the death awareness it discusses revolves around the intersection of death and self – the awareness of our own personal mortality. As such, not every mention of death would suit experimental activation needs; instead, researchers have used myriad ways to lead people to think about their eventual death, such as the completion of measures designed to assess fear of death and dying (e.g., Rosenblatt et al., 1989), television or movie clips, which focus on an individual's death through the use of the dying person's own point of view (Dar-Nimrod, 2012), presenting video clips containing fatal accident footage (Nelson et al., 1997), and even proximity to a funeral home (Pyszczynski et al., 1996). Among the different experimental death awareness activation methods, there is one that has been used most frequently; this method revolves around asking study's participants to reflect on their own death using a writing exercise task. This successful prime (commonly referred to as the mortality salience prime or MS prime for short) asks the participant to pen a very short essay in response to the following two questions: (a) 'Please briefly describe the emotions that the thought of your own death arouses in you', and (b) 'jot down, as specifically as you can, what you think will happen to you as

you physically die and once you are physically dead' (e.g., Arndt et al., 1998, p. 1218). Armed with appropriate tools to activate death thoughts, we can now look at various findings that have provided empirical support for TMT.

## 3.1 Evidence for the Effects of Proximal Reminders of Death

Proximal reminders of one's own death, according to TMT, lead to suppression and, thus, are not expected to lead to an increase in the accessibility of death cognitions. Greenberg et al. (1994) provided support for this claim with evidence that individuals who are asked to contemplate their own death showed increased accessibility of death thoughts only after they engaged in a different task (reading a mundane passage) after the contemplation. Individuals who completed the death thought accessibility measure immediately after the contemplation did not show a significant increased accessibility of those thoughts compared with individuals who were asked to reflect on a favourite television show.

The lack of accessibility of the death construct, however, does not mean that individuals are not affected at all by reminders of their own death. As one of the elements that accompanies suppression is denial, Greenberg et al. (2000) demonstrated that immediately following a death prime, individuals report their own dispositional levels of emotional expressiveness differently if they believed (based on experimentally induced bogus information) that this construct predicts longevity, such that their own expressiveness was more in line with longer survival. Individual in a control condition did not show the same protective pattern.

Apart from the often negatively viewed suppression and denial, research has also found beneficial outcomes from proximal reminders of death. For example, Routledge et al. (2004) found that women showed greater interest in protective sun exposure products immediately after a mortality salience prime, but not after a delay (nor did they find it when the women contemplated dental pain instead of death), showing positive health-behaviour intentions. Similar findings for other health behaviours were found (e.g., Arndt et al., 2003).

## 3.2 Evidence for the Effects of Distal Reminders of Death

Studies on the proximal effects of death awareness constitute a less dominant role in TMT-related research. The theory and the empirical research that follows mostly focus on the processes that take place once the death construct is supressed but ironically become more accessible outside conscious awareness. The theoretical distal defence mechanisms are then theorised to kick into gear to enable the person to manage their death anxiety. These mechanisms – self-esteem, worldview defence, and the ability to create and maintain close relationships – are widely researched, garnering much support for the theory in the last 30 years.

### 3.2.1 Evidence for the Protective Role of Self-Esteem

The ability to see oneself as a meaningful contributor to the world around us, to maintain positive self-views as a member of the culture we uphold as valuable, is one of the mechanisms that TMT postulates allow us to overcome our existential paralysis. Indeed, the first publication on the theory (Greenberg et al., 1986) was titled 'The causes and consequences of a need for self-esteem: A terror management theory'. The evidence in support of the role of self-esteem in ameliorating existential anxiety, however, is mixed.

Harmon-Jones and colleagues (1997) found that individuals with high self-esteem (either dispositionally or manipulated) did not have to resort to another defensive mechanism (i.e., worldview defence) to manage their existential anxiety following a distal MS prime. They also offered evidence that high self-esteem protected individuals from experiencing heightened death thought accessibility following the immediate suppression of the prime, seemingly allowing for the suppression to continue. This set of studies, along with others that produced similar support for the ameliorating properties of high self-esteem (e.g., Goldenberg & Shackelford, 2005; Kashima et al., 2004), provides support for this basic claim of TMT.

On the other hand, there is also evidence for the opposite phenomenon – high self-esteem amplifying people's worldview defence responses following a mortality prime. For example, McGregor et al. (2007) found that individuals with high self-esteem showed more zealous responses following such a mortality prime, compared with individuals with low self-esteem, indicating greater worldview defence reactions. Similar conceptual findings were demonstrated by others (e.g., Landau & Greenberg, 2006; Taubman-Ben-Ari & Findler, 2006).

In an attempt to reconcile these inconsistent findings, Schmeichel et al. (2009) investigated whether it is the nature of the self-esteem measured that may have caused this pattern. Previous studies on the role of self-esteem in TMT research utilised measures of explicit self-esteem, in which individuals traditionally self-report how positively they see themselves. Schmeichel et al. (2009) evaluated implicit self-esteem instead. Using measures that focus on how individuals associate themselves with positive features instead of how explicitly laudatory they are about themselves, they found that individuals with high implicit self-esteem (dispositionally or manipulated) tended not to resort to worldview defence after a mortality prime, while individuals with low implicit self-esteem did. In line with this research, in a summary of their meta-analytic findings on the role of self-esteem following mortality primes (MS), Burke, Martens, and Faucher (2010, p. 185) stated that '(i)n sum, self-reported self-esteem appears to increase the defensive response to MS, whereas self-esteem measured in more subtle ways—via manipulations and implicit measures—appears to diminish the response to MS'.

### 3.2.2 Evidence for the Protective Role of Cultural Worldview Defence

Arguably, the most intriguing construct in TMT is cultural worldview defence. The reason for the intrigue is that this construct subsumes numerous, diverse elements and phenomena, reflecting the richness of our cultures themselves. To show cultural worldview defence, one may demonstrate affinity to cultural values or symbols, practices or norms, and models or reputation. Alternatively, one may show greater proclivity to deride or reject norms or practices of other cultures. The richness of culture as a construct translated to cultural worldview defence being the most commonly studied element in TMT research.

The first empirical set of studies to assess the predicted use of cultural worldview defence following a mortality salience prime (Rosenblatt et al., 1989, Experiment 1) evaluated whether a reminder of our mortality, followed by a distracting task to allow that allows for the distal effects to emerge, is a classic example that highlights both the examined phenomenon and the methodological ingenuity that became a hallmark of many TMT-inspired studies. In the study, the researchers sent out study packages to 22 American municipal judges, in which half of them were asked to reflect on their own death and then to complete a filler task assessing their affect. All the judges were presented with a bail-setting task for the release of a women accused of prostitution (after the mortality prime for the judges who received these additional materials). The amount of the bail was considered an indication of punitive tendencies towards to accused. Prostitution is commonly viewed as a moral violation in the American (and many other) culture, so in line with TMT prediction that one would become more defensive of their (in this case moral) cultural worldview, it was expected that the judges who contemplated their death prior to setting the bail amount would be more punitive. The findings provided support for the prediction, as the judges in the death condition set up higher bail than those in the control condition. Particularly striking was the size of the observed effect. Despite the fact that municipal judges regularly set bail for alleged prostitution charges, the judges in the death condition set a bail amount that was nine(!) times larger ($455) than judges in the control condition ($50).

Similarly, TMT research has been used to demonstrate a litany of other defensive responses following distal mortality primes. It has shown people primed with their death demonstrating greater respect towards a person who lauds our national reputation or worthiness (e.g., Arndt et al., 1997; Greenberg et al., 1990), greater derision of a person who criticises it (e.g., Greenberg et al., 1990; Norenzayan et al., 2009), and finding increased culpability in a car accident for a foreign (vs domestic) car manufacturer, compared with control participants. Research also demonstrated increased aggression, following a mortality prime, towards individuals who oppose one of the most prominent features of our worldview – political persuasion (McGregor et al., 1998). In line with predictions that our Western culture encourages conspicuous consumption and thus death reminders should engender greater materialistic tendencies (Arndt et al., 2004), it has been demonstrated that people experience greater desire for materialistic goods (e.g.,

Dar-Nimrod, 2012; Mandel & Heine, 1999) after death reminders. These findings represent only a fraction of the myriad of relevant studies on the worldview defence effect, showing a more consistent pattern than the one found for the self-esteem effect (Burke et al., 2010).

### 3.2.3 Evidence for the Protective Role of Close Relationships

The latter addition to the defence mechanism from existential anxiety – secure attachment – has also received substantial empirical support. Mikulincer and Florian (2000) found that reminders of one's death led individuals with insecure attachment styles to show the expected increased derisive view of crimes (i.e., a worldview defence response) but did not significantly affect securely attached individuals. In the same vein, manipulating a sense of secure attachment led individuals to prefer a less violent approach for the worldview threatening terrorism (Weise et al., 2008).

In a recent review and meta-analysis of the empirical studies on the role of close relationship in attenuating the unsavoury effects of death awareness, Plusnin et al. (2018) found 73 empirical studies that evaluate this role. They concluded that 'people respond to MS by increasing efforts to initiate new close relationships and maintain preexisting ones by engaging in beneficial processes that foster intimacy and partner retention (e.g., increased commitment, forgiveness, intimacy striving, attraction, approach motivation, and adaptive jealousy) and preventing the manifestation of detrimental attitudes and behaviors (e.g., decreased fear of intimacy and rejection sensitivity)'. However, they acknowledged that these effects are not observed uniformly, stating that '(v)arious dispositional and situational factors inhibit peoples' intentions to gravitate toward close relationships for anxiety relief' (p. 335).

## *3.3 Evidence for the Role of Death Awareness in Mental Illness*

To assess support for the claim that death anxiety is a transdiagnostic construct that underlies mental illness rather than a relevant construct for a specific disorder only, we should find that the expression of the disorders (i.e., their symptoms) relates to the patient's fear of death. To establish this relationship, ideally, one would want to demonstrate two elements. First, we would predict that among individuals with a mental illness, their death anxiety correlates with the severity of their symptoms. Second, we would expect that priming patients with various mental disorders should lead them to exhibit disorder-specific elevation of symptoms.

To assess the first condition, exploring the relationship between death anxiety and psychopathology reveals numerous correlational studies that assessed the relationships between fears of death and symptoms' severity among individuals with various disorders. Death fears were assessed using a variety of measures, and the

findings provide ample indications that patients with different diagnoses who report greater death anxiety also experience more severe disorder-related symptoms. Whether they are diagnosed with schizophrenia (Lonetto & Templer, 1986), depression (Thorson & Powell, 2000), specific phobias (Menzies et al., 2019), general anxiety disorder (Menzies et al., 2019), separation anxiety disorder (Caras, 1995), obsessive-compulsive disorder (OCD; Menzies & Dar-Nimrod, 2017; also its various subtypes Menzies et al., 2020 for publication), body dysmorphic disorder (Menzies et al., 2019), post-traumatic stress disorder (Martz, 2004), somatic symptom disorder (Menzies et al., 2019), schizotypy personality disorder (Easden et al., 2019), alcohol use disorder (Menzies et al., 2019), or an eating disorder (Le Marne & Harris, 2016), a positive relationship was found between self-reported death anxiety and the severity of the disorder. In addition, a recent study found very substantial correlations between death anxiety and the psychopathology's severity (i.e., lifetime number of diagnoses, distress, depression, anxiety, and stress scores), ranging from $r = 0.55$ to $r = 0.75$(!), among a large treatment-seeking, clinical sample, consisting of individuals with various mental illnesses (Menzies et al., 2019).

The evidence for the second proposition, regarding the effect of priming mortality on mental health patients' symptomology, is much scanter at this time. Menzies and Dar-Nimrod (2017) found that priming death among patients with OCD (compared with priming dental pain) led individuals with the compulsive washing subtype to show increased cleaning behaviour when given the opportunity (e.g., longer washing time, increased use of soap). This difference was not found among compulsive checking subtype individuals whose symptoms do not relate to cleaning behaviours. Similarly, patients with a body scanning disorder (i.e., panic disorder, illness anxiety, or somatic symptom disorder) showed more dire self-evaluations related to bogus, purportedly health-relevant body indicators (e.g., one's teeth colour predicts their metabolism), following a death prime while taking longer time to assess their indicators (Menzies et al., 2021), compared with a non-death-related aversive prime (a visit to the dentist). This effect was not found among a different clinical group of patients whose symptoms are not related to health vigilance (i.e., depressed individuals). The nascent experimental work assessing the second claim also provides support for the transdiagnostic role of death anxiety in psychopathology, but there is a clear need for much more research in this space to be able to make confident claims.

### *3.4 Individual Differences in the Use of Defensive Mechanisms in the Face of Death Awareness*

As Plusnin et al. (2018) indicated above, dispositional elements play a role in the use of relational defences for death awareness (e.g., gender; Birnbaum et al., 2011). However, a host of additional individual differences have been shown to moderate responses to mortality primes in other domains as well.

Apart for previously discussed differences in theoretically foundational characteristics, such as self-esteem and attachment styles, studies have shown that a variety of traits and demographic variables attenuate responses to reminders of death. For example, following a mortality prime, age has been shown to moderate health-behaviours intentions (Bozo et al., 2009); political orientation moderated responses to politically relevant expressions of worldview defence (Greenberg et al., 1992); health optimism moderated health-behaviour intentions as a response to conscious thoughts about mortality (Arndt et al., 2006); authoritarianism moderated responses related to nationalistic reputation (Greenberg et al., 1990), as did subclinical depression (Simon et al., 1996); and perceptions of death moderated punitive responses towards social transgressors (Florian & Mikulincer, 1997). Thus, despite the lack of focus on individual differences (apart for self-esteem) in the original theory, subsequent experimental work provides a more nuanced picture, illuminating the role of personal characteristics in responses to mortality salience.

## 4 Criticisms of Terror Management Theory

An array of different studies has been reported challenging specific theoretical extensions of TMT, without necessarily undermining its foundation. For example, the heightened materialism hypothesis (Arndt et al., 2004) has been challenged by research in Africa on death rituals (e.g., Bonsu & Belk, 2003). Similarly, TMT's extension on the evolution of disgust (Cox et al., 2007; Goldenberg et al., 2001), has been challenged by other research and findings (Fessler & Navarrete, 2005).

A more condemning, recent research has targeted the heart of the empirical support for the theory. As part of a decade-long renewed focus on the replicability of psychological experimental research, commonly known as the 'replication crisis', researchers have attempted to conduct exact replications of TMT's previous, classic studies (e.g., Klein et al., 2019), finding that these previous effects did not replicate. Combined with the fact that many of the early classic TMT studies (e.g., Rosenblatt et al., 1989; Greenberg et al., 1990) demonstrated their effects using extremely small samples, which would have been impossible to publish in the leading journals they were published in today due to power concerns, these methodological concerns are quite substantial. However, more recent studies have found that these TMT effects were replicable when using sufficiently large samples (Chatard et al., 2020). Further, a meta-analysis of 277 experiments (Burke et al., 2010) found support for TMT's predicted effects on a myriad of variables, with little evidence of publication bias towards finding an effect that may indicate questionable research practices (although this meta-analysis was published prior to the breakout of the replication crisis and thus did not use the most updated analyses to assess such a bias).

Another distinctive feature of the research on TMT (but not only, e.g., Dar-Nimrod & Heine, 2011, for the heritability coefficient) is its lack of cultural representativeness. On the one hand, as indicated above, experimental support for the theory has been found in many countries across the globe. On the other hand, the

vast majority of this research has been conducted in WEIRD (Western, educated, industrial, rich, and democratic) societies that have been argued to provide poor representations of people as a species (Henrich et al., 2010). As the theory claims to capture some of the most basic psychological processes of our species, additional research with underrepresented samples from non-WEIRD societies, such as people from Africa, South Asia, South America, and perhaps most desirable people from hunter-gatherer societies, is sorely needed.

Finally, following Becker's (1973) lead, TMT's fundamental focus has revolved around death awareness. Its entire premise is established on the specific, unmediated claim that the combination of our unique ability for abstract thinking accompanied by a biological mortality imperative gives rise to paralysing existential terror. However, more recent theoretical accounts challenge the idea that it is the construct of death that uniquely leads to the numerous observed effects in TMT-inspired studies. Instead, these accounts suggest that the documented responses arise from a different fundamental construct, which death just happens to activate.

One such proposed alternative construct is uncertainty. McGregor et al. (2001, p. 473) argue that the 'main hypothesis is that when faced with the threat of personal uncertainty, participants cope by spontaneously emphasizing certainty and conviction about unrelated attitudes, values, personal goals, and identifications. A seemingly rigid and defensive way to do this might be to become more zealous about social attitudes and groups (i.e., going to extremes)'. As such, death is viewed as one (but not only) major cause for uncertainty (i.e., what happens to us when we die?), leading to what Claude Steele (1988, p. 267) termed 'fluid compensation' – a process in which a perceived threat in one domain (e.g., uncertainty) causes bolstering of existing beliefs in a different domain (e.g., reinforcing a cultural dogma). The Uncertainty Management Theory received support from various studies, showing, for example, that just like mortality salience led university students to greater denigration of a person critical of their institution (a common type of TMT finding), so did a prime that asked them to reflect on how our memories change and evolve through time, reducing our certainty about important events in our lives (McGregor et al., 2001, Study 3; for additional empirical support for the uncertainty construct, see also McGregor et al., 2010; Nash et al., 2011).

Another competing theory, which aims to subsume TMT by substituting the construct of death with an alternative, is the Meaning Maintenance Model (MMM; Heine et al., 2006). The theory contend that humans evolved to create mental representations of the world around them for survival purposes, and these representations (i.e., schema) create expectations about the world. When such expectations are threatened, existential concerns arise and different mechanisms may be set in motion to address the threatening experience (Proulx & Inzlicht, 2012); the fluid compensation process (Steele, 1988) is one of these mechanisms. The MMM does not only attempt to subsume TMT by arguing that death violates our intrenched schema of self-continuity (Heine et al., 2006) but also argues to subsume additional prominent psychological theories (e.g., cognitive dissonance; Randles et al., 2015). As in the case of Uncertainty Management Theory, the MMM provides ample empirical evidence, demonstrating that violations of existing mental representations

of the world, just like death, lead to compensatory processes, with cultural worldview defence being one (but not the only one) such process (e.g., Proulx & Heine, 2008; Proulx et al., 2010). They also demonstrate that a common pain relief medicine can reduce compensatory reactions to such existential concerns (whether they would be presented as a death prime or a schema's threat), offering a modern substitution for the evolved compensatory mechanisms, common to TMT and its competing theoretical accounts alike (Randles et al., 2013).

## 5 Summary

This chapter revolves around theoretical accounts for the effects that death awareness has on our affect, thoughts, and behaviour. Terror Management Theory, the most dominant psychological account of existential concerns, argues that the combination of our ability to contemplate our own mortality as a biological imperative and our organismic survival instinct leads to paralytic existential dread. It contends that evolved mechanisms – self-esteem, cultural worldview defence, and secure attachment style – allow us to overcome this paralysis through bolstering our self-worth, various cultural-promoting behaviours, such as denigrating violators of our cultural norms or reputation, or through seeking greater intimacy with close others. Empirical evidence supporting these suggestions, as well as delineating occasional moderators of the effects of death awareness, were also reviewed.

Whereas TMT faces its share of critiques, both methodological and conceptual, it has been one of the most generative theories in social psychology in the past 30 years, helping us illuminate many new directions relating to intergroup relations, intrapersonal processes, psychopathology development processes, and many other psychological phenomena. Even if future research will be able to provide conclusive evidence that one of the competing accounts to TMT (e.g., MMM, Uncertainty Management Model, the Compensatory Control Model; Shepherd et al., 2011) better captures the phenomena that have been discovered through mortality priming, the realisation that our death awareness can trigger such a variety of psychological responses will still remain as a vital part of our knowledge about the way that our mind works.

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# Fears of Death and Their Relationship to Mental Health


**Matteo Zuccala and Rachel E. Menzies**

**Abstract** The fear of death has been argued to be an important transdiagnostic construct, which underlies a wide range of psychological disorders. Death anxiety features centrally in many conditions, such as specific phobias, panic disorder, somatic symptom-related disorders, obsessive-compulsive disorder, and post-traumatic stress disorder. In addition, recent research highlights that death anxiety may even be associated with disorders that seem ostensibly unrelated to mortality, such as social and separation anxiety disorders, mood disorders, eating disorders, and psychotic disorders. In this chapter, we explore the evidence for the role of the fear of death in various mental health disorders. While theoretical understandings of the role of death anxiety in some conditions may need to be developed further, empirical research nevertheless supports its status as a transdiagnostic construct. Thus, it may be important to address underlying death anxiety in therapeutic interventions if treatment outcomes are to be maintained and the recurrence of further mental health problems is to be prevented.

**Keywords** Death anxiety · Psychopathology · Mental health · Anxiety disorders · Eating disorders · Somatic symptom disorders · Obsessive-compulsive disorder · Post-traumatic stress disorder · Social anxiety disorder · Specific phobias · Panic disorder · Agoraphobia · Mood disorders · Psychotic disorders

## 1 Introduction

In recent years, transdiagnostic constructs have gained increasing attention in clinical psychology. This is largely due to high comorbidity rates among mental health conditions, with studies finding that lifetime rates of mental illnesses are around

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double those of current disorders (Menzies et al., 2019; Simon et al., 2007). Further, Iverach et al. (2014) have described the "revolving door" often observed in mental health services in which a person may present with one disorder and receive an apparently effective treatment for this condition only to return to treatment at a later timepoint with a different disorder (p. 590). This clinical observation and supporting empirical data suggest that common threads underlying various mental health conditions may be unaddressed by current treatments.

One transdiagnostic construct that has been argued to play a role in this "revolving door" phenomenon is the fear of death. Death anxiety has been argued to underlie much of psychopathology (Iverach et al., 2014). For example, fears of death may create a sense of meaninglessness and loss of control and may result in maladaptive coping strategies such as avoidance (Yalom, 2008). Of relevance to this topic is Terror Management Theory (TMT), which is the leading theoretical perspective on death anxiety and human behavior. According to this account, humans have two main buffers against the terror of death: cultural worldviews and self-esteem (for a complete review of TMT, see chapter "Death Awareness and Terror Management Theory"). The majority of studies examining TMT have used a "mortality salience" design in which participants are primed with either a reminder of death or in the control condition, a topic that is unrelated to death. Recently, studies using the mortality salience paradigm have revealed that death anxiety drives a range of clinically relevant behaviors, demonstrating the causal role of this construct in mental health. In this chapter, we will review the theoretical and empirical evidence for the important relationship between death anxiety and psychopathology.

## 2 Anxiety Disorders

### *2.1 Specific Phobias*

Nearly a century ago, Kingman (1928) proposed that death anxiety lay at the heart of all phobias. Consistent with this idea, the most common specific phobias (e.g., heights, flying, spiders, snakes) all have the potential to directly result in death, an observation noted by evolutionary accounts for the development of phobias. Death anxiety has been argued to underlie various specific phobias by serving a protective function across the evolution of our species. For instance, needle phobias have been proposed to have evolved in humans in response to often fatal injuries sustained across our history from skin penetration (i.e., stabbing or piercing from teeth, claws, sticks, spears, and arrows; Hamilton, 1995). Similarly, in addition to the clear adaptive role a fear of spiders and snakes may serve, Mulkens et al. (1996) found that phobias of animals may have developed due to cultural associations concerning particular animals and increased risk of disease and contamination. Phobias of bodily fluids (e.g., blood, vomit) may be similarly explained by an evolutionary protection against death, with such fluids offering a risk of infection and illness.

Further, Veale (2009) argued that a specific phobia of vomiting might be driven by an individual's prior memories of vomiting that involved a feeling of suffocation, choking, or death. In light of these theoretical links between death anxiety and various specific phobias, some have argued that phobias develop as a means of focusing fears of death into a more concrete and manageable threat (Strachan et al., 2007). From this perspective, avoidance of the phobic object can be understood as a way of fending off death.

In addition to these theoretical arguments, a handful of studies have explored the relationship between death anxiety and specific phobias empirically. For example, de Jong and Merckelbach (1998) found moderate correlations between death-related disgust sensitivity (e.g., self-reported disgust in response to touching cremation ashes or a dead body) and both spider phobia severity ($r = 0.32$) and blood injury fear ($r = 0.30$). Further, one recent study found a large correlation ($r = 0.66$) between claustrophobia severity and death anxiety, among a small sample of individuals diagnosed with the disorder (Menzies et al., 2019). Another study involved asking participants with a specific phobia of heights to rate the likelihood of fatality from falling on a scale from 0 ("no injury") to 100 ("death") prior to and while climbing a ladder (Menzies & Clarke, 1995). The findings revealed that compared to control participants, those diagnosed with acrophobia were more likely to predict that a fall from a ladder would result in death, and their estimates of fatality significantly predicted their avoidance behaviors (i.e., the number of ladder rungs they chose not to climb; Menzies & Clarke, 1995). Similar results emerged from a follow-up study investigating the relationship between fatality estimates and avoidance of spiders among those with a spider phobia (Jones & Menzies, 2000).

Lastly, one experimental study investigated the causal role of death anxiety among individuals who met diagnostic criteria for a spider phobia (Strachan et al., 2007). Participants in the mortality salience condition showed greater avoidance of spider-related stimuli, as well as increased threat perception (i.e., rating spiders as being more dangerous to humans), compared to participants in the control condition. Notably, this effect was only found among those with a spider phobia, and reminders of death had no significant effect on behavior among the matched controls (Strachan et al., 2007). Thus, death anxiety has been experimentally shown to drive phobic responding among those with a fear of spiders. However, despite strong theoretical arguments drawing from evolutionary psychology, further research is needed to clarify whether death anxiety plays a causal role in other types of specific phobias.

## *2.2 Panic Disorder*

Death anxiety has been argued to play a central role in panic disorder (Furer & Walker, 2008; Starcevic, 2007). Verbal reports and clinical observations of those with panic disorder indicate that concerns around illness, such as worries about suffering a heart attack or collapsing due to panic attack symptoms, often lie at the

heart of the condition (Noyes et al., 2004). Existential concerns also manifest in the behaviors those with panic disorder often engage in, such as hypervigilance toward and monitoring of any possible signs of poor health (e.g., changes in heart rate), frequent medical testing and appointments with cardiologists, and excessive reassurance seeking from others.

Moving beyond clinical observations, empirical findings appear to suggest a relationship between fears of death and panic disorder symptoms. First, a large body of research indicates that hypochondriacal concerns feature heavily in panic disorder (e.g., Noyes et al., 2004; Starcevic et al., 2009). Regarding explicitly death-related concerns, one study (Starcevic et al., 1992) found that individuals with panic disorder reported scores on the thanatophobia subscale of the Illness Attitude Scales that were more than double community norms (e.g., Noyes et al., 1999). In addition, higher scores on this subscale were associated with more severe levels of an additional diagnosis of agoraphobia (Starcevic et al., 1992). Further, individuals with panic disorder have been shown to report significantly higher death anxiety compared to individuals with social anxiety and nonclinical controls (Furer et al., 1997). Radanovic-Grguric et al. (2004) similarly found that individuals with panic disorder reported significantly higher death fears compared to those with major depressive disorder (MDD) although results from a recent study did not appear to support this finding (Menzies et al., 2020, 2021a, b). In addition, a substantial relationship ($r = 0.80$) has been found between death anxiety and severity of symptoms among treatment-seeking individuals diagnosed with panic disorder (Menzies et al., 2019).

Some additional findings suggest that panic disorder emerges temporally alongside more pronounced death anxiety. Starcevic and Bogojevic (1997) found that 35.6% of participants with panic disorder and agoraphobia also reported at one point experiencing a "death-related phobia" (e.g., fear of funerals, cemeteries, or dead bodies). This study also found that a "death-related phobia" was more likely than other phobia types to share a year of onset with panic disorder (i.e., to emerge within the same 12-month period as the diagnosis of panic disorder). This led the authors to conclude that death anxiety is a risk factor for this disorder.

Emerging experimental findings have demonstrated that fears of death may in fact play a causal role in panic disorder. One recent study examined whether individuals with a "body scanning disorder" (i.e., panic disorder, illness anxiety disorder, or somatic symptom disorder) show increased anxious responding following mortality salience compared to those in a control condition and those with depression (Menzies et al., 2021a). Among the "body scanning disorder" group, 44% had a diagnosis of panic disorder, while the remaining participants were diagnosed with a somatic symptom-related disorder. This study found that for those with a "scanning disorder," reminders of death led to significant increases in time spent checking one's body for symptoms, perceived threat, and intention to see a medical professional in the next 2 months. This finding suggests that death anxiety plays a causal role in behaviors relevant to panic disorder, namely, hypervigilance, threat perception or catastrophic interpretations, and reassurance seeking.

Lastly, given the theoretical relevance of existential concerns in panic disorder, a small number of studies have explored treatments targeting these concerns. Starcevic

(2007) has argued that treatment for panic disorder should include modifying attitudes toward both illness and death. Further, in a single case study, Randall (2001) reported full remission of panic disorder following 3 weeks of existential therapy. Ishiyama (1986) has similarly described using existentially oriented therapy to reduce fear of death during panic attacks for a single case study. Of course, further research utilizing larger sample sizes and a control condition is needed to explore whether existential therapies may offer an advantage in treating panic disorder.

## *2.3 Agoraphobia*

Agoraphobia, an anxiety disorder defined by marked fear of specific (often public) situations, is often characterized by an overwhelming fear that escapes from such situations might be difficult, help may be unavailable, and thus that the individual is in mortal danger. It has consequently been suggested that underlying fears of dying may drive these individuals' fears of being in such situations (Iverach et al., 2014; Meyer, 1975). The onset of agoraphobia has been observed to often be preceded by traumatic events associated with death, such as a close encounter with death or the loss of significant others (Foa et al., 1984). Many of the fears reported among people with agoraphobia appear to be associated with death, such as an inflated anticipation of physical harm, heightened attention toward internal physical sensations, health-related worries, and intense fears of catastrophic events. It has been demonstrated that moderate and severe agoraphobia is associated with higher levels of death anxiety among patients with panic disorder (Starcevic et al., 1992). Unfortunately, however, there is an absence of experimental research in this area, limiting conclusions regarding whether death anxiety plays a causal role in agoraphobia.

## *2.4 Social Anxiety Disorder*

The diagnosis of social anxiety disorder is characterized by fears of negative social evaluation and interpersonal rejection by others. While social anxiety disorder is not the only disorder in which social fears are salient, they certainly feature most prominently in this condition. Self-report evidence suggests that while not as high as those with panic disorder, individuals with social phobia demonstrate significantly elevated levels of death anxiety compared to healthy populations (Furer et al., 1997). Large correlations between self-reported death anxiety scores and symptom severity among individuals diagnosed with social anxiety disorder have also been found (Menzies et al., 2019).

This self-report evidence is tempered by recent research, which suggests that it is important to understand how death anxiety relates to other transdiagnostic constructs if we are to understand its somewhat unclear role in social anxiety. Lowe and

Harris (2019) collected self-report data from 591 individuals and found that when controlling for intolerance of uncertainty and self-esteem, there was no significant independent relationship between death anxiety and social anxiety symptomatology. Recent research (Zuccala et al., 2021) found a significant correlation between death anxiety and trait social anxiety in a sample of participants with social anxiety disorder. Importantly though, this relationship was found to be strongly mediated by attachment anxiety, emphasizing the need to understand the role of attachment processes in the complex role of death concerns in social anxiety.

In addition to this preliminary self-report evidence, several empirical studies have examined the influence of death fears in social anxiety disorder. Strachan et al. (2007) found that when individuals high in self-reported social anxiety were reminded about death, compared to a control topic, they spent significantly more time avoiding a group discussion. The authors of this study concluded that reminders about death exacerbate behaviors associated with social anxiety for individuals with preexisting social fears. In a similar study, Finch et al. (2016) employed eye-tracking on an attentional bias task to examine whether death reminders increase avoidance of and hypervigilance toward socially threatening faces. While death priming did not affect social avoidance in this study, it did increase social hypervigilance for those already high in self-reported social anxiety.

Recently, Zuccala and Abbott (2020) sought to further explore the role of death anxiety in social anxiety disorder by confirming diagnosis with semi-structured clinical interviews (rather than relying on self-report questionnaires) and controlling for comorbid anxiety. Results from this study indicated that when individuals diagnosed with social anxiety disorder are reminded of death, they experience exacerbated physical anxiety (i.e., anxiety related to a task requiring the participant to inhale a gas) but *not* social anxiety (anxiety related to a public-speaking task). Further, this effect was not seen for individuals without social anxiety disorder. While these results did not support the basic presuppositions of Terror Management Theory, they nevertheless suggest an important role of death fears in social anxiety disorder.

As the current literature stands, it is clear that mortality concerns play an important role in social anxiety disorder. However, the exact process by which this occurs warrants further investigation. Nonetheless, these findings generally support the proposition that death anxiety plays a transdiagnostic role across anxiety disorders even when the cognitive focus of disorder seems unrelated to mortality.

## *2.5 Separation Anxiety Disorder*

Separation anxiety disorder, characterized by intense fears of separation from close loved ones, is another diagnosis in which the anxiety clearly centers on social processes. While it may initially appear that there is little direct connection between death fears and separation-related anxiety, an attachment theoretical perspective highlights how separation in early childhood would have been strongly related with

premature death for human children during our evolutionary history (Zuccala et al., 2021). It is thus unsurprising that there is a corpus of peripheral evidence that points toward a close connection between death anxiety and separation anxiety.

In a qualitative investigation in which participants were asked a single question – "Which aspects of death do you find most fearsome?" – Bath (2010) found that fears about being separated from loves ones featured most prominently. This study also discovered that individuals rated their fear of others' dying significantly higher than fear of their own death. A review of the death anxiety measurement literature similarly suggests that fears about being separated from loved ones is a central component of the "death anxiety" construct (Zuccala et al., 2019).

Nevertheless, despite the strong collateral evidence of an intimate connection between death and separation anxiety, studies using clinical samples remain sparse. Both death anxiety and separation anxiety have been shown to be elevated in clinical populations (Walser, 1985), and unsurprisingly, the two constructs are also positively correlated (Caras, 1995; Fleischer-Mann, 1995). Revisiting the attachment paradigm, higher death anxiety has been found to be associated with more insecure attachment (Caras, 1995). Specifically, death anxiety is strongly associated with attachment anxiety (but not attachment avoidance), which is defined by fears of separation from attachment figures (Zuccala et al., 2021). In all, it is clear that anxiety about separation from loved ones is intimately related to the fear of death, and this area of interest warrants further investigation.

## 3 Somatic Symptom-Related Disorders

Both empirical research and verbal reports from clients suggest that death anxiety may lie at the heart of the somatic symptom-related disorders. In conditions such as illness anxiety and somatic symptom disorder, which replaced the diagnosis of hypochondriasis in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013), death anxiety may manifest in a number of ways. These include preoccupation with the idea of suffering a fatal illness, excessive checking of one's own body for signs of poor health, increased likelihood of perceiving benign symptoms as threatening, and excessive reassurance seeking from medical specialists and requests for medical tests (Furer et al., 2007; Starcevic, 2005). Given the clear relevance of existential concerns to conditions such as health anxiety, fear of death has been proposed by numerous researchers to lie at the heart of the somatic symptom-related disorders (e.g., Furer et al., 2007; Hiebert et al., 2005; Starcevic, 2007; Stolorow, 1979).

A number of studies support the relevance of death anxiety to these disorders. One early study found that scores on the thanatophobia subscale of the Illness Attitude Scales among those with hypochondriasis were triple those of non-hypochondriacal psychiatric patients and six times greater than nonclinical controls (Kellner et al., 1987). Consistent with this, a study by Noyes et al. (1999) found that thanatophobia scores were significantly higher among those with hypochondriasis

compared to those without. Moderate to large correlations were also found between thanatophobia scores and two measures of hypochondriasis severity. In fact, out of 19 variables related to medical history (e.g., number of hospitalizations, serious injuries, operations, and doctor visits), the correlation between thanatophobia and scores on the Whiteley Index assessing hypochondriasis was eclipsed in size only by "satisfaction with health" (Noyes et al., 1999).

While much of the research has been based on those diagnosed with hypochondriasis, similar results have been found when using the more recent DSM-5 criteria (APA, 2013). That is, large correlations have been found between death anxiety and severity of both illness anxiety ($r = 0.75$) and somatic symptom disorder ($r = 0.62$; Menzies et al., 2019). Beyond these two disorders, death anxiety has also been shown to be relevant to those with medically unexplained symptoms (MUS). Among a sample of 68 individuals with MUS, 33% reported a fear of death when asked what they fear most about their unexplained symptoms (Sumathipala et al., 2008). When participants were asked about the severity of their symptoms, qualitative responses included "I will die and if so what will happen to the children?" "[I] won't live much longer" and "It may be cancer…My mother also died of cancer" (Sumathipala et al., 2008, pp. 4–5). These findings suggest the relevance of death fears to other somatic symptom-related disorders outside of hypochondriasis, such as functional neurological symptom disorder.

In addition to these cross-sectional findings, experimental evidence demonstrates that death anxiety drives a range of behaviors relevant to somatic symptom-related disorders. That is, as described above, reminders of death have been shown to increase time spent checking one's body for symptoms, threat perception, and intention to visit a GP (Menzies et al., 2021a). These results were found among a sample in which the majority of participants were individuals seeking treatment for either illness anxiety disorder or somatic symptom disorder.

Lastly, it has been argued that treatments for hypochondriasis may need to specifically address death anxiety as a core construct (Furer et al., 2007; Hiebert et al., 2005; Menzies et al., 2021a; Starcevic, 2005). For instance, Furer et al. (2007) propose a number of cognitive behavior therapy (CBT) strategies for reducing fears of death among those with health anxiety. These include in vivo and imaginal exposure to death-related situations, images, and themes (e.g., visiting hospitals or cemeteries, watching films exploring death, reading news articles featuring death, or writing one's own will or eulogy). At present, only one study has examined the effects of a treatment targeting death anxiety in a sample diagnosed with hypochondriasis. Hiebert et al. (2005) conducted a trial of CBT for death anxiety among 39 individuals diagnosed with hypochondriasis. Participants were randomly allocated to a group CBT treatment or a waitlist control. Those in the CBT condition received standard treatment components for the disorder (e.g., reduction of checking behaviors and reassurance seeking) in addition to novel components specifically targeting death anxiety. These included exposure to death-related situations and images, strategies to help increase acceptance of death, and cognitive challenging of beliefs toward death. At posttreatment, the CBT group demonstrated significant reductions in both fears of death and symptoms of hypochondriasis compared to the control

condition (Hiebert et al., 2005). While this promising finding suggests the relevance of fears of death to treatments for somatic symptom-related disorders, it remains to be seen how death anxiety treatments will compare to active control conditions in addition to how they will perform in larger-scale trials. The inclusion of standard hypochondriasis treatment components in the CBT condition (e.g., reducing bodily checking) also limits the conclusions that can be drawn regarding the potential additive benefit of the novel death anxiety components. Thus, while a body of research highlights the causal role of mortality concerns in the somatic symptom-related disorders, further research is needed to examine whether addressing these concerns may lead to overall symptom improvement.

## 4 Obsessive-Compulsive Disorder

Fears of death have been argued to underlie many manifestations of obsessive-compulsive disorder (OCD; Menzies et al., 2015). For example, individuals who engage in compulsive handwashing typically attribute their behavior to attempts to ward off fatal illnesses that could be contracted through contamination from germs. Similarly, the compulsive checking of stovetops, electrical outlets, and door and window locks is usually described as an attempt to prevent fire, electrocution, and household invasion.

Consistent with these theoretical accounts, strong relationships between death anxiety and overall OCD severity have been found across multiple studies using clinical samples, with estimates ranging from $r = 0.33$ to $r = 0.80$ (Menzies et al., 2019; Menzies & Dar-Nimrod, 2017). Further, this relationship does not appear to be restricted to only one manifestation of OCD. One recent study demonstrated significant correlations between death anxiety and the symptom domains of contamination, checking, obsessions, hoarding, indecisiveness, and need for things to be "just right" (Menzies et al., 2020). In addition, levels of death anxiety appear to predict the trajectory toward OCD. That is, individuals with higher death anxiety have been shown to experience more disorders prior to developing OCD (Menzies et al., 2021b). On the other hand, those with lower death anxiety are significantly more likely to develop OCD as their first disorder. These findings suggest that for highly death anxious individuals, OCD may be just one of many manifestations of this underlying fear.

At present, two experimental studies have demonstrated that fears of death may drive behaviors relevant to OCD. Strachan et al. (2007) found that reminders of death led to significant increases in handwashing among a student sample scoring high on compulsive washing. This study was replicated and expanded by Menzies and Dar-Nimrod (2017), utilizing a large sample of treatment-seeking individuals diagnosed with OCD. The findings revealed that among compulsive washers, reminders of death led to double the time spent handwashing in addition to significant increases in soap and paper towel usage. Notably, these effects occurred despite no significant difference in reported perceived cleanliness between the mortality

salience and control conditions, suggesting that the reminders of death produced behavioral change not explained by conscious threat expectancies. Thus, death anxiety has been shown to have a clear causal role in the contamination type of OCD. However, it remains to be seen whether reminders of death can exacerbate other OCD behaviors (e.g., compulsive checking), consistent with theoretical expectations.

## 5 Post-Traumatic Stress Disorder

The role of death anxiety in post-traumatic stress disorder (PTSD) is relatively clear – exposure to life-threatening events leads to beliefs about the world being unsafe and elevates one's fear of dying (Chung et al., 2005). Unsurprisingly then, it is well established that self-reported levels of death anxiety are significantly correlated with overall severity of PTSD (Hamama-Raz et al., 2016; Hoelterhoff & Chung, 2017; Vail III et al., 2019). Death anxiety has also been found to be associated with each of the three distinct symptom categories of PTSD – reexperiencing, avoidance, and hyperarousal (Martz, 2004; Safren et al., 2003).

The role of death-related fears in this disorder is evidently pronounced, leading several authors to emphasize the importance of addressing such fears in treatment for PTSD (Iverach et al., 2014; Martz, 2004). Some researchers have also pointed out that the level of death anxiety experienced *at the time* of trauma seemingly has an effect on the severity of PTSD later developed (Tural et al., 2001). Psarros et al. (2017) have consequently proposed that the "fear of imminent death" may play a distinct and important role in our understanding of post-traumatic responses.

TMT conceptualizes PTSD as a disruption of the buffering mechanisms typically employed to ward off underlying death anxiety (Kesebir et al., 2011; Maxfield et al., 2014). In support of this, research shows that participants with high post-traumatic stress do not show typical suppression effects when exposed to death reminders (Chatard et al., 2012). Death reminders have also been found to exacerbate trauma symptoms for individuals with high exposure to war (Chatard et al., 2012). It should be noted, however, that recent investigation seems to challenge the notion that these buffering mechanisms account for variations in the relationship between death anxiety and PTSD symptom severity (Herr, 2018). Nevertheless, the literature strongly supports the robust relationship between death anxiety and PTSD, suggesting that treatment targeting death fears may be a promising direction for clinical interventions.

## 6 Mood Disorders

There is a strong tradition of existential approaches toward treating depressive disorders, and many of these existential therapies emphasize the profound death-related fears that underlie these pathologies (Ghaemi, 2007; Stålsett et al., 2012). Early psychotherapy case studies have highlighted the importance of treating anxiety about dying for individuals suffering from depressive disorder (Chait, 1998; Hussian, 1983), and recent research supports these approaches, highlighting the connection between self-reported death anxiety and the experience of depression. Not only have elevated death anxiety scores been associated with increased depressive symptomatology (Miller et al., 2012; Ongider & Eyuboglu, 2013; Thorson & Powell, 2000), but authors have proposed that "death depression" be considered a significant construct of its own, given its close association with underlying fears of dying (Nassar, 2010).

In particular, death anxiety seems to play a prominent role in the development and maintenance of depression for individuals who may be "close to death" – either in age or in health status. The fear of death has been found to be moderately correlated with depression in elderly populations aged 60 or older (Bektaş et al., 2017). In corroboration, Bala and Maheshwari (2019) found that the very large majority (87%) of elderly individuals demonstrated moderate or severe "death depression," which was strongly associated with death anxiety (correlation of $r = 0.48$).

Death anxiety is similarly associated with the experience of depression in individuals suffering from terminal illnesses. Various life-threatening medical conditions seem to strengthen the connection between death anxiety and existential depression (Atalay et al., 2019; Eggen et al., 2020; Grabler et al., 2018). For example, cancer patients with death anxiety were found to have higher rates of axis I psychiatric disorders (including major depressive disorder) as well as elevated levels of depressive symptoms (Gonen et al., 2012; Krause et al., 2015), suggesting that the approaching threat of death exacerbates one's hopelessness about the future.

From a TMT perspective, major depression is caused by fragile buffers, limiting an individual's ability to invest in cultural worldviews, self-esteem, relationships, and ultimately their ability to cultivate meaning in their lives (Maxfield et al., 2014; Simon et al., 1998). As such, it has been proposed that individuals with underlying depressive pathologies require stronger buffering mechanisms to defend against the existential terror of mortality anxiety, and indeed, empirical evidence supports this. Employing the mortality salience paradigm, Simon et al. (1996) demonstrated that in response to death reminders, individuals with depression exhibit greater worldview defense mechanisms in comparison to nondepressed individuals. As such, TMT theorists propose that bolstering worldview beliefs may increase overall life meaning among depressed individuals and be an important approach toward treatment for this common mental illness.

## 7 Eating Disorders

Despite being relatively understudied compared to other disorder types, the relationship between death anxiety and eating disorders has been explored in a handful of studies. For example, Alantar and Maner (2008) argue that a fear of weight gain may serve as a defense against a fear of mortality, while others have noted that individuals with eating disorders often have a preoccupation with death and annihilation (Farber et al., 2007). However, only a few studies have empirically demonstrated this connection. Giles (1995) demonstrated that women with anorexia nervosa reported significantly higher death anxiety toward both themselves and others, compared to age- and gender-matched controls. In addition, one recent study found that death anxiety significantly predicted self-reported disordered eating behavior even after controlling for perfectionism, self-esteem, and age (Le Marne & Harris, 2016). Further, perfectionism was only a significant predictor of disordered eating when death anxiety and self-esteem were not included in the model. This is particularly notable given long-standing theoretical arguments that perfectionism plays a central role in eating disorders (e.g., Fairburn et al., 2003), and these recent findings attest to the unique rule of fears of death in relevant symptomatology.

Although limited conclusions can be drawn from such correlational and cross-sectional designs, they appear to be supported by experimental findings. Across a series of experimental studies, Goldenberg et al. (2005) found that death anxiety plays a causal role in behaviors relevant to eating disorders. Specifically, after being reminded of death, female participants ate significantly less during a subsequent "taste-testing" task. Experiencing a death reminder also led them to rate themselves as being further from their ideal thinness. Notably, this effect was only found among women, and mortality salience did not affect these behaviors among male participants. This finding further supports the argument that death anxiety may drive individuals to strive for the body shape valued by their culture (i.e., thinness for women in Western societies) as a way of increasing one's self-esteem and protect oneself from existential concerns (Goldenberg et al., 2005).

## 8 Psychotic Disorders

Over the last few decades, some researchers have proposed an association between fears of death and psychosis. For example, omnipotent delusions and hallucinations have been proposed to be a defense mechanism in the face of one's own impermanence and insignificance in the face of death (Searles, 1961). Supporting this idea, one review of psychiatric records of 205 individuals with schizophrenia found pronounced preoccupation with death and annihilation (Planasky & Johnston, 1977). In a similar vein, Walser (1985) demonstrated that individuals with schizophrenia reported significantly higher death anxiety compared to controls. Further, positive correlations have been found between death anxiety and schizophrenia symptoms

among hospitalized psychiatric patients (Lonetto & Templer, 1986). In one recent study, Easden et al. (2016) investigated the relationship between death anxiety and schizotypy (a personality dimension measuring one's proneness to psychosis). The results demonstrated that death anxiety significantly predicted schizotypy even after controlling for trait anxiety. Lastly, a series of case studies described psychotic patients frequently expressing concerns surrounding themes of mortality and other existential concerns and reported full recovery following existential therapy (Williams, 2012). Thus, a handful of studies have demonstrated an association between psychotic disorders and existential issues, including death anxiety. However, further research is clearly warranted to further explore this relationship and ascertain whether death anxiety may play a causal role.

## 9 Treatment Implications

Increasing evidence suggests that death anxiety plays a role in a range of different mental health conditions, cutting across a number of diagnostic constructs. Theoretical and empirical evidence suggests that death anxiety may be a relevant construct in eating disorders, trauma-related disorders, mood disorders, and psychotic disorders. In addition, findings drawn from both correlational and experimental studies suggest that fears of death play a causal role in a number of anxiety disorders, somatic symptom-related disorders, and obsessive-compulsive disorders.

Given the demonstrated prevalence of death anxiety across these conditions, treatments may need to specifically target this fear in order to see long-term amelioration of symptoms. Current standard treatments typically do not address the fear of death directly, often instead focusing on reducing the client's estimated probability of dying from one cause or another. For instance, cognitive challenging may be conducted to disprove the client's estimated likelihood of dying from a plane crash in the specific phobias. Similarly, for a client with panic disorder, treatment may involve behavioral experiments to "test out" the individual's belief that a change in heart rate is indicative of a heart attack. Treatments that focus solely on targeting the "proximal threat" (e.g., the plane crash or the heart attack) fail to address the underlying fear of death itself, the probability of which still remains certain despite the result of various standard CBT tasks. That is, while the client's panic disorder or fear of flying may be effectively eliminated, their death anxiety may potentially manifest in a different mental health condition in the future. Thus, standard CBT treatments that focus on disputing the client's current threat appraisals may be perpetuating the "revolving door" phenomenon and failing to prevent the accrual of further mental health problems across the life span. Treatments that specifically address death anxiety may be needed in order to ensure symptom improvement in the long term.

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# Creative Approaches to Treating the Dread of Death


**Rachel E. Menzies and David Veale**

**Abstract** A growing body of research suggests that death anxiety may underlie numerous mental health conditions. Given this, it is essential to develop treatments that specifically target fears of death. This chapter first outlines how to effectively assess for death anxiety using a clinical interview and self-report measures. Next, various approaches to treating death anxiety are explained with a particular focus on CBT-based techniques. Meta-analytic findings demonstrate that cognitive behavioural therapy (CBT) is the most effective treatment for death anxiety, producing significant reductions in this fear. In particular, exposure therapy has been shown to be effective at reducing fears of death. Given this, novel death-related exposure tasks, such as the use of films, music, games, and apps, are highlighted. In addition, strategies such as cognitive challenging, behavioural experiments, and imagery rescripting are discussed. Treatment approaches that normalise death and help to cultivate an attitude of neutral acceptance of death may be particularly useful. However, the efficacy of many of these techniques for death anxiety remains to be seen. Further research is needed to determine whether these strategies will significantly reduce death anxiety among those with mental health conditions and whether this will in turn produce broad improvements in psychopathology.

**Keywords** Death anxiety · Cognitive behaviour therapy · CBT · Assessment · Measurement · Exposure · Behavioural experiments · Psilocybin-assisted psychotherapy

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## 1 Introduction

In recent years, increasing theoretical and empirical evidence suggests that death anxiety may be a transdiagnostic construct, underpinning a range of mental health conditions (Iverach et al., 2014; Menzies et al., 2019). Given this, standard treatments that fail to directly target fears of death, instead focusing on the client's presenting problem at any given time, may in fact be contributing to the "revolving door" often seen in mental health (Iverach et al., 2014, p. 590). That is, it is not uncommon for an individual to experience one mental illness, to receive effective treatment for this particular condition, only to return to therapy later in life with an altogether different disorder and set of symptoms. If death anxiety is truly underlying these conditions, then fears of death may need to be directly treated in order to see long-term improvement in symptoms and to reduce the likelihood of future disorders. However, if death anxiety is truly an existential given, and "the worm at the core" of the human condition (James, 1985), is it even something that can be reduced with treatment?

Fortunately, the evidence indicates that psychological interventions that reduce fears of death do exist. One recent meta-analysis of randomised controlled trials (RCTs) for death anxiety found that cognitive behaviour therapy (CBT) was particularly efficacious, producing significant improvements in fears of death compared to control conditions (Menzies et al., 2018). Notably, other therapies did not produce such a reduction, nor did death education programs (i.e., workshops that aim to inform relevant health professionals of death-related information). The five CBT interventions included in the meta-analysis typically focused on graded exposure, both imaginal and in vivo, to death-related stimuli. Based on these results, exposure therapy currently appears to be the most effective means of treating fears of death. However, it should be noted that at present, there have been no RCTs examining the effects of such interventions on death anxiety in samples diagnosed with mental health conditions. The vast majority of RCTs have used convenience samples consisting of students or those in health professions (e.g., nurses) with a minority of studies involving cancer patients.

Notably, one trial of CBT for patients with advanced cancer who were clinically depressed found no difference between CBT and treatment as usual (Serfaty et al., 2020). Although existential issues were discussed as they arose, fear of death was not a primary focus. Although therapists were trained to have discussions about death and dying (Serfaty et al., 2019), 90% of therapists did not address the issue of dying in palliative care (Serfaty et al., 2020). Qualitative interviews with therapists suggested they may have avoided discussion of death and dying (Hassan et al., 2018). This may have been because they were not relevant. However, patients and therapists did not discuss existential issues when ACT was delivered to people with advanced cancer (Serfaty et al., 2018). The impression was that both therapists and patients were avoiding touching on issues around death and dying.

Given that the topic of death anxiety escapes the focus even of studies investigating terminal illness, the scarcity of studies examining this construct in mental health

samples is perhaps unsurprising. As such, RCTs that explore whether the effects of CBT found in non-clinical samples do indeed generalise to those with mental health problems are sorely needed. Despite this, the finding across multiple studies that treatment can effectively reduce death anxiety may indicate hope for improvement among those with more severe fears. Given this, what might such treatments look like?

## 2 Assessment

### *2.1 Clinical Interview*

#### 2.1.1 Screening for Death Anxiety

In order to treat fears of death, a detailed clinical interview exploring the client's life history and emotional, behavioural, and cognitive responses to death is essential. In addition to standard questions a clinician may ask in the first assessment session, the topic of death should be discussed specifically when death anxiety is seen as potentially relevant. A simple screening question such as "Do you ever worry about your own or another person's death?" can be used to introduce the topic. Where there is sufficient information to suspect that the client's behaviours are driven by death fears (e.g., this will often be the case for presentations related to health anxiety, panic disorder, specific phobias, and many subtypes of OCD), this connection can be presented to them for their feedback (e.g., "What relationship do you see between fears of death and your current experience?"). This will then allow further assessment of the topic of death specifically and help provide a rationale for delving deeper into this area.

It is essential to try and understand the nature of the client's fear, and time should be spent exploring their specific worries (e.g., "What exactly are you frightened of?"). For example, do their fears centre on their own death or that of loved ones? Do the worries revolve around some aspect of the dying process, such as pain, or loss of mental faculties or physical capabilities at the end of life, or does the individual instead fear non-existence itself? Is the client worrying about not knowing whether or not there is an afterlife or about their belief in eternal punishment after death? Do they fear a fate worse than death, such as being buried alive, or existing in a parallel world or different plane of existence? Identifying specific worries surrounding death and dying will be a crucial step in order to assist with directly reframing unrealistic or unhelpful beliefs later in treatment. It is important to assess the degree of preoccupation and the nature of these processes. For example, "For how many minutes or hours a day is death at the forefront of your mind?" More than an hour a day would be regarded as a preoccupation. It is important to then identify the nature of the cognitive processes, such as rumination, worry, comparing, or self-criticism.

### 2.1.2 Emotional, Cognitive, and Behavioural Responses

This assessment should examine the specific emotions clients feel surrounding death (e.g., "When you think about death, what feelings does it bring up for you?"). This line of questioning may help elicit the types of thoughts or images the client has about death. For example, a client expressing fear is likely to be experiencing catastrophic and unhelpful predictions about death (e.g., "dying is going to be painful", or "I'll fall apart when my partner dies"), whereas a client expressing anger is likely to be experiencing some thoughts associated with "should" thinking (e.g., "I shouldn't have to lose those I love", or "life should be longer").

One transdiagnostic concept that appears relevant for many people with death anxiety is the intolerance of uncertainty. It refers to the subjective negative emotions experienced in response to the unknown aspects of a given situation (Dugas et al., 1997; Freeston et al., 2020). Thus, for some individuals, it is not the threat of going to hell, heaven, or nothingness. These events involve "aleatory" uncertainty that we cannot know in advance (rather than epistemic uncertainty, where some facts are known, but there is ambiguity). The possibility that there may be life after death can be just as unsettling for someone with an intolerance of uncertainty as the possibility that there may be no life after death or hell. For these individuals, it is not the valence of what happens, simply the inability to know. This may lead to them trying to obtain further information, but this is often contradictory and leads to further doubts and intolerance of uncertainty.

As in any comprehensive assessment, the client's responses to their fears will also be crucial to identify. These can be broadly divided into (1) marked avoidance of reminders of death, (2) marked time and effort to obtain certainty and control around death, and (3) marked procrastination in decision-making linked to death.

1. Avoidance of reminders of death (e.g., of watching the news, going to hospitals, or suppressing thoughts related to death, making one's will) or of things believed to increase the likelihood of death (e.g., driving, flying, doing activities that increase one's heart rate or going to sleep) will often feature in these presentations. Experiential avoidance may also manifest in excessive attempts to distract oneself or keep oneself busy, or self-medicating, such as through substance use.
2. Other behaviours that are associated with trying to obtain certainty include mental review of information, excessive reassurance seeking (e.g., frequent visits to medical specialists), and checking (e.g., of information about dying on the Internet or physical symptoms and/or internal sensations that may signal the end). Overcompensatory behaviours, such as excessive exercise, vitamin supplementation, or investing a lot of time into nutrition or physical wellbeing, may also be reported. Other clients may overcompensate and try to plan every detail of what will happen at their funeral or in the execution of their will and other consequences. Because they are not in control over such events, they may seek excessive reassurance that everyone will comply with the instructions and have further doubts when they do not trust their executors or receive ambiguous information.

3. When there is a high level of intolerance of uncertainty, there may be marked procrastination and avoidance of making any decision, such as making one's will or expressing any wishes about funeral arrangements.

### 2.1.3 Life History

Assessment should naturally include taking a standard life history, including the individual's early life experiences, relationships with caregivers, major life events, and so forth. It is also essential to enquire about what led the client to therapy. That is, why are they seeking treatment now? Has there been a clear trigger, such as a recent loss or diagnosis of an illness, or is the trigger for the most recent episode unknown? In addition to this, an assessment should also enquire into the individual's experiences of death and loss, which may include near-death experiences or confrontations with physical threats. For instance, do they remember any early losses in their life? If so, how did they respond? How significant was the loss? How did those around them respond to the loss at the time?

Enquiring into conversations the individual remembers in early childhood or memories of what they were taught about death as a child may also provide useful information. Being aware that an individual grew up in a household where death was never talked about, or conversely, talked about by caregivers in catastrophic ways (e.g., death may be just around the corner), will assist the clinician in understanding factors that may have contributed to their current pronounced fear. Attitudes towards death held by those close to the client may also be relevant when considering the support the client will have for later exposure tasks; for example, an individual whose family has historically refused to discuss death may present some resistance to a client's exposure task of discussing their own end-of-life preferences.

### 2.1.4 Protective Factors

In addition to assessing factors that appear to be driving or maintaining the anxiety, examining protective factors is also valuable. For example, information about the individual's religious beliefs (or lack thereof) is often highly relevant as these beliefs may serve to buffer (i.e., through beliefs in life after death) or exacerbate (i.e., through beliefs about eternal punishment or damnation) anxiety surrounding death. This can be done through an open-ended question such as "What do you think happens to you when you die?" Naturally, the goal in assessing religious beliefs is to explore what factors may be shaping the individual's views about death rather than challenging their worldview and spiritual beliefs. This is particularly the case for the many individuals for whom religious beliefs appear to play a protective role and allay some of their anxiety. In order for therapists to understand the client's belief system and the role it plays for them, finding a good authority on beliefs about death in different religions may be valuable.

One factor that has been proposed to buffer fears of death is meaning in life, with one study finding that death reminders only increased state death anxiety for those who lack a sense of purpose (Routledge & Juhl, 2010). Given this, a question such as "What makes your life purposeful or meaningful right now?" (or, for those who report feelings of meaninglessness, "What do you think would help life feel more meaningful?" "Can you think of a time when you had a sense of purpose in life? What did your life look like at that time?") will likely prove useful. Assessing the client's sense of purpose also provides valuable information when considering treatment possibilities as those reporting feelings of meaninglessness may benefit from working on values-based living, in line with strategies from Acceptance and Commitment Therapy (Hayes & Smith, 2005).

### 2.1.5 Establishing Treatment Goals

Working with the client to establish clear and practical therapy goals is often useful to guide treatment and determine treatment success. These should be established collaboratively, and individuals should be encouraged to develop realistic goals based upon their values and what they have been avoiding. It is important to keep in mind the universality of death anxiety, and clients should be steered away from aiming to rid themselves of anxiety or other unpleasant emotional responses entirely. Instead, realistic goals around acceptance or reducing anxiety and its impacts on one's life should be encouraged (e.g., reducing the time they spend worrying about death each day or finally being able to visit a loved one in hospital despite some anxiety).

## *2.2 Measures*

In addition to the clinical interview, administering a relevant questionnaire can prove useful in both gathering more information about client's worries and measuring the severity of their distress. Currently, few measures have been validated in clinical samples (for a systematic review of death anxiety measures, see Zuccala et al., 2019). However, despite the need for future measures, which are more psychometrically sound, the following measures may be recommended for use in clinical practice.

### 2.2.1 The Collett-Lester Fear of Death Scale–Revised (CLFDS-R)

The CLFDS-R (Lester, 1990) is a 32-item measure of death anxiety with four subscales: death of self (e.g., "the total isolation of death"), dying of self (e.g., "the pain involved in dying"), death of others (e.g., "the loss of someone close to you"), and dying of others (e.g., "having to be with someone who is dying"). Most notably for

clinical practice, the CLFDS-R is the only measure to demonstrate responsiveness to treatment, suggesting that it may be the most valuable measure for examining client change (Zuccala et al., 2019).

#### 2.2.2 The Multidimensional Fear of Death Scale (MFODS)

The MFODS (Hoelter, 1979) is a 42-item measure with eight subscales: fear of the dying process, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death. Although the MFODS is one of the longer measures of death anxiety, the numerous subscales are useful to provide a more detailed portrait of the individual's specific fears surrounding death. The MFODS is the only death anxiety measure at present for which clinical means exist for multiple disorders (MFODS means are reported for 12 different disorders in Menzies et al., 2019).

## 3 Treatment Approaches

There are a number of treatment approaches that can be utilised for addressing the fear of death. In order to introduce the rationale for treatment and build motivation, it may be helpful to provide the client with an overview of death anxiety and its treatment (see further, Furer et al., 2007, pp. 151–153; Willson & Veale, 2009). Working with the client to help develop a formulation of their difficulties, based on the information gathered during the assessment, is also crucial. A comprehensive formulation and understanding of the problem will not only help guide treatment but will also help provide the client with a rationale as to the purpose of treatment and what maintaining factors will be specifically targeted.

### *3.1 Cognitive Approaches*

As the Stoic philosophers observed 2000 years ago, "it is not things themselves that trouble people, but their opinions about things" (Epictetus., 2018, p. 11).[1] This underlying principle shared by Stoic philosophy and CBT emphasises that it is our beliefs about events that cause us distress, not the event itself. This shared principle is just as relevant to fears of death as it is to any other subject of fear. Each of us have particular beliefs and attitudes towards death, and these beliefs will be associated with feeling anger, sadness, calm, or fear in the face of it. Importantly, some of our

[1] Interestingly, Epictetus immediately follows this claim with using death as an example: "Death, for instance, is nothing terrible (otherwise it would have appeared that way to Socrates as well), but the terrible thing is the opinion that death is terrible" (p. 11–13).

beliefs about death may be adaptive, such as the belief that death is universal and thus not to be feared or that we would be understandably distressed with the death of a loved one but would ultimately cope. Of course, there are a number of unhelpful or unrealistic beliefs one could also hold towards death, such as viewing death as unnatural, unfair, necessarily painful, or something that one must control. Such beliefs will understandably create distress for the individual endorsing them. Given this, the goal of cognitive therapy in this area is to assist the individual in coming to a more balanced and realistic view of death, to assist in cultivating an attitude of "neutral acceptance", a construct that has been shown to predict reduced fear (Tomer & Eliason, 2000).

For this purpose, careful assessment of the client's own particular beliefs is essential in order for those that are unhelpful to be identified. As with other anxiety problems, introducing clients to the idea of "unhelpful thinking styles" early in treatment will also assist with this process. The following categories of thinking styles are often particularly relevant: fortune telling (e.g., "I know that dying is going to be painful", or "When my mother dies, I'll never get over it"), awfulising (e.g., "Dying will be absolutely horrible and I won't be able to bear it"), "should" statements (e.g., "I need to achieve all my goals before I die", or "death is unfair – it shouldn't happen to me), all-or-nothing thinking (e.g., "If I die before I have achieved everything I want to, then I'm a failure"), emotional reasoning (e.g., "Because I feel anxious about dying, it must be a horrible experience"), and over-generalisation (e.g., "I was devastated when my uncle died, so I know I just can't cope with death").

Where such unhelpful beliefs are identified and the person is cognitively flexible, then reappraisal may help the client come to a more balanced perspective (for a review of cognitive approaches, see Menzies, 2018). Standard lines of cognitive techniques, such as evaluating the evidence for or against the thought and considering how likely the thought is to be true or helpful, may be useful where there is cognitive flexibility. In addition to these, one especially useful avenue regarding death anxiety is accepting not knowing what will happen after death and understanding that the process of trying to know is the problem. This is related to control – that is, individuals often tend to worry about something that is outside of one's control. Thus, an individual's worries about death may involve them worrying about things that are completely unknown and outside of their control or influence and, thus, trying to solve them as actual problems increases their distress. This focus on what is not known and outside of one's control is a particularly valuable line of questioning when one's beliefs may in fact be realistic (e.g., "If I were to suddenly die, my family would probably be upset for a long time").

This view of death as outside of one's control and being largely an unknown, and thus unhelpful to problem solve, is at the heart of neutral acceptance, which has been shown to predict the most positive outcomes concerning coping with death (Tomer & Eliason, 2000). It is also at the heart of Stoicism, the ancient Greek school of philosophy on which Aaron Beck and Albert Ellis originally based CBT and Rational Emotive Behaviour Therapy, respectively. At the heart of the teachings of the Stoic philosopher and ex-slave Epictetus is the idea that "happiness and freedom

begin with a clear understanding of one principle: Some things are within your control, and some things are not" (Epictetus, 1995). One particular line of worry that the Stoics responded to was that of non-existence. For some clients, it is not a fear of pain or suffering that distresses them but the idea of non-being after death. The state of not existing at all, and the notion that life will continue on despite one's absence, can appear to some to be too difficult to even imagine. In response to this specific worry, Yalom (2008) suggests the use of the Stoic "symmetry" argument and the idea that one has already experienced non-being, that is, before they were born. This idea is expressed persuasively by Seneca, not only in his writings to the bereaved Marcia after the death of her son ("[death] returns us to that peace in which we reposed before we were born. If someone pities the dead, let him also pity those not yet born"; Seneca, 2018c) but also in his *Epistle*:

> Wouldn't a man seem to you the greatest of all fools, if he wept because for a thousand years previously, he had not been alive? He's just as great a fool if he weeps because he won't live for a thousand years to come (Seneca, 2018b).

Reading into the philosophy of the Stoics, who wrote extensively about death and the importance of accepting it may be particularly beneficial for clients who are open to this (see further, Menzies & Whittle, 2022). *How to Die: An Ancient Guide to the End of Life* (Romm, 2018), a collection of writings by Seneca, and *A Guide to the Good Life: The Ancient Art of Stoic Joy* (Irvine, 2009) are valuable starting points.

Lastly, some individuals may hold beliefs centring on death being an unjust or catastrophic outcome. Often, such beliefs are based on the erroneous assumption that one was always guaranteed their existence. Helping clients understand the incredible unlikelihood of their own existence can help to shift this perception. Richard Dawkins persuasively emphasises this idea in his opening to *Unweaving the Rainbow*, noting that "we are going to die, and that makes us the lucky ones", given that we "won the lottery of birth against all odds" (Dawkins, 1998, p. 1). One exercise to help clients cultivate gratitude for the unlikelihood of their existence involves calculating the probability of their parents ever meeting in the first place (followed by their grandparents and so on) and thus the unlikelihood of them ever coming into being (Menzies, 2012). Clients should therefore be guided away from the inaccurate assumption that their existence on this planet was ever guaranteed and instead encouraged to focus on the miraculous improbability of their own unique sequence of DNA ever appearing at all.

Given that clients know that death is ultimately inevitable, disputing the probability estimates of one specific means of death is likely to fail at addressing their underlying fear death itself. As such, it is crucial to focus on reducing the cost of dying rather than the probability (which, of course, will always be 100%) and to tolerate uncertainty about what will happen after death. For some clients, the cost of death will be viewed quite highly due to unrealistic beliefs about dying, such as "If I die prematurely, my children will end up in social services". To develop an alternative belief, clients can be encouraged to prepare and distribute surveys to close friends and family, to assess their loved ones' coping strategies and ability to care

for their children in the event of their early death (Silver et al., 2004). Of course, asking the client to prepare a will in the case of their early death, to arrange what will happen to their children, will also aid in this process. Similar methods may be used to challenge beliefs such as "My partner's life would be completely destroyed if I die", or "Nobody will miss me if I die".

Of course, being able to identify and question one's own thoughts requires cognitive flexibility and minimal perseverative thinking, which some clients may find challenging. For clients who struggle with this skill, behavioural strategies may prove more helpful.

### *3.2 Behavioural Experiments*

Like CBT for health anxiety (Salkovskis & Bass, 1997), a client may be guided to consider two opposing theories: one that is in line with their current belief (e.g., theory A: "If I were to die prematurely, my partner wouldn't be able to cope, and our children would end up in protective (social) care") and another that proposes an alternative (e.g., theory B: "This is a worry problem, and trying to get certainty over what will happen if I die is the problem"). The client is then encouraged to garner evidence for the two theories in a behavioural experiment of worrying more or less (ABAB experiment). Thus, they may discover that if they worry more and try to solve the problem and get more information and reassurance, they will generate more doubts. Furthermore, trying not to solve the problem and fully accept the uncertainty will decrease the worry.

### *3.3 Exposure Therapy*

In modern Western society, humans are more separated from death than at any other time in history (Willmott, 2001). Advancements in modern medicine have extended the human lifespan further than ever before, and cultural and societal changes have led to most deaths happening in hospitals or aged care homes as opposed to within the family home itself. Further, whilst caring for a dying person or bathing the body of the deceased used to be the sole responsibility of close family members, these traditional tasks are now typically left in the hands of medical staff and the funeral industry. Whilst these changes have arguably benefited our society in a number of ways, they have meant that opportunities to avoid any reminder of death are now more possible than ever before. This is particularly problematic given that avoidance is one of the most common ways of coping with death anxiety (McKenzie et al., 2017).

As discussed earlier, results from a recent meta-analysis reveal that CBT interventions that focus on graded exposure appear to produce greater improvements in death anxiety, relative to control conditions, or alternative treatments (Menzies

et al., 2018). The CBT interventions included in that meta-analysis used a combination of in vivo and imaginal exposure. As such, exposure therapy targeting death-related stimuli or situations will likely play a crucial role in ameliorating clients' fears and testing out their expectations (e.g., testing out one's belief that they would not cope with even thinking about death). As in other forms of exposure therapy, whilst there are many possible exposure tasks to face a fear of death, wherever possible, exercises for the client should be tailored to their own specific fear. For instance, priority should be given to exposing the client to situations (e.g., funerals, cemeteries), themes (e.g., terminal illness, losing a loved one), or stimuli (e.g., images of skulls or gravestones) that they typically deliberately avoid (Furer et al., 2007).

Whilst exposure therapy is beneficial for many types of anxiety, it may be particularly useful for fears of death, given that death is the one feared situation that the client is actually guaranteed to experience. Given this, exposure tasks can also be seen as a way of preparing for the inevitable. In much the same way that we would practise role plays if we had an important job interview coming up, exposure therapy may increase the likelihood of us coping with death effectively. This echoes the idea of the Stoic philosophers, who argued that it is essential to prepare for death, given that there is no escaping it. In the words of Seneca. (2018), "Study death always, so that you'll fear it never".

Imaginal exposure tasks can be particularly useful for helping clients confront their own unique fears about death. Of course, any exposure tasks must be linked with information garnered from the original assessment and tailored to specifically address the feared situations and beliefs of the client. Furer et al. (2007) encourage clients to write vivid stories imagining their own specific fears and worries about death. For example, a client who worries about losing their parent may write a detailed description of their mother being first diagnosed with a terminal illness, then being by their mother's side through the dying process, then the actual death itself, and followed by a description of the imagined funeral and the client's description of their own grieving and coping process. Similarly, a client who fears dying themselves may write a similarly detailed story depicting their own imagined dying process. They should write it in the first-person present tense as if it is happening now. The story should be written as if it is through their own eyes (rather than observing themselves) and should use as many different senses as possible, such as describing what they see, feel, hear, and smell. It is important to focus on their specific fears (e.g., suffocating) and to include a description of the death itself. These stories can then be read over repeatedly by the client until their ability to tolerate their anxiety improves. Acceptance and Commitment Therapy has also popularised a similarly creative task, involving the client writing their own tombstone inscription and imagining their own funeral (Hayes & Smith, 2005).

There are also numerous examples of in vivo exposure tasks that may prove useful. This includes visiting cemeteries, funeral homes, or hospitals (Bohart & Bergland, 1979a, b) or reading obituaries online or in the newspaper (and in particular, looking for individuals who died at one's own current age; Furer et al., 2007). Preparing one's own will, writing one's own obituary or eulogy, making

arrangements for a guardian for one's children, or having discussions regarding one's own end of life preferences may also be valuable exposure tasks (Furer et al., 2007; Henderson, 1990). Clients may be encouraged to make an Advance Care Directive or living will (i.e., to formalise their decisions regarding whether or not they want to be resuscitated, who would they like to be in charge of their care, whether they would like to be on a ventilator, etc.) and to consider whether they would like to opt into (or out of) organ donation. In addition to reducing the client's anxiety around death, these practical tasks may also help increase their sense of control and autonomy and provide reassurance about how their passing may transpire. Taking these concrete steps to ensure one's wishes are carried out after death may not only help clarify one's own values and preferences surrounding death but may also challenge one's assumptions that others will not cope with their death by reducing some of the decision-making burden from the family who will be bereaved. Some clients will demonstrate resistance to these practical tasks occasionally due to magical thinking related to the belief that planning for one's death may increase the likelihood of it coming about. For these individuals, it may be helpful to remind them that their will is already written unless they do something about it. That is, their assets will be distributed regardless but that without a will, they might end up being distributed to people they would rather not share in their estate. Exposure tasks also provide an important chance to test out the client's individual beliefs. As such, it is important to review these after an exposure task (i.e., Is this more evidence for theory A, or theory B, now that you have completed this exercise?). Whilst learning to tolerate anxiety, they are also testing out their expectation (e.g., that they would not cope with the feelings or that the feeling would go forever), which can be evaluated after an exposure task.

For clients who fear death due to their religious beliefs (e.g., the uncertainty of going to hell), tasks may include discussing their beliefs and concerns with relevant religious authorities, who may be able to provide corrective information if the beliefs are not in line with contemporary religious teachings or that they have no decision over what happens after death. However, it may be important for the therapist to check with a religious authority about what they may be told before a client meets them.

Fear of death often overlaps with superstitiousness. Being anti-superstitious was originally celebrated as far back as the 1880s where rationalists would host dinners for 13 people on Friday the 13th to walk under ladders and spill a salt shaker. Therefore, when one of us had his 50th birthday, it was celebrated by an anti-superstitious and anti-necrophobia party. Thus, 13 guests were sat around each table, and they were invited to break a mirror or put up an umbrella in the house. There was a Grim Reaper and someone else dressed as the devil to welcome guests. An actor played a funeral director who kindly measured people up for a coffin and discussed their wishes for their funeral. There was even a coffin in the garden to try out. One of the band's numbers was to improvise on the funeral march. After dinner, chocolates consisted of "Obols", which could be put under one's tongue to pay the ferryman, Charon, to take one across the River Hades in the garden.

The recent upsurge in popularity of the "death positive" movement also introduces a wide array of creative opportunities for exposure therapy. Death positivity is a social and cultural movement that aims to normalise death and challenge the silence that so often surrounds it. The death positive movement has led to increased resources for coping with death (such as user-friendly websites designed to help you plan your funeral), death-themed festivals and workshops, clubs at which members gather to build or paint their own coffins, and even death-themed, adult-colouring books, through which people can mindfully colour in images of decomposition, embalming, and funeral rites from around the world. Alongside this movement, the last decade has seen an increase in the number of "death cafés" held worldwide. Death cafés are not-for-profit events designed to stimulate open and honest conversation about death in a non-judgemental setting. They are typically held in an informal place, such as in a member's home or a local café, to encourage attendees to share their views on death with friends or strangers whilst enjoying some tea and cake. There have been over 10,000 death cafés held to date, in 70 countries, meaning that they are likely to be accessible to a number of clients. Attending a death café is likely to normalise the topic of death for a client and encourage them to face this feared topic in a supportive and open environment.

When considering creative approaches to exposure therapy, the use of media such as film, television, literature, and music warrants particular mention. These can often serve as powerful tools to emotionally shift client's perspectives on death in addition to merely exposing them to the fear in the vein of classic exposure tasks. Films with themes of death have been utilised as exposure tasks in prior studies (Bohart & Bergland, 1979a, b). Movies that explore death (e.g., *Beaches*, *The Green Mile,* or *Departures*) or, more broadly, themes of impermanence and the shortness of life (e.g., *Bladerunner*) may be valuable. Children's films on the topic can also be surprisingly moving and may serve as useful exposure tasks. Animated films such as *Coco* and *Up* explore ideas relating to continuing bonds with the deceased and coping with the loss of a loved one. Television programs may also prove equally valuable (e.g., *Six Feet Under,* and several episodes of *Black Mirror,* which explore mortality, including "Be Right Back" and "San Junipero"). Songs such as *Don't Fear the Reaper* by Blue Öyster Cult, with lyrics addressing the universality and natural aspects of death, or *All Things Must Pass* by George Harrison, which underscores the importance of embracing impermanence, can also be listened to (the album *See You in the Morning Light* by Deep Pools, written and recorded after the artist lost his father to cancer, offers a particularly vivid example of the value of creative approaches to exploring mortality). If relevant, clients may like to consider making one such song their ringtone to serve as periodic reminders of mortality throughout the day.

Fiction (e.g., *The Death of Ivan Ilyich* by Leo Tolstoy) or non-fiction books (e.g., Mitch Albom's memoir about his dying mentor, *Tuesdays with Morrie*; Paul Kalanithi's *When Breath Becomes Air,* a neurosurgeon's account of being diagnosed and eventually succumbing to cancer; Atul Gawande's *Being Mortal, and Mortals: How the Fear of Death Shaped Human Society*, written by Rachel and Ross Menzies) all make relevant reading. The recent upsurge in the death positive movement has

fortunately led to the publication of increasing numbers of books about death, including *Advice for Future Corpses (and Those Who Love Them)* by Sallie Tisdale; *Gratitude*, written by neurologist Oliver Sacks during the last few months of his life; and *Smoke Gets in Your Eyes: And Other Lessons from the Crematorium* (in addition to *From Here to Eternity*) by mortician and death positivity advocate Caitlin Doughty.

The value of humour should also not be understated, and material that offers a light-hearted perspective on what is typically viewed as a dark and taboo subject can be unexpectedly powerful. Relevant materials include films such as *Death at a Funeral*, television shows such as *Afterlife* (a black comedy that poignantly explores grief), or books such as *Everybody Dies: A Children's Book for Grown Ups* by Ken Tanaka or *Dead People Suck: A Guide for Survivors of the Newly Departed* written by comedian Laurie Kilmartin following the death of her father.

Technology should also be considered for the creative opportunities it provides for exposure tasks. Apps like *We Croak* or *Kick the Bucket* offer the user frequent reminders throughout the day of their own mortality through push notifications and accompanying quotes related to death. Gaming apps related to death may also prove useful. One such example is *A Mortician's Tale* in which the user plays as a mortician working in a funeral home, proceeding through the various steps of cremation or embalming for her deceased clientele. The death positive movement has also seen an increase in games designed to start conversations about death with others (e.g., *The Death Deck,* and *Mortalls: The Death Positive Conversation Game*, which involves players answering questions such as "Would you rather die or be cremated?" or "If you had just one day left to live, how would you decide to spend it?"). In addition to being useful exposure tasks, playing a game such as these helps to normalise the topic of death and also opens up conversations about mortality with loved ones, which the player may find personally meaningful and valuable.

## *3.4 Tolerating Uncertainty*

If the fear of death is associated with uncertainty paralysis and an unstructured and disrupted routine, one of the first steps is to build a sense of safety by creating structure and routine. This overlaps with activity scheduling and involves choosing tasks that are avoided and valued in order to create a sense of order in one's life. This may include a sleep routine and getting up at a regular time. Once safety is established, it is then important to include small but novel tasks and more flexible routines. It is important to otherwise keep their routine and gradually add more novelty and flexibility of a routine to build gradual tolerance of uncertainty.

### 3.5 Imagery Rescripting

Imagery rescripting (ImRs) is a transdiagnostic intervention that can be used for aversive memories that are associated with the onset of intrusive images and still have a sense of "nowness" (Arndtz, 2012; Veale et al., 2015). This involves trying to provide the younger "self" with what he or she needs (usually a sense of control over events) and developing an alternative meaning to the event. Thus, although the efficacy of ImRs on death anxiety has not yet been empirically examined, ImRs might be used for an aversive memory about how a close friend or relative died to help a client come to terms with the loss and potentially develop a more helpful meaning for it.

### 3.6 Psilocybin-Assisted Psychotherapy

Lastly, research is currently being carried on the role of psychedelic-assisted psychotherapy for depression, anxiety, addictions, and the psychological challenges associated with death and dying (Rucker et al., 2018). Moreton et al. (2020) suggest that reduced death anxiety may be a key mechanism underpinning the therapeutic effects of psychedelics and provide a review of the mechanisms through which psychedelics may reduce death anxiety. There has been one controlled trial with psilocybin that measured death anxiety as a secondary outcome. Griffiths et al. (2016) used a double-blind, randomised, crossover design with 51 patients with life-threatening cancer and associated anxiety and depressive symptoms. In this study, the placebo condition was a subtherapeutic dose of psilocybin. The treatment condition involved a high dose of psilocybin administered in a counterbalanced sequence with 5 weeks between sessions and 6 months follow-up. Psychological support was provided before, during, and after the session with psilocybin. The results showed that the high dose was superior in terms of depressed mood and anxiety, along with increases in quality of life, life meaning, and decreases in death anxiety. At 6-month follow-up, these changes were sustained, with about 80% of participants continuing to show clinically significant decreases in depressed mood and anxiety. No serious adverse events were reported, and significant associations between mystical-type experiences and enduring positive changes were observed. Further research is needed to clarify the potential efficacy of psychedelic-assisted psychotherapy for death anxiety.

## 4 Conclusion

Increasing evidence suggests that death anxiety may be a driving factor in a number of different mental health conditions. Given the transdiagnostic role of this construct, there is a need for treatments that directly target the client's underlying fear of death rather than merely addressing the overt symptomatology of a particular disorder. CBT interventions that focus on exposure therapy have been shown to reduce death anxiety across a number of studies. As such, creative exposure exercises will prove valuable in enabling the client to face their feared situations surrounding death. Other CBT techniques such as cognitive challenging and behavioural experiments are also likely to help target maladaptive or unrealistic beliefs about death although empirical evidence is needed to demonstrate the efficacy of these techniques on death anxiety. At present, only a small number of RCTs have demonstrated the efficacy of CBT in reducing death anxiety, and studies in clinical samples are lacking. Further research is essential to determine whether these aforementioned strategies will be effective in ameliorating fears of death among those with mental health conditions.

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# Part III
# Isolation

# Existential Isolation: Theory, Empirical Findings, and Clinical Considerations


**Peter J. Helm, Ronald F. Chau, and Jeff Greenberg**

**Abstract** Yalom (1980) identified three forms of isolation: intrapersonal, interpersonal, and existential. This chapter focuses primarily on existential isolation, both as an existential reality and as a subjective experience. Existential isolation refers to the inherent unbridgeable gap between any two beings and the impossibility of knowing with certainty how anyone else experiences the world. The chapter begins with discussion of existential isolation as an existential reality and how awareness of it can be threatening to a species that relies upon shared social validation for meaning and psychological security. The chapter then examines the consequences and potential benefits of confronting existential isolation, considers how existential isolation relates to other existential concerns, and reviews empirical research on the topic. The chapter concludes with a discussion of ways in which psychotherapy could help clients develop resources to manage the anxiety associated with awareness of existential isolation.

**Keywords** Existential isolation · Identity · Meaning · Freedom · Death · Terror management theory · Meaning maintenance · Existential loneliness

## 1 Introduction

Therapists and mental health workers have recognized the prevalence of social disconnection for a long time, and the consequences of disconnection are well documented (e.g., Holt-Lunstad et al., 2015). Chapters "Isolation, Loneliness and Mental Health" and "Social Prescribing: A Review of the Literature" will primarily focus

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on the most commonly researched form of isolation, loneliness. While some researchers might dispute the degree to which loneliness constitutes an existential concern, it is recognized as a universal experience (McGraw, 1995; Perlman, 2004). Moreover, affiliation, social connection, and belongingness constitute key sources of meaning that are threatened by loneliness (Van Tilburg et al., 2019), and loneliness has been found to be associated with lower perceived meaning (Hicks et al., 2010).

Nevertheless, isolation is rarely discussed in an existential context, especially among empirical psychologists. Unlike other existential concerns (e.g., death, meaning), research on existential isolation has remained relatively sparse. Yet recent efforts have begun to investigate the subjective experience and awareness of existential isolation and compare its consequences to those of other forms of isolation (e.g., Helm, Greenberg, et al., 2019a; Pinel et al., 2017).

The present chapter will focus on existential isolation, both as an existential reality and as a subjective experience. This chapter will start with a discussion of the definition of existential isolation as described by Yalom's (1980) *Existential Psychotherapy*. It will consider how awareness of existential isolation can be threatening to a species that relies upon shared social validation for meaning and psychological security. The chapter then examines the consequences and potential benefits of confronting existential isolation. The chapter then considers how existential isolation relates to other existential concerns, reviews empirical research on the topic, and concludes with a discussion of potential ways in which psychotherapy could help alleviate existential isolation in those negatively affected by it.

## 2 Existential Isolation

Existential psychotherapist Irvin Yalom (1980) describes three types of isolation: intrapersonal, interpersonal, and existential. Intrapersonal isolation "is a process whereby one partitions off parts of oneself" (p. 354). In severe cases, this process can refer to clinical disorders (e.g., dissociative disorders) but can also refer to any fragmentation of the self, such as instances in which a person suppresses their own thoughts or desires, mistrusts their own judgments, or knowingly acts inauthentically.

Yalom (1980) notes that interpersonal isolation, "generally experienced as loneliness, refers to an isolation from other individuals" (p 353). Interpersonal (i.e., between person) isolation is most frequently conceptualized as social isolation or as loneliness. Social isolation (e.g., Child & Lawton, 2017) is understood as an *objective* lack of relationships or contact with others (i.e., one is physically separated from others). Though, as Yalom argues, interpersonal isolation is most often experienced as loneliness, which refers to the *subjective* and distressing feeling associated with dissatisfaction with one's social contacts (e.g., Peplau & Perlman, 1982), it should be noted that interpersonal isolation can also be experienced positively as in

solitude, which often is viewed as a restorative experience and a venue for creative or religious experiences (see Coplan & Bowker, 2014; Mansfield et al., 2019).

The third type of isolation is existential isolation, which "refers to an unbridgeable gulf between oneself and any other being. It refers, too, to an isolation even more fundamental—a separation between the individual and the world" (Yalom, 1980, p. 355). When a person becomes aware of their existential isolation, they may feel as if no one understands their perceptions, that they are alone in their subjective experience (Pinel et al., 2017). Yet if interpersonal isolation refers to "between person" separation, then wouldn't existential isolation fall into this category? Indeed, in Yalom's extended discussion of existential isolation, he refers to it as a "vale of loneliness" (p. 356) and suggests interpersonal and existential isolation are so closely related that the boundaries between them are semipermeable. Moreover, the subjective experience of the two forms of isolation "may feel the same and masquerade for one another" (p. 355).

Thus, what makes existential isolation unique? Yalom (1980) proposes that existential isolation does not ultimately stem from interpersonal relationships but rather exists as an existential reality (i.e., it flows from the givens of existence). In other words, all humans across time and space must contend with existential isolation (e.g., Sullivan et al., 2012). Insofar that humans can only experience the world through their personal sensory organs and cannot read another's mind, no matter how close two individuals get, there always exists "an unbridgeable gulf" between people preventing them from truly knowing firsthand the experience of another (Mueller, 1912). Becker (1971) describes awareness of existential isolation as emerging out of developmental processes; as we develop a theory of mind, we realize that "we come into contact with people only with our exteriors—physically and externally; yet each of us walks around with a great wealth of interior life, a private and secret self" (p. 28).

This awareness of one's inherent isolation is particularly problematic for a species that continuously relies upon abstract symbolic representations of the world (e.g., Becker, 1971; Berger & Luckmann, 1966; Rank, 1945). From an existential perspective, there is no inherent meaning or purpose to life, and thus humans invest in socially constructed and maintained symbolic conceptions of reality that imbues life with meaning, order, and permanence (Becker, 1971; Greenberg et al., 1986; Kierkegaard, 1981). These symbolic organizations can range from microlevel (e.g., feeling confident in one's basic conceptions and interpretations of reality) to macrolevel (e.g., abstract symbolic belief systems such as national or religious identity) conceptions (e.g., Arndt et al., 2013). Importantly, because these abstract representations are ultimately fictions, their validity depends upon social validation and agreement.

Many theories across disciplines underscore the importance of socially shared and constructed bases of psychological processes (e.g., Asch, 1952; Barrett, 2017; Becker, 1971; Cooley, 1964; Echterhoff et al., 2009; Festinger, 1954; Mead, 1934). For example, Festinger's (1954) theory of social comparison asserts that the validity of our personal beliefs depends upon shared belief by similar others. Similarly,

research on reflected appraisals argues that people learn about themselves most directly from others rather than from introspection or self-observation (Vazire, 2010). Becker (1971), and later terror management theory (Greenberg et al., 1986; Routledge & Vess, 2019), argues that socially shared belief systems ultimately address core fundamental human concerns (e.g., How did I get here? What is the meaning and purpose of my life?).

Awareness of one's existential isolation threatens to thwart the protective nature of these symbolic constructions of reality. Existential isolation is the awareness that one is ultimately alone in their interpretation of reality (i.e., one can never truly know with certainty the subjective experiences of another), thus undermining the protective function of socially constructed symbolic conceptions (Pinel et al., 2004). For example, imagine a devout Christian is listening to a lecture from a Buddhist monk on the cycles of reincarnation and finds herself intrigued and comforted by these notions. Meanwhile, other members of her congregation are reacting with horror and disbelief. The listener realizes she is having very different reactions than those around her and, even more concerning, having reactions that may be at odds with her current belief system. She becomes aware her perceptions may not be shared by those around her, and if the doctrine of another religion is more comforting than her own, which should she believe? In essence, awareness of her existential isolation (i.e., uniqueness of experience) threatened the foundation of her socially constructed beliefs. A wide variety of research finds that when people's sense of shared reality is undermined, it can leave them feeling uncertain and vulnerable (e.g., Asch, 1951; Echterhoff et al., 2009).

## 3 Confronting Existential Isolation

> "We are all lonely ships on a dark sea. We see the lights of other ships—ships that we cannot reach but whose presence and similar situation affords us much solace. But if we can break out of our windowless monad, we become aware of the others who face the same lonely dread. Our sense of isolation gives way to a compassion for the others, and we are no longer quite so frightened. An invisible bond unites individuals who participate in the same experience—whether it be a life experience shared in time or place (e.g., attending the same school) or simply as a member of an audience at some event."
>
> *- Irvin Yalom, Existential Psychotherapy*

Confronting existential concerns is not an easy or comfortable task (Heidegger, 1927; Kierkegaard, 1981). Like existential threats more broadly, awareness of one's existential isolation induces the potential for negative affect, whether consciously or unconsciously (Sullivan et al., 2012). Yalom (1980) writes, "The experience of existential isolation produces a highly uncomfortable subjective state and…is not tolerated by the individual for long. Unconscious defenses 'work on it' and quickly bury it—outside the purview of conscious experience" (p. 362). Thus, similar to proximal defenses in terror management theory that serve to push death thoughts out of

conscious awareness (see Burke et al., 2010, for a review), defense processes operate to bury awareness of isolation.

The primary mechanism of isolation denial is relational in nature (Fromm, 1963; Yalom, 1980), which can include relationships with one's work (e.g., becoming a workaholic), orgiastic states (e.g., engaging in religious or sexual states), or conformity (e.g., merging or fusing with a group, investing in interpersonal relationships). Work on *identity fusion* (e.g., Swann et al., 2012), which occurs when people experience a visceral feeling of oneness with a group, is an example of extreme isolation denial tendencies. The act of "fusion [with another person, group, cause, country, or project] eliminates isolation in a radical fashion—by eliminating self-awareness" (Yalom, 1980, p. 380).

Though Yalom (1980) cautions that while no relationship can eliminate isolation entirely (though fusion may give the impression one has), aloneness can be shared in such a way that "love compensates for the pain of isolation" (p. 363). Echoing sentiments expressed by Martin Buber (1970), Yalom argues that mature, authentic relationships marked by empathy, perspective taking, and reciprocity best serve to assuage one's existential isolation. Through even a brief relational encounter, the self is altered because it internalizes the encounter; "it becomes an internal reference point, an omnipresent reminder of both the possibility and reward of a true encounter" (Yalom, 1980, p. 396). If the relational encounter is positive and authentic, the internalized experience serves as a tempering of existential anxiety (Yalom, 1980). While relationships can perhaps bridge the existential gulf momentarily, and may facilitate growth, it is ultimately incumbent upon the individual to bear the pangs of existential stress "resolutely" (Camus, 1955; Heidegger, 1927; Hobson, 1974; Kierkegaard, 1981; Yalom, 1980). Through engaged and directed confrontation with one's existential isolation, one may develop a tolerance to be able to cope with one's situation.

Other thinkers have also argued that confronting existential isolation can be a process toward growth though the meaning of growth is often poorly articulated (see Ettema et al., 2010, for a review). Generally, a confrontation with existential isolation is thought to have the potential to foster three types of growth. These are personal growth, in which an individual's potential might be actualized (e.g., Mayers et al., 2005; Park, 2006); interpersonal growth, where one's relationships deepen and feelings of intimacy are heightened (e.g., Lindenauer, 1970; May & Yalom, 2000); or spiritual growth, where one relates to himself or herself in a more transcendent mode (e.g., Collins, 1989). By acknowledging that one is existentially isolated, a person may also discover their internal resources and strength in the face of this fact. The development of such resilience may be an important first step in living with existential isolation in an adaptive manner. It has also been suggested that acceptance of one's existential predicament can lead to increased empathy and perspective taking toward others who are in the same situation.

One potential problem with this perspective is that it benefits those who already have adequate resources in place to confront their existential anxiety—a rich get richer, poor get poorer dilemma. Individuals who are already able to relate to others

in secure and mature ways are most able to confront and tolerate their isolation. In contrast, those without these resources struggle to find safety and security (e.g., Plusnin et al., 2018).

## 4 Existential Isolation in the Day-to-Day

> Individuals are often isolated from others and from parts of themselves, but underlying these splits is an even more basic isolation that belongs to existence—an isolation that persists despite the most gratifying engagement with other individuals and despite consummate self-knowledge and integration.
> - *Irvin Yalom, Existential Psychotherapy*

As we have argued so far, and as Yalom articulates in the quote above, existential isolation is an ever-present concern, persisting despite our interpersonal connections and irrespective of level of self-knowledge. Experiences with existential threats are part of the normal range of experience of the average person within a given culture (e.g., Sullivan et al., 2012; Tillich, 2000). Thus, confronting existential concerns is not necessarily pathological or the result of a neurotic condition. However, the average person, at least in Western cultures, is not likely to be aware of, or to be able to understand when, existential concerns are influencing thoughts, emotions, and behavior.

**Factors that May Contribute to Keeping Existential Isolation Out of Consciousness** Social psychological research has identified a variety of cognitive biases that may combat awareness of existential isolation. For example, *confirmation bias* is the tendency to interpret and attend to information that supports one's own position and to ignore information that does not support one's attitudes (Landau et al., 2004; Nickerson, 1998). Research on the *false consensus effect* (Ross et al., 1977) suggests that people typically overestimate the number of other people who share their beliefs and attitudes. In both cases, these projective heuristics lead to the sense that one's subjective beliefs are accurate and shared by others, thus reducing the likelihood that one will become aware of their existential isolation. An American conservative watching Fox News and an American liberal watching CNN are both likely to feel like their views are shared much more than they really are.

Other work suggests that as we develop close and intimate relationships, we naturally tend to assume the other person shares our internal perspectives. For example, work with people in satisfying and stable relationships reveals that they tend to perceive similarities with their partners even when these similarities are not evident in reality (e.g., Murray et al., 2002). These egocentric assumptions help the individual to feel understood and satisfied in their relationship, but ultimately, these assumptions are distortions and serve a protective function against isolation awareness. Other research suggests that people will even change their own views to coincide with others in uncertain situations (Asch, 1951; Echterhoff et al., 2009), thus

perhaps ignoring their own intuitions to avoid confronting their fundamental isolation.

Anxiety buffers may also contribute to keeping awareness of existential isolation at bay. Theories of psychological defense (e.g., terror management theory, anxiety buffer disruption theory, meaning maintenance model; see Hart, 2014) propose that humans are motivated to protect themselves from potentially anxiety-evoking threats by investing themselves in a variety of buffers including close relationships, self-esteem, and cultural worldviews. From these perspectives, anxiety buffers function to allow us to operate with relative psychological equanimity in the face of existential concerns (e.g., inevitable death, inherent isolation). Research has found that strong anxiety buffers ameliorate anxiety and are associated with better health. For example, research has found that high self-esteem (either dispositionally or experimentally elevated) attenuates the threat of death (e.g., Greenberg et al., 1992; Harmon-Jones et al., 1997) and is associated with greater mental and physical health (e.g., Kernis, 2005). Along these lines, it is reasonable to expect strong anxiety buffers to also mitigate the threat of existential isolation.

**Factors that May Contribute to a Greater Propensity to Experience Existential Isolation** In contrast to the various mechanisms and processes that serve to keep existential out of focal awareness, other factors may contribute to a greater propensity to experience fundamental isolation. Aside from the more straightforward proposition that weak anxiety buffers (e.g., low self-esteem, weak interpersonal relationships, doubting one's cultural worldviews) would therefore contribute to elevated existential isolation, cultural factors are also likely important.

Researchers have identified a range of dimensions upon which cultures vary. One commonly researched dimension is *individualism-collectivism* (Triandis, 1995). Individualist societies (e.g., the United States) tend to value the individual over the group, and people tend to prioritize their personal goals over the goals of others. Collectivist societies (e.g., Japan) tend to value in-groups (e.g., family, organization) over individual needs. In individualistic cultures, people tend to think of themselves as discrete and tend to use others as a source of social comparison to confirm their uniqueness (Cross et al., 2011; Markus & Kitayama, 1991). In collectivist cultures, people tend to think of themselves in relational terms (e.g., friend, coworker) and tend to use others as a way to determine if they are fulfilling their relational obligations (Cross et al., 2011). A society's level of individualism may influence the degree to which its members are likely to experience existential isolation. Insofar that individualistic people see themselves as distinct from others and place greater value on their personal experiences and goals while downplaying the perspectives of others, they should be more likely to become aware of their fundamental disconnection from others. In contrast, members of collectivistic cultures, who are constantly aware of the needs and perspectives of others, should be less likely to become aware of their fundamental disconnectedness (Pinel et al., 2020).

## 5 Relating Existential Isolation to Other Existential Concerns

Many thinkers have argued that existential concerns are interrelated and awareness of one may activate another (e.g., Pyszczynski et al., 1990; Tillich, 2000; Yalom, 1980).

**Death** Yalom (1980) argues awareness of one's own death ultimately leads an individual toward a confrontation with their fundamental isolation and writes, "Each of us enters existence alone and must depart from it alone" (p. 9). Though a person may be surrounded by family and friends, though others may die at the same time or for the same cause, "at the most fundamental level dying is the most lonely human experience" (Yalom, 1980, p. 356). By this reasoning, contemplating one's inevitable death leads one to a realization of their inherent isolation. In the reverse direction, death is arguably the highest order, or most distal source, of existential threat (Pyszczynski et al., 1990; Tillich, 2000). Without the threat of nonbeing, other existential threats would lose their impact. Thus, any confrontation with existential isolation should ultimately lead one toward death-related concerns.

**Meaning** An existential framework suggests that humans live in an inherently meaningless and absurd world. Yet humans strive to create and maintain systems of meaning, which provide buttresses against existential angst. A confrontation with meaninglessness leads the individual to feel as though the world is chaotic and human endeavors are pointless (e.g., Kierkegaard, 1981; Tillich, 2000). Awareness of one's existential isolation may undermine one's sense of meaning (Kuperus, 2018). Given that systems of meaning are ultimately substantiated by confidence in social validation, awareness that one can never truly have their subjective feelings validated by another leaves the structures of meaning on insecure foundations. In this sense, the threats of existential isolation and meaninglessness may have a bidirectional relationship.

**Freedom** The existential concern of freedom refers to the ability to choose one's path at any moment (e.g., Sartre, 2001), leading humans to cope with the responsibility of self-creation. Awareness of authorship implies that others are therefore not responsible for one's actions, and thus, one must contend with the isolation of self-creation (e.g., Yalom, 1980). In other words, awareness of choice (and the corresponding responsibility) leaves the individual vulnerable to existential isolation because the individual is alone in having to make and live with their choices.

**Identity** The concern of identity refers to the inability to have full knowledge of oneself and arises through the courage to be part of groups or through affirmation processes. These processes reflect differences in personal and social identity (e.g., Castano et al., 2004). Personal identity refers to identification with the self, restricted to one's body and being. Social identity, in contrast, extends beyond the self and

refers to identification with a group or community. Social identity theorists (e.g., Hogg & Mahajan, 2018; Tajfel, 1978) argue that social groups in part function to assuage existential concerns. Yet as discussed, effectively merging with a social group may be thwarted by awareness of one's inherent separateness from others. Moreover, Yalom (1980) discusses a primary consequence of self-awareness, and inward focus is an awareness of one's existential isolation. Insofar that the problem of identity illuminates inward focus and requires an individual to self-create, it should also activate a potential for awareness of one's existential isolation.

## 6 Empirical Research on Existential Isolation

**Assessment Measures** There has been very little research focusing on existential isolation compared to other existential concerns (i.e., death, meaning) though recently, researchers have begun to study this experience empirically. Until recently, most papers considering existential isolation focused on qualitative experiences of patients in palliative care or with psychological disorders (e.g., Ettema et al., 2010; Kazanjian & Choi, 2013; Mayers et al., 2002; Mayers & Svartberg, 2001). There have been two prominent exceptions to this trend. Mayers and colleagues (Mayers et al., 2002) developed an Existential Loneliness Questionnaire (ELQ) to assess the experience among women with HIV, and Pinel and colleagues (Pinel et al., 2017) developed a trait Existential Isolation Scale (EIS), which measures the degree to which individuals regularly feel as though others do not or cannot understand their subjective perceptions and experiences. This scale has also been adapted to assess state or in-the-moment experiences of existential isolation.

The ELQ has multiple items that specifically reference HIV diagnoses and was found to correlate very highly with general loneliness, depression, and purpose in life in a sample of women with HIV, suggesting the questionnaire may assess a construct that overlaps with other constructs, at least in clinical samples. The EIS scores showed small to moderate correlations with general loneliness, demonstrate stability over time, and showed adequate concurrent and discriminant validity with related constructs. The majority of the research highlighted below focuses on work utilizing the Pinel et al. (2017) scale.

**Correlates of Existential Isolation** Empirical work has examined the extent to which awareness of existential isolation relates to a variety of social psychological phenomenon in an attempt to underscore the utility of assessing isolation in an existential sense rather than only interpersonally. One such body of research has found that existential isolation is indeed associated with a weakened anxiety buffer (Helm et al., 2019b). As reviewed above, humans have various anxiety buffers (i.e., cultural worldviews, self-esteem) in place that buffer against potential anxiety-inducing threats (for a review, see Burke et al., 2010). Terror management research has found that when these anxiety buffers are threatened, they no longer prevent our

consciousness from contemplating death, and death thoughts become more accessible in consciousness.

Emerging work, however, has begun to focus on baseline death-thought accessibility, which is conceptualized to be indicative of a weak or fragmented anxiety buffer (e.g., Hayes et al., 2010). Researchers reasoned that if existential isolation threatened the foundations of our anxiety buffers (i.e., undermined the social validation of these symbolic conceptions), then it would be associated with elevated death thoughts. Indeed, existential isolation was found to be associated with elevated death-thought accessibility and that reminding participants of their existential isolation increased death thoughts compared to control primes (Helm et al., 2019b). Moreover, this work found that existential isolation was associated with less importance of one's national identity and lower self-esteem. Importantly, the relationship between existential isolation and death thoughts could not be explained by loneliness though the relationship between loneliness and death thoughts could be explained by their mutual relationship to existential isolation.

Other work has examined how existential isolation may relate to attachment orientations. Guided by research that found loneliness to be associated with insecure attachment (e.g., Hazan & Shaver, 1987), researchers proposed that individuals who have a history of relationships with unavailable, rejecting, and inconsistently attentive attachment figures should be high in existential isolation. Consistent with these propositions, researchers found existential isolation to predict both attachment avoidance and attachment anxiety (Helm et al., 2020a) though existential isolation was more related to attachment avoidance than to attachment anxiety. Interestingly, those with secure attachment consistently reported low existential isolation, mirroring Yalom's (1980) assertion that mature relationships may buffer existential isolation.

In similar research focusing on how existential isolation may impact community relationships, Pinel et al. (2020) found participants with higher existential isolation were less likely to endorse humanitarian values (e.g., "one should be kind to all people") and prosocial behaviors (e.g., "I donate to local causes"). Complementing the finding above that existential isolation predicts less identification with one's group, these works suggests that those who are most aware of their existential isolation may also feel less integrated with, and supportive of, their local communities.

Other work (Park & Pinel, 2020) examined how existential isolation may vary culturally. In a study conducted in South Korea, they found average levels of existential isolation to be lower than those found in the United States. Moreover, existential isolation was negatively correlated with collectivism, such that the greater one's collectivist values, the lower their reported existential isolation. In a different series of studies conducted in the United States (Helm et al., 2018), existential isolation was found to be higher among men than women, and this difference was explained by differences in communal value endorsement, mirroring the cross-cultural findings. These studies complement research that finds self-reported loneliness to be lower in more collectivist cultures (e.g., Heu et al., 2019).

Given that feelings of existential isolation are conceptualized as the sense that others do not, or cannot, understand one's subjective experiences, it makes sense

that individuals with nonnormative experiences may report elevated levels of existential isolation (e.g., Kazanjian & Choi, 2013; Mayers & Svartberg, 2001). Yawger and colleagues (Yawger et al., 2020) found that individuals with minority identities (e.g., non-White, nonheterosexual, heavy weight[1]) reported higher existential isolation than their majority identity counterparts (i.e., White, heterosexual, non-heavy weight). In other work examining individuals with nonnormative experiences, Helm and colleagues (Helm et al., 2020b) found that student veterans reported higher existential isolation than did other undergraduate students. Moreover, student veterans who interacted with other veterans at least occasionally reported lower existential isolation than those who rarely interacted with other veterans. These studies suggest that interacting with, or thinking about, individuals with a common identity or shared experience may serve to temper feelings of existential isolation.

Previous qualitative and conceptual studies on existential isolation have found it to be inherently connected to death awareness, especially among those in end-of-life care (e.g., Bolmsjö et al., 2019). Recent research has also begun to examine the empirical relationship between existential isolation and mental health. Multiple studies have found existential isolation (though some utilizing an indirect assessment) to be correlated with depression (Kretschmer & Storm, 2017; Mayers et al., 2002), stress, and anxiety (Constantino et al., 2019). In another study, Helm and colleagues (Helm et al., 2020a) compared the effects of existential isolation and loneliness on depression and suicide ideation and found them to have independent and unique effects. This study also found existential isolation and loneliness interacted to predict depression, such that individuals who had both elevated existential isolation and loneliness reported an average depression that qualified for mild clinical depression. Thus, individuals who are experiencing multiple types of isolation may be the most prone to mental health concerns.

Taken together, these preliminary research findings suggest there are important antecedents and consequences to the experience of existential isolation. Helm and colleagues (Helm et al., 2019a) recently articulated a state trait existential isolation model, which focuses on how high existential isolation can be a temporary state triggered by a specific situation; it may be context dependent, and it can be experienced consistently over time as a trait. Situations or events that may elicit elevated state existential isolation are likely those where an individual is aware she or he is having a different experience or reaction than others (either from another person or a group). Though this model is theoretical and has not been fully tested, Helm and colleagues (Helm et al., 2019b) found asking participants to write about an existentially isolating event increased state existential isolation. More broadly, it seems likely that the trait form of high existential isolation, because of its chronic nature, is most likely to impact mental health negatively.

[1] Heavy weight status was characterized by individuals with a body mass index (BMI) above 25 (calculated by participant's height and weight), and those with non-heavy weight status had a BMI at 25 or below (Centers for Disease Control, 2016).

## 7 Implications for Psychotherapy and the Treatment of Existential Isolation

Given the association between existential isolation and poorer mental health and negative affect, it is worth exploring psychotherapy's utility in alleviating the pangs of existential isolation and its effects on psychological well-being. We can approach existential isolation treatment from two directions. First, we can address existential isolation directly by reducing a client's propensity to become aware of existential isolation through authentic relationships. Second, we can address existential isolation indirectly by attending to its aftereffects and specifically anxiety and the erosion of meaning.

Yalom (1980) argues that psychopathology can stem from avoiding existential isolation because it can lead to problematic defense mechanisms. One individual might avoid the terror of existential isolation by attempting to fuse with another, losing their sense of self by dominance or subservience to another in a dependent relationship. Another might blindly conform to their in-group and vilify out-groups, denigrating the "other." Still another might engage in compulsive sexual relationships to heal their sense of aloneness.

The psychotherapist can help the client become aware of maladaptive patterns of behavior stemming from avoidance of existential isolation and assist the client in developing more productive patterns of behavior associated with approaching their existential isolation. Along these lines, Yalom (1980) argues perhaps the most important element of therapy, transcending the therapist's theoretical orientation, is the therapeutic alliance between the therapist and patient.

Though there is disagreement about precisely defining the therapeutic alliance, it refers to the bond between the client and therapist and a sense of collaboration, warmth, and support (e.g., De Re et al., 2012). Almost 40 years of psychotherapy research has found the therapeutic alliance to be an important aspect of successful treatment, a consistent predictor of therapy outcomes, and one of the core mechanisms in the change process (De Re et al., 2012; Kuutmann & Hilsenroth, 2012). There are many recommendations for the therapist who wants to cultivate authentic relationships with clients. Kaiser (1965) emphasizes the importance of honest communication and a dispositional interest in people, sensitivity to duplicity, and the absence of theoretical views or neuroses that interfere with communication. Sequin (1965) describes a "psychotherapeutic eros" or genuine, nonreciprocal caring for the client's well-being and growth as essential for authentic connection. Similarly, Rogers (1951, 1980) suggests bringing an attitude of unconditional positive regard, empathy, and authenticity to every client session (see also Norcross, 2010).

Each of these recommendations emphasizes fostering authentic encounters by relating to the client in a genuine, caring fashion. Yalom (1980) maintains that authentic relationships allow the therapist to "enter the patient's world and experience it as the patient experiences it" (p. 409). Thus, the therapeutic alliance may directly reduce existential isolation via an authentic encounter within the therapy

room. Though the therapist-client relationship is temporary, the client can realize from this experience that such genuine connections are possible and enriching. This realization can motivate a client to seek and establish similar authentic connections with others.

Yalom (1980) argued that group therapy sessions can also be valuable for clients to practice recognizing their own and others' patterns of maladaptive responding to existential isolation (e.g., inauthentic relating) and sharing these perceptions with each other. These group relationships can also improve the quality of future relationships by serving as "dress rehearsals" for new modes of relating.

Drawing from empirical research cited earlier, support groups organized around specific social identities may be particularly useful in directly reducing existential isolation. Though it is impossible to truly bridge the existential gap between human beings, group meetings among individuals who share an identity or experience can help validate their experiences and give the impression that others can understand their experiences. For example, consider the treatment of addiction. Uncomfortable awareness of existential isolation could lead to substance use as a means to alleviate the negative feelings associated with it. Group therapy can serve as a venue for addicts to recognize and discuss their maladaptive patterns of behavior in response to existential angst (Kelly et al., 2020; Rogers & Cobia, 2008). This venue would presumably be additionally helpful for those feeling the pangs of existential isolation because others attending the group have had similar experiences, thus reducing their sense of existential isolation. As quoted above, "an invisible bond unites individuals who participate in the same experience," and group therapy sessions provide such an experience.

A key issue that drives maladaptive behaviors associated with existential isolation is that people often opt for inauthentic relationships to manage the anxiety and negative affect associated with it, yet these relationships are likely to be ineffective long-term solutions (Kassel, 2010). Cognitive behavioral therapies (CBT) focus on modifying unhelpful cognitions and behaviors. Given that clients may have such distorted beliefs about the utility of engaging in inauthentic relationships, a program for altering patterns of thought and behavior that supports more authentic modes of relating may be helpful.

The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2018; Farchione et al., 2012) is an emotion-focused CBT developed to treat the entire range of anxiety and unipolar mood disorders. UP combines the key features of many CBT modalities, including changing maladaptive cognitive evaluations, emotion-based action tendencies, discouraging emotion avoidance, and promoting emotion exposure. In particular, UP emphasizes understanding the nature of emotions (i.e., associated bodily sensations, cognitions, behaviors), the adaptive function of emotions (e.g., anxiety teaches us to be careful), and recognizing and changing maladaptive responses to these emotions. From the perspective of UP, a client's instinctive reaction to engage in inauthentic relationships to avoid the anxiety of existential isolation might be a maladaptive "emotionally driven behavior." In addition, the client may have maladaptive beliefs that support this behavior,

such as "my partner and I are one; I can lose myself in my partner." This belief is false because there is no way to eliminate existential isolation no matter how close you become to someone. Therefore, part of the work from a UP standpoint is the identification of these problematic patterns of thought and behavior, understanding the nature and universality of the anxiety associated with existential isolation, and practicing an approach orientation toward these feelings while attempting to relate to other people in a new and authentic way.

Acceptance and Commitment Therapy (ACT; Hayes et al., 2006; Hayes et al., 2011) is another popular, approach-oriented CBT. ACT focuses on cultivating psychological flexibility through mindful acceptance of emotions and connection with one's values and taking committed action to live a meaningful life despite emotional difficulties. Like UP, ACT can teach individuals to accept the anxiety associated with existential isolation while simultaneously helping them to respond to it in a more adaptive way. For instance, a client could cultivate mindful acceptance of their anxious response to existential isolation while at the same time choosing to connect with their values (e.g., authenticity) and practice courage and vulnerability as they open up to others in a genuine way.

Both UP and ACT serve to address existential isolation in both direct and indirect ways. As mentioned, UP and ACT facilitate movement away from inauthentic relationships toward authentic relationships. Specifically, beyond the authentic connection possible through a good therapeutic alliance, these cognitive behavioral approaches involve guidance, support, and homework that assists clients in building authentic relationships outside the therapy room, thus providing opportunity to reduce existential in the real world.

Perhaps less obvious, ACT also addresses existential isolation indirectly by addressing the erosion of meaning possibly stemming from existential isolation (Hayes et al., 2011). As mentioned, existential isolation is problematic in that it undermines the social validation that supports one's worldview. ACT explicitly focuses on connecting a client to their values and fosters their commitment to taking action to live a meaningful life, which can also strengthen a client's perceived meaning in life and faith in their worldview.

## 8 Concluding Remarks

Existential isolation is an inherent component of the human condition. It is impossible to know with certainty that anyone else experiences the way you perceive the world or truly understands your subjective experiences. Awareness of one's existential isolation can threaten the symbolic foundation of our systems of meaning and psychological security. A confrontation with one's isolation often leads to defensive behaviors aimed at pushing it out of conscious awareness, but many theorists contend that confrontation can ultimately lead to growth. Empirical studies have found that existential isolation relates to a variety of mental health concerns (e.g.,

depression, suicide ideation), cultural factors (e.g., collectivism), and interpersonal factors (e.g., insecure attachment style, minority status). Treatment considerations should focus on the healing aspects of the therapeutic alliance and the insights offered by recent cognitive behavioral therapies.

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# Isolation, Loneliness and Mental Health


**Isabella Ingram and Peter J. Kelly**

**Abstract** In this chapter, we discuss two conceptualisations of loneliness: a singular construct and a multidimensional construct that can be experienced in both social and emotional forms. Based on these two views of loneliness, we discuss measurement approaches and difficulties capturing loneliness, which can be a highly subjective experience. We review two key theories that may help to explain how loneliness arises, is maintained and may be overcome. These are cognitive theories of loneliness and the social identity approach. The chapter goes on to highlight the significant physical and mental health implications of loneliness, including proposed mechanisms by which health affects loneliness and conversely how loneliness can affect health. Finally, we discuss research about the relationship between loneliness and various forms of psychopathology, including depression, anxiety, psychosis and substance use disorders. Empirical studies are reviewed throughout, and clinical implications of this evidence are highlighted.

**Keywords** Loneliness · Mental health · Theory · Measurement · Depression · Anxiety · Psychosis · Substance use disorder

## 1 Interpersonal Isolation and Loneliness

Interpersonal isolation refers to the loneliness created by social distance. Loneliness is described as a distressing emotional experience that results from a discrepancy between the relationships an individual perceives they have and those that they desire (Peplau & Perlman, 1982). A sense of belonging is a fundamental human need (Maslow, 1943). Loneliness has been argued to serve an evolutionary function, such that positive social interactions are affectively rewarding for humans, while

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social deprivation and the experience of loneliness are punishing (Baumeister & Leary, 1995). Early evolutionary perspectives suggest that the feeling of loneliness serves to protect individuals from the danger of remaining socially isolated (Baumeister & Leary, 1995). Thus, the feeling of loneliness triggers us to seek social connectedness, trust, cohesiveness and collective action, all of which are needed to ensure safety and wellbeing (Cacioppo et al., 2014).

## 2 Conceptualisation and Measurement of Loneliness

Throughout the literature, loneliness has been considered as both a one-dimensional construct and a multidimensional construct. This multidimensional conceptualisation encompasses different forms of loneliness that depend on the different types of relationships that are present and fulfilling in one's life. Weiss (1973) proposed that different relationships fulfil distinct interpersonal needs and that loneliness will be experienced differently depending on which of six social provisions is unmet. These social provisions are (1) attachment, which is provided by relationships in which a sense of safety and security is received; (2) social integration, provided by relationships centred on shared interests; (3) opportunity for nurturance, provided by relationships in which others rely upon the individual for their wellbeing; (4) reassurance of worth, provided by relationships in which the individual's competence is recognised by others; (5) reliable alliance, derived from relationships in which an individual can obtain tangible assistance from others; and (6) guidance, provided by relationships in which others can be relied upon for advice and assistance (Andersson, 1998; Russell et al., 1984; Weiss, 1973).

Based on the premise that not all relationships can fulfil all of these needs, Weiss (1973) proposed that loneliness was comprised of two distinct types of loneliness: social loneliness and emotional loneliness. Social loneliness results from a deficiency in social relationships in which an individual feels as though he or she belongs and shares common interests. Emotional loneliness is proposed to result from the lack of attachment to another person who affirms one's values or upon whom the individual feels he or she can rely for emotional support. This type of loneliness is most often associated with romantic relationships and close friendships (Weiss, 1973). Weiss's two-factor conceptualisation of loneliness has been widely accepted across the literature (DiTommaso & Spinner, 1997), with a number of theoretically derived measurement tools having been developed based on this typology (de Jong Gierveld & Van Tilburg, 2006; DiTommaso & Spinner, 1993).

Measures of loneliness have been subjected to critical analysis in the literature. This is largely due to the lack of theoretical clarity in conceptualising loneliness as distinct from related constructs such as social isolation and solitude and whether loneliness is best conceptualised as a singular or multidimensional construct. The most commonly used measure of loneliness is the University of California Los Angeles Loneliness Scale (UCLA; Russell et al., 1978), which has undergone a number of revisions (see Russell et al., 1980; Russell, 1996). This measure has

demonstrated good psychometric properties; however, it only captures the two types of loneliness proposed by Weiss (1973). Other measures of loneliness, such as the De Jong Gierveld scale (de Jong Gierveld & Van Tilburg, 2006), have been criticised due to omitting the terms 'lonely' or 'loneliness' in order to avoid cueing participants. Additionally, some measures such as the 3-item loneliness scale (Hughes et al., 2004) appear to capture objective isolation (little social contact with others) rather than the more subjective state of loneliness (perception that one is alone) (Beller & Wagner, 2018). Researchers have raised concerns over the face validity of such measures (Shiovitz-Ezra & Ayalon, 2012), and this has led to difficulties understanding the effects of loneliness on health and wellbeing (e.g., Beller & Wagner, 2018). Despite this, the UCLA continues to be the most widely used and psychometrically sound, measure of loneliness, and its broad use allows for comparisons of loneliness to be made across differing populations. There is also an 8-item version available, which might be more useful for practitioners who do not want to use the full 20-item version (Roberts et al., 2016).

## 3 Theoretical Understandings of Loneliness

### *3.1 Cognitive Approaches*

Cognitive theories take an individual-level perspective to explain how loneliness arises. It is proposed that expectations about the quality or quantity of interpersonal relationships influence the way people evaluate relationships and in turn how they feel about their relationships (Cacioppo & Hawkley, 2005). The widely applied cognitive discrepancy theory (Peplau & Perlman, 1982) explains that loneliness arises when our individual need for social inclusion is high, yet our social environment is incongruent to this need. Additional perspectives of loneliness have been born from this theory, including a 'loneliness reduction perspective', in which individuals seek social connections when their environment is inadequate to provide a sense of belonging, and a 'loneliness perpetuation perspective', in which the feeling of loneliness may lead to a desensitisation to experiences that are socially rewarding (Vanhalst et al., 2015). This perpetuation of loneliness may be due to a range of cognitive attributions that are characteristic of lonely individuals.

Attributions are a cognitive construct that have received some attention within the loneliness literature. Attribution theory suggests that in attempts to explain the cause of their loneliness, lonely people are likely to attribute causality (Heinrich & Gullone, 2006; Michela et al., 1982). This is due to an attribution style that is internal and stable; that is, these individuals believe their loneliness is due to some shortcoming of their own (internal) and that this shortcoming is unchangeable (stable) (Anderson, 1999; Solano, 1987; Vanhalst et al., 2015). For example, a longitudinal study compared prominent attributions of chronically lonely (i.e., a number of years; Shiovitz-Ezra & Ayalon, 2010) adolescents to those who were not chronically lonely. Participants of this study were required to rate attribution and

emotional responses to vignettes depicting social inclusion and social exclusion situations. The findings revealed that those who were chronically lonely were more likely to deem social inclusion as being due to external circumstances (e.g., coincidence) and to attribute social exclusion to their own internal and non-changing factors (e.g., their likeability) (Vanhalst et al., 2015).

In conjunction with an internal and stable attribution style, a range of social cognitions and attitudes have been found to be characteristic of lonely individuals. In particular, lonely individuals have been found to have a hypervigilance for social threat, negative expectations of relationships and unhelpful biases to social cues (McHugh et al., 2018). In a large review of studies involving children, adolescent and adult samples, attentional biases for social threat, negative attributions, negative evaluations of self and others and expectations for rejection were found to be common and pervasive cognitive traits in those who were lonely (Spithoven et al., 2017).

Social expectations are closely tied to the concept of schemas. Schemas are internal models of the world, constructed in early childhood and often enduring into adulthood. These are comprised of cognitions, memories, emotions and physiological sensations (Young et al., 2006, p. 7). Young (1995) proposed a number of maladaptive schemas that are interpersonally oriented and likely to be relevant to isolation and loneliness. These include 'social isolation/alienation', 'dependence/incompetence', 'enmeshment/underdeveloped self', 'abandonment/instability', 'mistrust/abuse' and 'approval-seeking'. Maladaptive schemas and unhelpful social cognitions paradoxically serve to maintain loneliness over time (Cacioppo et al., 2015). Figure 1 illustrates the role of social cognitions in maintaining feelings of loneliness and, in particular, the role of attributions and self-defeating thoughts. Specifically, lonely individuals are vigilant to signs of threat in their social world (e.g., signs of others negatively evaluating them). These inherent biases may mean that these individuals find evidence in their environment to confirm their beliefs about self and others. Confirmation of such beliefs is likely to lead these individuals to behave in socially counterproductive ways, such as withdrawing from others, avoidance of social contact and sabotage of social relationships. These behaviours in turn might elicit responses from others that maintain the individual's sense of isolation and expectations of their relationships.

Cognitive theories of loneliness offer insight into the intrapersonal and interpersonal processes that serve to maintain loneliness. However, this approach potentially fails to address fully the wider social context within which individuals live (Mann et al., 2017). In the next section, we describe a theory that accounts for the influence of individuals' group and community connections—the social identity approach.

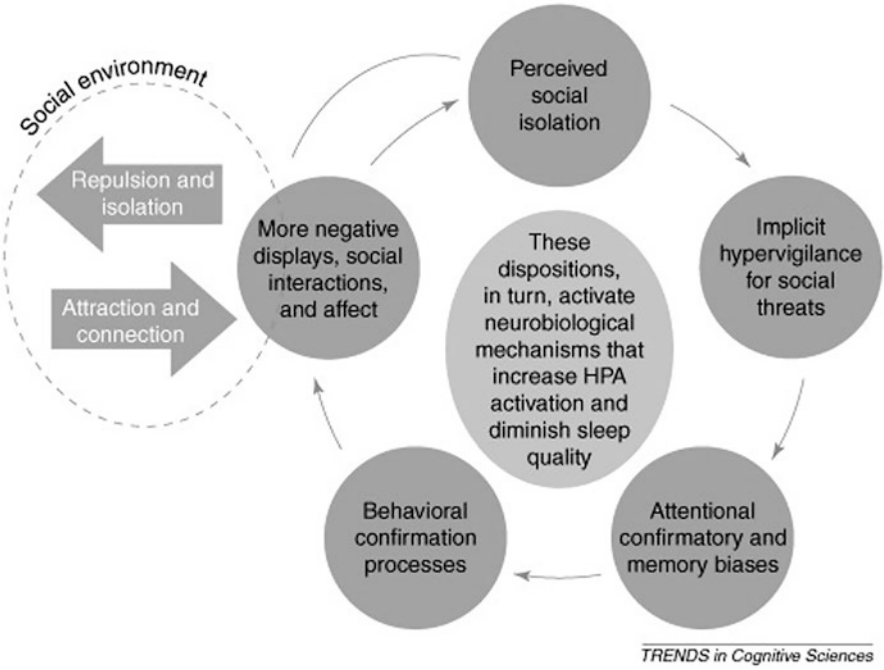


**Fig. 1** Model of perceived social isolation (loneliness) and social cognition. (From Cacioppo and Hawkley (2009), reproduced with permission from author L. Hawkley)

## *3.2 Social Identity Approach*

The social identity approach (SIA) was developed in the social psychology field of intergroup relations and is composed of social identity theory (SIT; Tajfel & Turner, 1979) and self-categorisation theory (SCT; Turner et al., 1987). The social identity approach describes how social groups shape identity and affect behaviour in both helpful and unhelpful ways. SIA recognises that one's identity is informed by both their individual attributes and traits and also by the social groups to which they belong. Categorisation of individuals into groups based on shared attributes facilitates identification with those social groups (Hogg, 1996). Ongoing affiliation with such groups then fosters a sense of identity that becomes part of an individual's self-concept (Tajfel & Turner, 1979). Changes to one's social network can also bring about shifts in identity in terms of one's group memberships and subsequently their values, norms and behaviours (Dingle et al., 2015). Through the lens of SIA, loneliness is considered to arise from a loss or lack of identification with social groups. This suggests that individuals experiencing adversity or undertaking a period of transition or social identity loss (e.g., through relocation, separation, illness or retirement,) are most vulnerable to loneliness.

Social group memberships are considered to be protective against loneliness since they offer opportunities to cultivate close relationships with others through shared meaning. Research has found that belonging to a group that offers meaning and purpose to the individual can lead to an improved sense of self-worth (van Veelen et al., 2016), decreased loneliness, improved mood and increased wellbeing (Cruwys, Dingle, et al., 2014; Cruwys, Haslam, et al., 2014; Williams et al., 2019). The function of group memberships is likely to be dependent on which of the social needs are being fulfilled for the individual, as per the Weiss (1973) notion that different social groups fulfil different social needs. The SIA to understanding loneliness extends beyond the individualised perspective offered by cognitive theories. Through utilising the SIA, one can move beyond the view that it is the lonely individual's inherent beliefs, thought processes or traits that are causing them to feel lonely. Instead, loneliness can be understood by the influence of the social groups to which the individual feels they do or do not belong. See chapter "Social Prescribing: A Review of the Literature" for a description and evaluation of SIA informed interventions for loneliness.

### *3.3 Combined Approach to Understanding Loneliness*

Together, cognitive theories and SIA offer an expansive perspective on how loneliness can arise and persevere. Membership and identification with different social groups are likely to be dependent on how people evaluate themselves and others within these groups (i.e., social cognitions) (Roth et al., 2018). In addition, people's expectations of social relationships and their inherent beliefs about their self and others will be largely affected by their group identification (i.e., their social identity) (e.g., Watson et al., 2007). As such, these theories can be used to inform one another and to help explain how and why individuals become and stay lonely. Research has found that social identity can shape one's attribution style and in turn attenuate feelings of depression (Cruwys, South, et al., 2014). In addition, a qualitative study of older adults found that cognitions associated with fear of rejection and fear of losing preferred identities were key barriers to overcoming loneliness and participating in social activities (Goll et al., 2015). Together, these findings point to the necessity of addressing attributions, social cognitions and schemas and group-based social identities in order to overcome loneliness and highlight the conjoint role of cognitive theories and SIA in explaining social behaviour and subsequent loneliness.

## 4 Loneliness, Health and Psychopathology

Amongst the general population, loneliness has consistently been linked to poor physical and mental health (Beutel et al., 2017; Christiansen et al., 2016; Hawkley et al., 2008; Segrin et al., 2018). Research that has examined the relationship

between loneliness and physical health has found that somatic complaints, sleep disturbances (Cacioppo et al., 2002, 2015), fatigue (Jaremka et al., 2014), poorer cardiovascular functioning (Cacioppo et al., 2002) and chronic illness (Petitte et al., 2015) have all been found to be associated with higher levels of loneliness. This relationship is potentially explained by lonely individuals exhibiting higher systemic inflammation biomarkers (see Nersesian et al., 2018). Similarly, loneliness has been associated with poor health behaviours (e.g., substance use, smoking, less exercise, poor nutrition) (Christiansen et al., 2016; Stickley et al., 2013).

The relationship between loneliness and health is proposed to be reciprocal in nature, such that poor health may lead people to feel lonelier (potentially through variables such as one's physical functional ability or isolation) (Savikko et al., 2005; Shankar et al., 2017) or the experience of loneliness may cause people to experience poorer health (potentially via altering one's physiology) (Luo et al., 2012). Loneliness has been proposed to affect health through the experience of stress (Christiansen et al., 2016; Segrin et al., 2018), whereby lonely people have been found to report higher levels of stress compared to people who are not lonely (Cacioppo et al., 2003; Segrin & Passalacqua, 2010). Stress may be especially problematic for people experiencing loneliness because they often lack social supports to help them manage stress and other mental health problems (Cacioppo et al., 2003).

The negative impact of loneliness on the physical and mental health of individuals has been well established. Overall, findings related to loneliness and health have been so well documented that the negative physical and mental health effects of loneliness have been compared to risk factors for mortality, such as smoking, physical inactivity and obesity (Holt-Lunstad et al., 2015), with a number of first-world countries now having established national campaigns to tackle loneliness (e.g., Australian Coalition to End Loneliness; Campaign to End Loneliness, UK; Connect2Affect, USA).

Research examining mental health variables and loneliness has found loneliness to be consistently linked with poorer quality of life (Theeke et al., 2014) and low self-esteem (Vanhalst et al., 2013). In addition, lonely people typically have higher rates of mental health disorders including depression and anxiety (Richardson et al., 2017), schizophrenia (Tremeau et al., 2016) and features of suicidality (McClelland et al., 2020; Schinka et al., 2012; Stravynski & Boyer, 2001). The remainder of this chapter is dedicated to discussing the relationship between loneliness and psychopathology, including depression, anxiety, serious mental illnesses and substance use disorders.

## *4.1 Loneliness and Depression*

Depression and loneliness are often highly correlated constructs, which share some common causes and intrapersonal features such as poor social skills, shyness, poor self-esteem, introversion, lack of assertiveness, an external locus of control (Blai, 1989), neuroticism (Mund & Neyer, 2016) and a maladaptive attribution style

(Anderson, 1999). However, these experiences are distinct, where loneliness is more specifically related to social deficits, and depression is a diagnosed disorder caused by a broader range of difficulties (Blai, 1989). Depression has been linked to both social and emotional forms of loneliness; however, one study found depression to be best predicted by emotional loneliness (Russell et al., 1984).

Early research that explored the relationship between loneliness and depression found that approximately 50% of people who reported feeling lonely also reported feeling depressed (Rubenstein & Shaver, 1982). Several studies have suggested that loneliness may have a causative role in depression. This has been found across a range of ages and stages of life, such as adolescents, college students and elderly people, whereby feelings of loneliness predicted subsequent depression up to 3 years later (Green et al., 1992; Joiner et al., 2002; Koenig & Abrams, 1999). Conversely, depression has not been found to predict subsequent loneliness in some studies (e.g., Richman et al., 2016). The direction of this relationship suggests that targeting loneliness, and related social constructs, such as enhancing social support and sense of belonging can improve depressive symptoms in some samples (Dingle et al., 2021; Cruwys et al., 2013, 2014; George et al., 1989).

The relationship between loneliness and depression may be explained by factors such as self-esteem and self-concept. Since social relationships largely constitute people's self-concept via their group memberships, loneliness (or a subjective lack of social relationships) is likely to lead to negative self-conception. Additionally, those who are not satisfied with their social world, or do not feel that they belong, may not derive a sense of validation from their networks, which in turn impacts one's self-concept. Poor self-concept and self-esteem are, in turn, highly characteristic of depression. The mediating role of self-concept has been studied amongst a sample of community-dwelling adults. This study found that loneliness predicted depression over a 2-year period and that confusion in one's self-concept mediated this relationship (Richman et al., 2016). Such findings suggest that self-concept may be an important clinical target for depressed individuals who also report feelings of loneliness.

## *4.2 Loneliness and Anxiety Disorders*

Anxiety disorders are highly prevalent with a global lifetime prevalence of up to 34% (Bandelow & Michaelis, 2015). While there is a range of anxiety disorders, social anxiety disorder, panic disorder, agoraphobia and generalised anxiety disorder are most likely to be implicated in loneliness. A primary underlying feature of these anxiety disorders is a hypervigilance to threat and cognitions that drive social behaviour. This hypervigilance to social threat can lead to the use of safety behaviours and engagement in avoidant behaviours. Such avoidance can, in turn, prevent the individual from being in situations that might disconfirm their beliefs about their social world. Such cognitions are not only implicated in the cycle of anxiety but are also characteristic of loneliness (see section above about loneliness and cognitive

theory). Like most forms of psychopathology, the causal direction of the relationship between anxiety and loneliness remains unclear, and it is likely that this relationship is reciprocal.

Loneliness has been proposed to affect anxiety through enhancing one's vigilance to social threat. According to the evolutionary perspective of loneliness, those who are lonely should feel unsafe (in the absence of groups that provide collective action and safety). This lack of safety should in turn trigger feelings of anxiety and subsequent patterns of thinking that are characteristics of anxiety disorders (Cacioppo et al., 2006). Empirical findings suggest loneliness is related to avoidant thinking styles (over and above intrusive thoughts) (Cacioppo et al., 2006). Such findings support the notion that loneliness appears to be more likely to be related to social anxiety disorder over alternate anxiety disorders, such as obsessive-compulsive disorder (Eres et al., 2020). While most research appears to explore social anxiety and loneliness above other forms of anxiety, a recent review concluded that there is a scarcity of research examining indicators of social isolation (including loneliness) as a risk factor for social anxiety. While cross-sectional studies suggest a strong relationship between social anxiety and loneliness across a range of age groups, the review refrained from making conclusions about the causal nature of the relationship (Teo et al., 2013). Social anxiety disorder is characterised by cognitions related to embarrassment and fear of negative evaluation by others. Typical of social anxiety disorder, those who experience extreme discomfort during social interactions may avoid social situations, withdraw from others and consequently become isolated and lonely. A longitudinal study found that social anxiety directly predicted loneliness, and the authors attributed this finding to the avoidance of social contact that is characteristic of social anxiety, which in turn meant opportunity to reduce loneliness was hindered (Lim et al., 2016).

Behaviourally, agoraphobia and social anxiety disorder are not dissimilar. The behaviours characteristic of both can take the form of subtle avoidance (e.g., averting eye gaze) to complete social avoidance and withdrawal. Despite these similarities, social anxiety and agoraphobia are usually cognitively distinct. Agoraphobia, in which one fears situations in which they may be unable to escape should anxiety intensify, tends to be propelled by beliefs about control and safety in public situations (associated with having a panic attack in public). Like social anxiety disorder, the disabling effects of agoraphobia mean opportunities for social contact that can alleviate loneliness are significantly reduced. Through the lens of the social identity approach, loneliness can be alleviated through the sense of belonging and social identity that is derived from group memberships.

Paradoxically, social anxiety disorder and agoraphobia make the notion of seeking out social groups seem somewhat impossible for many individuals. Identification with certain groups is proposed to affect treatment outcomes for social anxiety disorder. A study by Meuret et al. (2016) found that the extent to which one identified with an in-group (other people who experience anxiety) and an out-group (people who do not experience anxiety at clinical levels) following a cognitive behaviour therapy intervention predicted social anxiety symptom severity. That is, closer identification to both groups predicted fewer social anxiety symptoms. While not

empirically tested in this study, the sense of belonging and acceptance that accompanies closer social identification may directly or indirectly influence symptoms of social anxiety.

Overall, cognitions and behaviours characteristic of anxiety disorders are likely to contribute to social isolation and feelings of loneliness. Reduced opportunity for social contact in order to alleviate loneliness is often the result of the safety-seeking and avoidant behaviours that accompany anxiety. Conversely, those who are lonely may view their social environment as threatening, which in turn can enhance symptoms of social anxiety. For clinicians, the identification of symptoms of anxiety and addressing these cognitions and behavioural outcomes may be necessary in order to alleviate loneliness. Additionally, when treating anxiety disorders, it may be necessary for clinicians to include initial and ongoing assessments of loneliness.

### *4.3 Loneliness and Psychosis*

Loneliness is highly prevalent amongst people living with serious mental illnesses, such as psychosis (Stain et al., 2012). Loneliness appears to be pervasive for many individuals experiencing psychosis, regardless of the onset (early or late) of psychotic symptoms or the presence or absence of positive symptoms. Additionally, little research has found that severity of psychotic symptoms (both positive and negative) is related to loneliness (see Lim et al., 2018).

Loneliness has been proposed to affect psychotic symptoms, just as psychotic symptoms are likely to affect feelings of loneliness. A common feature of psychotic disorders is poor theory or mind, or social understanding, meaning often people with psychosis have difficulty initiating and maintaining functioning relationships (Stain et al., 2012). Such difficulties in interpersonal interactions are likely to leave a person vulnerable to social isolation and subsequent feelings of loneliness. While people with psychosis typically report reduced access to social supports (Lim et al., 2018), even those who do have social networks in place may not derive a subjective sense of belonging and support from these networks.

Social adversity has been proposed to be a risk factor for the development of psychotic symptoms such as paranoia (Lim et al., 2018). People with psychotic disorders face high rates of social marginalisation, which in turn can contribute to the development of internalised stigma and negative perception of self and others (Corrigan et al., 2011). It has been proposed that one way to cope with such stigma may be to choose *not* to identify with a devalued social group or to decide not to disclose one's stigmatised identity (Camacho et al., 2020). However, such denial of this identity has been shown to be associated with enhanced distress and reduced treatment compliance amongst people with mental illnesses (see Meuret et al., 2016, for a complete discussion). Acceptance of this social identification is one challenge that people who experience psychosis may experience, and a lack of identification with social groups may in turn enhance feelings of loneliness (see earlier discussion related to the social identity approach to loneliness).

Self-concept and self-esteem appear to be largely at play in the dynamic between loneliness and psychosis, with studies consistently finding a correlation between loneliness and self-esteem amongst people with psychosis (see Lim et al., 2018). It has been proposed that loneliness may affect psychotic symptoms, such as paranoia, through the experience of anxiety and related cognitions surrounding one's acceptance by others (Sündermann et al., 2014). Anxiety has been long observed to trigger delusional thoughts and hallucinations. As discussed in the preceding section of this chapter, loneliness and social anxiety are highly correlated constructs, which appear to feed into one another. When lonely, one may become socially anxious due to distorted social cognitions, appraisals of social threat and reduced social contact/opportunity to disconfirm these maladaptive social appraisals. The maintaining cycle may in turn reinforce both feelings of loneliness and anxiety, which in turn may exacerbate psychotic symptoms, such as delusions surrounding social humiliation or subjugation.

Loneliness may further impact on psychotic symptoms through functional and structural aspects of one's social network. When lonely or isolated, individuals are unlikely to have a supportive confidant in which they can discuss symptoms of psychosis with. As such, the ability to consider alternatives to any unusual ideas they may experience might be hindered by the absence of a confidant who can provide more normalising explanations. This reduced access to support and correcting explanations may in turn exacerbate paranoia (Garety et al., 2001).

Taken together, literature that examines loneliness amongst people with psychosis suggests that symptoms characteristic of psychosis, such as an impaired theory of mind, and reduced social functioning make this population vulnerable to loneliness. Loneliness in turn is likely to affect psychotic symptoms through enhanced social anxiety, related social cognitions and reduced access to confidants that may be necessary in order to challenge and overcome these cognitions.

## *4.4 Loneliness and Substance Use Disorders*

Loneliness has been linked to problematic substance use in numerous studies. In particular, loneliness has been associated with tobacco use (Beutel et al., 2017), increased alcohol use and dependence (Akerlind & Hornquist, 1992; MacNeill et al., 2016) and illicit drug use (Cacioppo et al., 2002; Stickley et al., 2014). A number of studies have found that people with substance use disorders (SUD) are lonelier than non-clinical comparators (Hosseinbor et al., 2014) and that people who are actively using substances may be lonelier than those who are in recovery (Allen et al., 1981; Elton & Hornquist, 1983).

While these studies provide a basis for the belief that people with SUD are vulnerable to loneliness, there is little understanding of whether loneliness is an antecedent to, or a consequence of, substance dependence or perhaps both (see Ingram, Kelly, Deane, Baker, & Dingle, 2020). Few studies have examined the direction of the association between loneliness and substance use; however, some research

points to loneliness as a precursor to substance use. For many members of the general population, substance use has been reported to serve as a social facilitator (Phillips et al., 2018). Individuals who have high needs for social approval are prone to increased substance use (Caudill & Kong, 2001).

The social function of substance use has been explored in a review by Cooper et al. (2015). This study sought to examine personality traits and social and cognitive motives for alcohol, marijuana and tobacco use across a range of populations, life stages and countries. Findings from this review suggested that beliefs that alcohol can be used to attain positive social outcomes and to help regulate affect are widespread and that these beliefs predict use-related outcomes. The findings were mixed for other substances where light marijuana use was linked to social and conformity motivations, and tobacco use was driven by habit and withdrawal cues. Despite this, the review revealed that substance use serves a social function of enhancing connections with others and that this can be influenced by individuals' sense of insecurity and social discomfort (Cooper et al., 2015).

In contrast, substance dependence may be a precursor to loneliness due to stigma, the transient nature of social networks and limited social supports available during addiction and recovery. People with SUD have been found to be subject to estrangement from social contacts and, as such, may have significantly less access to social support (Phillips & Shaw, 2013) and a greater proportion of interpersonal difficulties (Segrin, 2001). Additionally, people with SUD may make and maintain relationships that meet their needs at the time of active substance use, but once in recovery, their social needs are likely to have changed (e.g., toward non-using contacts). There is evidence to suggest that greater engagement with networks of people supportive of recovery can sustain longer maintenance of recovery (Frings & Albery, 2015). As such, when in recovery, there may be a need to avoid those situations and relationships that perpetuate ongoing substance use and to connect with people who support one's recovery (Best et al., 2011). While the rationale behind such ideas is to best facilitate one's recovery from addiction, this process is likely to increase the risk of loneliness for people with substance use problems, particularly those that are in the early stages of recovery.

A recent review of 41 studies that examined loneliness in people with SUD (Ingram, Kelly, Deane, Baker, Goh, et al., 2020) found preliminary evidence to suggest that people with substance use problems are lonelier than the general population (i.e., Ingram et al., 2018) and that females and those who were younger may be lonelier (although the mean age of these samples varied). This review also concluded that for people with SUD, loneliness was consistently related to poor physical and mental health across studies that included these variables. Since data were predominantly correlational in nature, the causal sequence of these relationships cannot be determined, and it is possible that loneliness leads to poorer health, or those experiencing poorer health become lonelier, or both. While it remains unclear whether differences in loneliness exist based on type of substance of dependence, a consistent finding was that higher severity/duration of substance dependence is related to higher loneliness. No research has clarified the causal direction or dynamic of this relationship, but it is possible that those who use substances to a greater

extent (i.e., higher severity) are also those who are more likely to have difficulty maintaining relationships and/or to be stigmatised in society and ultimately become lonelier as a result of social isolation and stigma.

## 5 Conclusion

This chapter highlights the conceptualisation of loneliness as a multidimensional construct, encompassing both social and emotional forms. The experience of these different types of loneliness is largely dependent on the types of relationships that are missing from one's life. Loneliness is implicated in poor physical health to the extent that it predicts poorer cardiovascular functioning, fatigue and chronic illnesses. While loneliness may alter physiology (through stress) to impact upon one's physical health, physical health can also impact upon feelings of loneliness. This is likely to be due to objective social isolation that can result from stigma attached to health conditions or reduced functional ability that restricts social contact. Furthermore, loneliness plays a key role in a number of mental health conditions. In this chapter, we discussed the relationship between loneliness and depression, anxiety disorders, psychoses and substance use disorders. Taken together, discussions presented throughout this chapter suggest that loneliness can contribute to, and be an outcome of, several significant mental health conditions. Due to the cognitions and social behaviours that are shared perpetuators of both loneliness and psychopathology, assessing and targeting loneliness in clinical interventions are likely to have positive implications for recovery from mental health conditions.

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# Social Prescribing: A Review of the Literature


**Genevieve A. Dingle and Leah S. Sharman**

**Abstract** This chapter presents an overview of interventions to address loneliness including individual therapies, group interventions and community-based approaches. We argue that individual cognitive behaviour therapy is neither necessary nor sufficient to address loneliness. Instead, we advocate for applying cognitive behaviour therapy strategies to help people overcome cognitive barriers to connecting with others, implemented within their social contexts. Such cognitive barriers include stigma, fear of negative evaluation and mistrust of others. The chapter describes some novel group and community approaches. The Groups 4 Health program for people experiencing loneliness (Haslam et al., J Consult Clin Psychol 87(9):787–801, https://doi.org/10.1037/ccp0000427, 2019) and Groups 4 Belonging program for people in addiction recovery (Dingle et al., Taking social identity into practice. In: Frings D (ed) Handbook of alcohol and alcoholism, Elsevier, London, 2020) help participants to overcome loneliness and social anxiety through reconnecting with existing groups and joining new groups that are meaningful to them. Another approach is social prescribing, which provides a non-clinical referral pathway for isolated people to engage with community groups that help to meet their social needs aligned with their interests (such as arts, exercise and educational groups). We summarise evidence that social prescribing to community groups is effective for managing loneliness in diverse populations.

**Keywords** Loneliness interventions · Social prescribing · Group programs · Stigma · Fear of negative evaluation · Mistrust

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## 1 Addressing Loneliness

Loneliness is not a diagnosed health condition, and as such, it has tended to be under-recognised and treated within psychology practice. That said, clinicians should be alert to signs of loneliness in their clients due to its association with a range of mental health conditions, such as those described in chapters "Existential Isolation: Theory, Empirical Findings, and Clinical Considerations" and "Isolation, Loneliness and Mental Health". Furthermore, we can apply many cognitive behavioural strategies to the causes and effects of loneliness. In this chapter, we will briefly describe how individual interventions have been applied to clients who experience isolation and loneliness. Based on this research evidence, we argue that individual cognitive behaviour therapy is neither sufficient nor always necessary to address loneliness. Instead, we advocate for applying cognitive behaviour therapy strategies to help people overcome barriers to connecting with others, implemented within their social contexts such as families, places of study and work and broader communities. Group interventions in the community provide excellent opportunities for practicing new ideas and social skills within a safe social context. Tailored and link worker-supported referral to such community groups is at the heart of social prescribing.

## 2 Individual Therapy

As earlier researchers have pointed out, simply bringing lonely people together does not result in the development of friendships, and health services designed around mental health symptom management are not optimally effective in helping clients to develop social networks or friendships (Stevens, 2001). Nevertheless, a range of strategies for reducing loneliness and/or social isolation have been evaluated and have revealed four primary strategies used in loneliness interventions:

1. *Improving social skills*, including practical skills, such as learning conversational skills, interpreting non-verbal social cues, as well as friendship enrichment training.
2. *Enhancing social support* through the creation of support groups for people with a common issue, such as weight loss groups and groups for those undergoing life transitions, such as retirement or bereavement. These interventions are usually supported by professionals, rather than groups created within communities, and run by peers.
3. Programs that increase *opportunities for social interaction*. These tend to revolve around the natural formation of relationships through involvement in a new activity such as volunteering to deliver food parcels to others in the community (Pilisuk & Minkler, 1980).
4. *Addressing maladaptive social cognition*, often in combination with social skills training. These are often CBT-based programs, primarily in groups, and tend to

attribute the cause of loneliness to cognitive biases (e.g., irrational, self-defeating thoughts) that result from increased vigilance to social threats (Cacioppo & Hawkley, 2009).

The efficacy of these types of intervention for loneliness have primarily been evaluated using qualitative methods (Cattan et al., 2005; McWhirter, 1990; Perese & Wolf, 2005; Rook, 1984) with mixed findings. However, many of the qualitative studies have been found to be of low quality with many not resulting in reductions to loneliness. To better understand the evidence around interventions for loneliness using higher-quality research, a meta-analysis reviewed the evidence from quantitative studies (Masi et al., 2011). This review included 50 studies of loneliness interventions and revealed that much of the literature was characterised by single-arm, pre-post and non-randomised studies. Overall, the effect sizes were modest and only the randomised studies showed significant mean effect sizes. Of these, studies that addressed maladaptive cognition were found to be more effective than those attempting to improve social skills, enhance support or increasing opportunities for social contact.

More recent interventions have attempted to use technology to decrease feelings of loneliness. This has included the development of a smartphone application called +Connect that delivers daily positive psychology content to users for 6 weeks (Lim et al., 2020). A pilot evaluation of the app with 12 participants experiencing psychosis found high levels of engagement and completion of the 42-day course. There was tentative evidence that using the app may reduce loneliness, with scores decreasing from pre-intervention to 3 months post-intervention. A majority (90%) of participants agreed that +Connect helped them to increase their social confidence, enjoy life, look forward to being with other people and feel more connected with others. A related pilot of the +Connect app with 9 participants diagnosed with social anxiety disorder (SAD) and 11 participants with no mental health conditions indicated that the app is less acceptable for young people with SAD (Lim et al., 2019). The drop-out rate was nearly twice as high among participants with social anxiety compared to the others. Loneliness scores decreased over time in both subgroups. Although the participants with SAD reported that +Connect was easy to understand and helped them accept their mental health symptoms, many reported dissatisfactions with aspects of the app, including creating new relationships and increasing social confidence. The authors indicated that further refinements were being made to address this feedback (Lim et al., 2019).

Taken together, these findings suggest that focusing on individual risk factors and traits underlying loneliness is not enough. There is a clear need to embed loneliness interventions within social groups and communities to help people to overcome barriers to connecting with others. We will consider group interventions and social prescribing to community group programs in the following sections.

## 3 Group Interventions

Group interventions are common in hospital mental health services, where patients might attend a group therapy session every day. They are also common in outpatient services where participants typically attend group sessions once a week for, say, 6–10 weeks (Bieling et al., 2013). There is ample evidence that group cognitive behaviour therapy (CBT) is effective for common presenting complaints such as social anxiety (Piet et al., 2010), depression (Oei & Dingle, 2008) and substance use disorders (Carter-Sobell & Sobell, 2011). Group CBT offers participants a space to share and normalise their experiences of mental illness with other group members. Challenges to distorted thoughts may be more powerful coming from other group members than from the therapist. Further, exposure therapy in a group setting provides a safe environment with immediate feedback and support from group members. But is group CBT effective for managing loneliness?

A study of 92 adults attending an intensive group CBT program assessed loneliness, indexed by social isolation schema scores (Schmidt et al., 1995) assessed at the beginning and end of the program. This study found that social isolation schema scores decreased significantly during group CBT but only among participants who formed a strong identification with the therapy group (Cruwys et al., 2014). This idea that group identification is a key mechanism in its effectiveness is drawn from the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987). Originally developed in the social and organisational psychology fields, this framework has more recently been applied to a range of health conditions and populations (Haslam et al., 2018; Jetten et al., 2012). According to the social identity approach, groups can influence a person's health and wellbeing in both positive and negative ways.

Interestingly, groups do not have to be formal therapy groups to influence participants' mental health and wellbeing. Research shows that arts groups, such as choir singing, music production and creative writing, and exercise groups, such as yoga and futsal, help vulnerable people to increase their wellbeing over time to the extent that they identify with their group (Cruwys et al., 2018; Forbes, 2020; Kyprianides & Easterbrook, 2020; Williams, Dingle, Jetten, & Rowan, 2019). These benefits of group identification occur irrespective of what the group does together. One of the mechanisms for the effect of community-based groups on mental wellbeing is through the development of a sense of belonging (Williams, Dingle, Calligeros, et al., 2019) – in other words, helping participants to overcome their loneliness. We will come back to this point in the section on social prescribing.

## 4 Groups 4 Health

The social identity framework underpins the Groups 4 Health program (Haslam et al., 2016, 2019), a group intervention designed to help individuals strengthen their social connections and overcome loneliness. Although it is not framed as a

CBT program, elements such as psychoeducation, goal setting, problem solving and social support are common to both approaches. The program comprises five sessions over 8 weeks, and groups typically have around six participants and two facilitators. The first session seeks to raise participants' awareness of the beneficial effects that social group memberships have for health and, conversely, the costs of neglecting the social dimensions of health. This session also emphasises peoples' capacity to counter these effects by self-managing their groups and group-based resources. The second session engages participants in the process of social identity mapping (SIM) (Bentley et al., 2019; Cruwys et al., 2016), which allows them to visualise their social group networks and psychological resources. The map is then used as the basis for discussion of how people would ideally like their social groups to be in the future and to identify any gaps in their group networks.

The third session helps participants to develop strategies to identify and strengthen their existing valued groups memberships and identities. The fourth session uses the Groups 4 Health group as a model for developing new social group connections whilst also identifying which connections to develop. Participants are assisted to write a social plan of action that they work on for the next month until the final session. Session five is a booster session in which facilitators help to troubleshoot any problems that participants have encountered in implementing their social plans. Participants create another SIM and compare it to their earlier map to examine how their networks have changed over the course of the program. The skills that have been learned across the course are reviewed and key messages reinforced with the goal of encouraging long-term maintenance.

The Groups 4 Health program improves a number of outcomes. In a proof-of-concept study involving 26 young people completing the program and 25 controls, Groups 4 Health demonstrated effectiveness in reducing social anxiety and loneliness and increasing life satisfaction and social functioning (Haslam et al., 2016). A full trial in which 120 participants were randomly assigned to Groups 4 Health (G4H) or treatment-as-usual (TAU) provided further evidence to support the program. In this trial, G4H produced a greater reduction in loneliness ($d = -1.04$) and social anxiety ($d = -0.46$) than TAU ($d = -0.33$ and $d = 0.03$, respectively). G4H was also associated with fewer general practitioner visits at follow-up ($d = -0.33$) and a stronger sense of belonging to multiple groups ($d = 0.52$) relative to TAU ($d = 0.30$ and $d = 0.33$, respectively). Depression declined significantly in both G4H ($d = -0.63$) and TAU ($d = -0.34$) (Haslam et al., 2019). Several adaptations to the Groups 4 Health program for various populations are currently being evaluated. The next section describes the Groups 4 Belonging program that was developed for people in recovery from addiction problems.

As mentioned in chapter "Isolation, Loneliness and Mental Health", loneliness is a particularly common experience among people seeking treatment for substance use disorders, with around 70% reporting that loneliness is a serious problem for them (Ingram, Kelly, Deane, Baker, Goh, et al., 2020; Ingram et al., 2018; Li et al., 2017; McDonagh et al., 2020). Loneliness is challenging for recovery as it is a potential antecedent to substance use. It is also associated with hypervigilance for social threats and can lead a person to distance themselves from others (Layden

et al., 2018). A qualitative analysis of interviews with adults in residential treatment revealed several key cognitive barriers to building new (sober) group memberships, including stigma, mistrust and fear of negative evaluation (Ingram, Kelly, Deane, Baker, & Dingle, 2020). Let us examine each of these in turn and then explore how the Groups 4 Belonging program addresses these in an intervention.

## 5 Cognitive Barriers to Connecting with Others

### *5.1 Stigma*

Stigma can adversely affect health and wellbeing in several ways (Haslam et al., 2018). In depressed young people, for instance, the non-disclosure of depression contributes to social distance and loneliness (Achterbergh et al., 2020). When the stigma is thought to be justified, it prevents people from identifying with others who share that stigma. Rusch and colleagues found that self-prejudice can exacerbate the effects of mental illness because self-discrimination means that people fail to pursue employment or independent living opportunities (Rüsch et al., 2005). Stigma often leads to the marginalisation and devaluation of substance-using groups and the creation of unhelpful 'us-them' divisions between those who need help and other members of society who might be able to provide it. Several studies have found that people with substance use disorders are more highly stigmatised than people who experience other health conditions (Corrigan et al., 2017; Room, 2005). Stigma surrounding certain behaviours (such as using substances during pregnancy or being drunk in a public place) and groups (such as people who inject drugs) are widely accepted, culturally endorsed and enshrined in policy and the law. This also means that in addition to the many challenges that people with substance abuse problems confront when they go into treatment, they must also deal with the fact that they belong to a highly stigmatised social group. Stigma has numerous consequences including ill treatment by others and loneliness (Hörnquist & Akerlind, 1987; Itzick et al., 2019). One way to overcome stigma is to provide a safe space for people to share their experiences and to feel accepted and regarded as a whole person rather than just a diagnosed health condition.

### *5.2 Mistrust*

A second cognitive barrier to joining with others who might provide social support is mistrust, an abiding belief that others are likely to treat you badly or harm you in some way. Roper and colleagues compared scores on the Young Schema Questionnaire (which assesses the mistrust/abuse schema as well as 15 other maladaptive schemas) from 50 people with alcohol use disorders with scores from 50

control participants (Roper et al., 2010). They found that the mistrust/abuse schema was the most strongly endorsed maladaptive schema in the alcohol sample (*Mdn* = 4.1 out of 5) and was markedly higher than in the controls (*Mdn* = 1.9). Participants endorsed the mistrust schema significantly less strongly (*Mdn* = 3.0) after a brief residential alcohol treatment involving group cognitive behavioural therapy, indicating that supportive group contexts can help people to overcome their mistrust. This is important because mistrust of others exacerbates difficulties accessing and engaging with health providers (Merrill et al., 2002). Mistrust is particularly common among individuals with a history of interpersonal abuse or neglect, a substantial subgroup in any alcohol treatment service (Perryman et al., 2016). Clearly, mistrust beliefs have the potential to act as a barrier against joining new groups and communities because people are vigilant to potential interpersonal threat and tend to avoid getting close to others and sharing their experiences for fear of being manipulated or let down in the process.

> *I think …I've made myself feel lonely because of the trust issues I have with people. So, I pushed myself away even further. Like, I've been asked, had the question put to me, why don't you want to…why can't…why won't you let anyone love you?* – Elise, female resident in alcohol and other drug rehabilitation (Ingram, Kelly, Deane, Baker, & Dingle, 2020)

## *5.3 Fear of Negative Evaluation*

Social anxiety disorder is another disorder that commonly co-occurs with alcohol use disorders. A fear of negative evaluation explains the link between the two disorders as well as coping motives for disordered drinking (Stewart et al., 2006). Fear of negative evaluation is a fear of making a mistake or appearing to be nervous, stupid or awkward in front of others, of attracting scrutiny and evaluating the consequences of such scrutiny as severe. Fear of negative evaluation is a core feature of social anxiety and loneliness. For example, Lim and colleagues recruited 1000 people aged 18–87 years old from the general community to complete online questionnaires on three occasions over a 6-month period (Lim et al., 2016). Results of a cross-lagged model controlling for trait levels and prior states indicated that earlier loneliness predicted future states of social anxiety, paranoia and depression. However, in the same model, social anxiety was the only predictor of future loneliness. It appears that fear of negative evaluation prevents people from reconnecting with former groups who they have had conflict with in the past and may also act a barrier to joining new groups because affected individuals are concerned that others will judge them negatively and reject them.

> *I really can't share in the meeting because I'm just scared that I'm going to be judged.* – Nathan, male in alcohol and other drug rehabilitation (Ingram, Kelly, Deane, Baker, & Dingle, 2020)

To summarise, stigma, mistrust and fear of negative evaluation present cognitive barriers that must be overcome if people are to successfully develop sober social

networks to support their ongoing recovery. People in treatment for substance use will need to identify these potential barriers and to learn skills to overcome them in an intervention that focuses on managing their social group-based social identities. A new intervention called Groups 4 Belonging aims to give people the knowledge and strategies they need to increase their social group belonging and reduce feelings of loneliness whilst addressing these cognitions.

## 6 Groups 4 Belonging

Groups 4 Belonging comprises six 90-minute group sessions. It adapts content from three of the five Groups 4 Health modules and extends on these to include components of mindfulness-based cognitive behaviour therapy to target particular barriers experienced in addiction contexts that might undermine their capacity to connect with others in ways that support their recovery (Dingle et al., 2019, 2020). The first session includes psychoeducation and a card-sorting activity about the relative importance of social factors for health and longevity alongside of other well-known health factors such as exercise, diet, smoking and weight. Facilitators then guide participants to create an SIM to visualise their own social networks. Session two focuses on the meaning and consequences of loneliness, and participants learn how to identify and address thoughts and feelings associated with loneliness. They practice two mindfulness exercises as strategies for detaching from these unhelpful thoughts and sensations that are risks for drinking.

In the third session, participants are taught to differentiate between the quantity and quality of their social connections. They complete an imagery exercise to help identify their values in relationships and explore how the groups identified in their SIM groups reflect important values that they hold. The focus of session four is reconnecting with existing social groups. Participants consider how groups currently meet their needs and how they anticipate these groups will meet their needs as they progress through the recovery pathway. They complete an exercise in how to manage knock-backs. They also discuss stigma and how it may be overcome to connect with others. Social goals are developed for reconnecting with known groups. Their social goals are further developed in session five with a focus on developing new group memberships. Here, participants explore group-based activities in their community and ways to overcome any fears they have about facing negative evaluation from others. Participants continue working on their social goals between sessions. The sixth (and final) session reviews participants' progress on their social goals and focuses on overcoming barriers associated with mistrust. It also includes an exercise in which participants use music listening as an alternative to mindfulness practice for regulating negative emotions.

The Groups 4 Belonging program was piloted to explore demand for (recruitment, attendance and retention) and acceptability of the program with individuals in residential substance use treatment. Over half of the people attending the services were interested in participating in Groups 4 Belonging. Of 41 participants who

commenced the program, 20 participants completed the program per protocol. In terms of acceptability, the average number of sessions attended was 3.7, and satisfaction with the program was high, with 95% of participants reporting they enjoyed Groups 4 Belonging. It was concluded that Groups 4 Belonging may be feasible for delivery in residential substance use treatment services (Ingram, Kelly, Haslam, O'Neil, Deane, et al. 2020). This program shows preliminary evidence in support of integrating cognitive therapy strategies with group- and community-building strategies to help participants to overcome loneliness. For people who are not attending a structured program such as Groups 4 Belonging, another approach to building group and community connections is called social prescribing.

## 7 Social Prescribing

Social prescribing is a relatively new model of healthcare that provides patients with non-medical supports through reconnection to the community. This model was developed as an innovative way to move beyond the medical model and address the wider social determinants of health (Kimberlee, 2013; Woodall et al., 2018). One rationale for social prescribing is that patients who frequently present to general practitioner (GP) clinics with complex physical or mental health problems are often presenting because of unmet social needs, namely, loneliness (Cruwys et al., 2018). In fact, it is estimated that 10% of patients attending GP clinics account for between 30% and 50% of appointments. Social prescribing enables GPs and other health and social care professionals to refer people experiencing loneliness or social isolation to a range of community services that can address these social needs. Whilst there is no widely agreed model for social prescribing, schemes commonly involve three components: (1) a referral into the program via a GP, allied health professional, community member or self-referral, (2) consultation with a link worker (also known as wellbeing coordinators or community development workers), and (3) the use of local voluntary groups and community organisations. Simply talking about community programs with patients or giving them a brochure does not constitute social prescribing. Instead, it would be considered 'sign posting' due to the absence of several important 'ingredients'.

One key ingredient for successful social prescription is the link worker who supports clients to engage with social programs provided by third-sector organisations in the community. These are carefully selected based on the individual's interests and needs and could involve anything from volunteering with meal delivery to playing croquet to joining a swimming squad (Kellezi et al., 2020). Link workers utilise diverse methods of communication, planning and adaptation, both to their clients' needs, who often have varying levels of chronic illness and physical disability, and with community group facilitators who may need extra guidance to support these clients. Their role involves not only working with clients to co-develop a health plan and supporting their engagement with new group(s) but also ensuring that clients' other health and social needs that may be barriers to social engagement are taken

care of (Sharman, Hayes, McNamara & Dingle, 2022). This can, and often does, include advocating for clients in other spaces, such as welfare, disability support and within mental healthcare (Bertotti et al., 2018; Kellezi et al., 2020; Sharman, Hayes, McNamara & Dingle, 2022; Woodall et al., 2018). In this sense, social prescribing has been described as having the potential to develop a 'holistic health service' where social, physical and mental health concerns can be addressed (Kellezi et al., 2019).

Advocacy in the role of link workers is most often to address various health and social barriers to joining and engaging in groups. Anecdotally, the most common barriers described by Australian link workers and clients in the United Kingdom are financial, transport and mental health barriers, namely, social anxiety (Kellezi et al., 2019; Sharman, Hayes, McNamara & Dingle, 2022). Although barriers for each person can be wide-ranging, the link worker's role in overcoming these cannot be underestimated. They utilise an array of strategies to ensure that clients are in the best position to re-engage in the community and their preferred groups. For social anxiety, these strategies may be simply attending groups with clients or introducing group facilitators to clients before an initial session, or it may involve referral to counsellors or psychologists. Overcoming transport issues, although often intertwined with financial barriers, have involved catching a bus with a client so they know the route to take and can feel confident, whilst financial issues are often addressed through links with social welfare programs as well as attempts to find the most low-cost or free programs that still suit clients' wants and needs.

Whilst link workers are involved in physically connecting clients to groups and helping them overcome the barriers they face to attendance, the success of that connection is not guaranteed. Although we do not yet know which groups work and for who, successful social prescribing is dependent on the quality of the relationship with other group members and the strength of the therapeutic relationship with link workers. This has been reflected by clients and link workers:

> *I felt as though they gave me the chance to reason out that I was getting better. I listened to them. I knew what was going on in my head, but I couldn't always, I didn't always want to tell anyone. I seemed, with the link-worker, I seemed as though I could get over that more quickly. He wasn't demanding. He was very quiet and very gentle with it, and that is the way that I needed somebody to be, to maybe listen to me, really listen to me, and hear what I was saying, if you can understand that*. Client (Kellezi et al., 2019)

> *…the success of the program is really dependent on the relationship the wellbeing coordinator has with the client. If they can develop a relationship of trust and rapport, that they feel that they can engage in something and be taken on that journey, then they feel safe to be able to do that and to engage and to be able to - They feel like somebody's listened to them, somebody really understands what their needs are, somebody really wants to bring them into be engaged in something that they're interested in.* Link worker (Sharman, Hayes, McNamara & Dingle, 2022)

> *…but it's the sense of belonging and inclusion that comes with being part of a group that I think really has the most benefit for people who are experiencing social isolation and loneliness*. Link worker (Health_and_Wellbeing_Queensland, 2020)

Whilst evidence of the various benefits of social prescribing continues to emerge, it has so far been limited in terms of providing clear guidance about what groups work and for whom. Evaluating these schemes can be complex due to the diverse array of group programs available, the time taken to gain benefits with varying levels of link worker intervention and relatedly, the wide-ranging health issues and circumstances of the clients. This has led to several studies with poor methodological quality and a lack of standardised theory and outcome measures. Indeed, a review of 15 quantitative social prescribing programs with strict entry pathways (i.e., health practitioner referral only) found that research in this area is significantly limited by studies with poor design, including lack of follow-up, and small sample sizes (Bickerdike et al., 2017).

This lack of robust evidence, of course, does not mean social prescribing does not lead to improvements. The evidence base for social prescribing programs, incorporating quantitative and qualitative evaluations with wide-ranging measures across studies, demonstrates that social prescribing programs are effective for improving health and wellbeing among clients (Chatterjee et al., 2018). Specifically, this review of 86 articles found that social prescribing programs reduced feelings of loneliness and social isolation and led to improvements in sociability and communication (Chatterjee et al., 2018). A variety of other key outcomes were also observed from the research reviewed, such as improvements to physical health, anxiety, depression, increased self-esteem, feelings of control and empowerment. Furthermore, qualitative evaluations have shown that clients enjoy their relationships with link workers where they feel a sense of trust and ability to confront their social problems, feel a sense of belonging and connection to their social groups and are generally satisfied within their social prescribing schemes (Carnes et al., 2017; Kellezi et al., 2019; Wildman et al., 2019).

## 8 Conclusion

Whether lonely people develop skills and strategies to self-manage their social group connections (by attending programs such as Groups 4 Health or Groups 4 Belonging) or do this with the assistance of a cognitive behaviour therapist or link worker, it appears that trustworthy relationships with group facilitators and link workers are important, and the person's interests and needs are central to the co-designed social plan. Further, clients need to feel welcome and safe within the groups they attend, and this relies in part on the skills and sensitivity of the community program facilitators and the other members of the group. Social prescribing to community groups is an emerging area and one that requires a validated theoretical framework and robust research with the use of randomised control trials to ensure the best quality of evidence. Although it is early days for social prescribing, this approach has exciting implications for how we view health and wellbeing. No longer confined to specialised medicalised care in hospitals and clinics, social prescribing shifts the agent of health to the client and the space for health to homes,

places of study and work and the broader community. Loneliness is fundamentally a social problem that is best addressed within these social contexts.

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# Part IV
# Identity

# Identity and the Courage to Be: From Kierkegaard to Covid-19


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**Abstract** Who am I? How can I be true to myself? How can I be authentic given the world I live in? These questions have been explored by existentialist philosophers, positioning courage in the face of dread as central to the development of a unique, embodied identity. Rather than being a fixed construct, based solely on the circumstances of birth or prescribed roles and stereotypes, identity can be created, after experience and despite anxiety, fleeting, liminal a part of the continued process of individuation. In this chapter I will trace the existentialist approach to identity, from the spiritual dimensions of Kierkegaard and Tillich to the humanist self-determined reinvention of Sartre. I will consider the ontology of selfhood further, particularly through the fleeting temporal and storied conceptualizations of Heidegger and Ricoeur, highlighting our identity as a continuous process of becoming. Heidegger and Merleau-Ponty will also remind us that identity cannot be understood with reference to materiality, specifically our historicity (being in the world) and corporeal body. Any discussion of roles and stereotypes, however, must also consider oppression and marginalization as primary threats to non-being. I will consider critical existentialisms, including the feminism of Simone de Beauvoir, the post-colonialism of Fanon, and the identity politics of Judith Butler. Lastly we will turn to the dynamics of identity in an era of global dread, exploring the ways in which the anthropocentrism of traditional existentialism is inadequate for the crises of climate and Covid-19.

**Keywords** Identity · Becoming · Courage · Existentialism

> *We only become what we are by the radical and deep-seated refusal of that which others have made of us.* (Sartre, cited in Judaken, 2006, p. 168)

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## 1 Vignette

Oscar Wilde, poet, playwright, and journalist was one of the most enduring literary characters of the late nineteenth-century Britain, an aesthete, concerned with the beauty of things in themselves rather than their inherent meaning. He was a tremendous artistic success, publishing *The Picture of Dorian Gray* (Wilde, 1891) written in contempt for bourgeois society, the story of a hedonistic man who sells his soul for eternal youth. His satire, *The Importance of Being Earnest* (Wilde, 1895), follows similar themes, positioning irreverence as a preferred morality to the social customs and rituals of Victorian England. Schultz (2001) highlights the two Acts in the narrative of Wilde's life. This first one, of the shameless provocateur, resisting attacks from the press with aphorisms, a Victorian Icarus. The second, once imprisoned, a less shallow more genuine Wilde, engaged with an interiority, 'revealed after everything fell away' (Schultz, 2001, p. 72.). Wilde was charged in 1895 with gross indecency, due to his love affair with Lord Alfred Douglas. Soon after his wife divorced him and his mother died and he never saw his two sons again. After 3 months of hard labor, he began writing a letter to his lover, which came to be titled *De Profundis* (Wilde, 1905). While much of this work is performative, he describes his suffering and despair.

> *I wanted to eat of the fruit of all the trees in the garden of the world ... And so, indeed, I went out, and so I lived. My only mistake was that I confined myself so exclusively to the trees of what seemed to me the sun-lit side of the garden, and shunned the other side for its shadow and its gloom.* (Wilde, 1905, p. 11)

Wilde describes imprisonment as "the tragically critical moment of my life" (1905, p. 7) but also a turning point: "I am conscious now that behind all this beauty, satisfying though it might be, there is some spirit hidden of which the painted forms and shapes are but modes of manifestation, and it is with this spirit that I desire to become in harmony" (1905, p. 89). After prison Wilde is certainly a broken man, poor, and exiled to France until his death in 1900. Regardless he reveals a different identity, publishing two unique pieces. The Ballad of Reading Gaol (1898), written for the proletariat, tells the story of the brutalization of the criminal class. He also writes a letter to *The Daily Chronicle*, The Case of Warder Martin: Some Cruelties of Prison Life (1897), demanding reform for children in jail.

Oscar Wilde's story is an archetypically existential one, concerning itself with the themes of this chapter: how to be one's own unique self in the face of conformity; accepting the threats to non-being, reconstituting oneself regardless; and ultimately how to suffer in a way that deepens authenticity, realizing and remaining true to one's own deeper nature.

## 2 Identity, Existentialism, and Christianity

> *The greatest hazard of all, losing one's self, can occur very quietly in the world, as if it were nothing at all. No other loss can occur so quietly; any other loss – an arm, a leg, five dollars, a wife, etc. - is sure to be noticed.* Kierkegaard (1849, pp. 32–33)

Kierkegaard (1813–1855) was arguably the Father of Existentialism, explicating the search for selfhood well before the mainstay of the movement in the twentieth century. He was also a Christian existentialist, paving the way for more contemporary religious thinkers such as Tillich, Bultmann, and Barth. For Kierkegaard the greatest threat to finding ones' true identity was the doctrinal systems of the Church. A focus on respectability and absolutes was for Kierkegaard an anathema to freedom: "This falsification is really forgery brought about over the centuries, whereby Christianity has gradually become just the opposite of what it is in the New Testament" (Kierkegaard, 1885, p. 74).

Kierkegaard considered Christianity to be a subjective experience, mystical, interior, emergent, one that revealed the uniqueness of the individual rather than suppressing it for the crowd (Thomas, 1953). The search for oneself was a not a journey of the head, but one of the heart. It involved first the experience of anguish and despair, his "sickness unto death," the experience of being isolated from self, and also of not-willing-to-be-oneself, the separation from the person that God intends you to be (Beabout, 1978). This journey is necessarily filled with *fear and trembling*, anxiety resulting from the dizziness of freedom when one leaves the crowd behind. Eventually, however, through the absurdity of faith, jumping into the unknown, there is the possibility of a reconciliation of the finite and infinite. In this sense one's identity can only be found in God.

Paul Tillich was born 10 years after Kierkegaard died, but his career followed many similar themes. He too was a man of faith, questioning the theism of the Church is favor of the existential encounter. For Tillich God was not a being, but rather being-itself, numinous, and accessible only through suffering (Peterson, 2015). Tillich's ontology of courage has three types (Tillich, 1952). Central is the capacity to face death-anxiety, the recognition of our mortality. We are courageous when we seek our own answers for what will happen to us after death rather than relying on the prescriptions of others. Second is moral courage, which comes from recognizing our failings but deciding to accept ourselves anyway. Third is spiritual courage, the capacity to face the feeling that we have no place in the world, no purpose for our existence. For Tillich, self-affirmation is not a purely conscious act of the will, but rather an acceptance, of these negative states before one enters into "the state of being grasped by the power of being-itself" (Tillich, 1952).

## 3 Identity and Existential Humanism

### *3.1 Sartre and Heidegger: Identity as Reinvention*

Despite its origins in Christianity, classic existentialism, personified in Sartre, Camus, and Heidegger, is humanist, focused on identity as self-creation, based on personal choices, rather than found in an encounter with God. For Sartre (1905–1980), the person in search of an authentic identify must find meaning in a world empty of God, standing alone in front of the abyss, abandoned. Selfhood comes from the choices one makes in the face of this terrifying freedom, with identity molded by the ways one choses to find meaning to understand what is happening to you. As Sartre famously put it, "existence precedes essence"; our identity cannot be found in human nature or predetermination, but can be constructed by us as we see fit (Sartre, 1969).

His short story, Intimacy (Sartre, 1948b), is a study in these themes. It is the story of a young woman called Lulu, unhappily married to her passive husband Henri, who is depressed with the meaninglessness of her roles as wife. On the insistence of her girlfriend, she decides to run away to Nice to live an ideal life with her lover and recreate herself. She cannot quite believe, however, that this new self might be possible. She imagines it is a myth and returns to her husband. This story exemplifies how, for Sartre, identity can be found in the tension between the two poles evident in this story: firstly *facticity*, or current roles and their social and historical situatedness, including our personality traits and patterns of our behavior, and secondly *transcendence*, the freedom to make oneself up without deference to norms. Identify is found in the negotiation of these poles, between which characteristics we chose to keep and those we seek to transform as unique (Bilsker, 1992).

Lulu, in Intimacy, however, fails in this regard and acts in what Sartre calls *bad faith*, the avoidance of the discomfort and uncertainty. In this sense she withdraws in fear from becoming the person she might be or the person she yearns to create.

Heidegger's (1889–1976) theory of identity formation is very similar, involving the same conflict between a retreat to our given state and one that is uniquely formulated (Bilsker, 1992). Heidegger argues that we are *thrown* into the world, born into a context that we did not chose, with beliefs, values, and ideas that belong to the mass culture around us, inviting us to be passive participants (King, 2001). If we follow we experience *fallenness*, choosing a *foreclosure* identity, becoming lost to a public they (DeCenso, 1988). This can be a comforting position, given that anxiety can be clouded by television, news, and gossip, each answering questions that we ourselves did not pose. For Heidegger, an authentic identity is *Dasein*, or *being there*, living in relation to the world while ultimately being alone (Dreyfus, 1990).

### 3.2 Heidegger and Ricoeur: Identity as Momentary

> *To be a human being means to be on the earth as a mortal. It means to dwell*. (Heidegger, 1972, p. 147)

While Sartre and Heidegger shared much in their humanist view of identity, Heidegger introduced a temporality to the process that challenges the idea of the self as a fixed internalized selfhood. Heidegger's subjectivity did not involve the development of an "I," set apart from the flow of time, but rather a subjectivity might be best seen as *experience*, a momentary encounter with the changing contextual self. Human identity retains its historicity, a *being in the world*, perhaps also understood in the contemporary reading of the word *grounded* (Escudero, 2014). Heidegger's Dasein is open to the world, hence differing from the interiority of Kierkegaard. Courage comes from actively revealing oneself in the public sphere, "to leave one's private hiding place and showing who one is, in disclosing and exposing one's self" (Arendt, 1998, p. 176).

Humanist Paul Ricoeur (1913–2005) was also concerned with temporality and identity, building on the work of Heidegger to develop his narratology. Ricoeur too argued against essentialist versions of the human subject, such as that of the rational, isolated Cartesian cogito. Instead, he argues for a personal identity that is not fully stable or self-transparent, but is also not incoherent or self-alienated (Reagan, 1996). For Ricoeur, the self-relationship is achieved through narration, an active interpretation in the present, rather than fully autonomous self-authoring. Narrative means more than simply a story here but refers to the way that humans experience time, the way we mentally organize our sense of the past and understand our future potentialities (Ricouer, 1983). In this sense our identity only exists where the past meets the future, the process of *becoming* is all that really exists (Morny, 1997).

When considering notions of identity, one can see that Ricoeur, while a narratologist, mirrored the anti-essentialist identity negotiations of his humanist peers, positioning the authentic human subject as a self-narrator, resisting sedimentation in favor of innovation (Widder, 2011). Rather than negotiate between dogma and freedom, social mores, and self-creation, however, Ricoeur's ontology involves one between retrospect and prospect. Ricoeur mirrors Sartre's *existence precedes essence*, in stipulating that identity can only be narrativized retrospectively. Humans tend to carry out *emplotment*, drawing together disparate past events into a meaningful whole, by establishing causal and meaningful connections between them. This occurs from the end point of the story (i.e., in the present moment). The future should be approached with uncertainty, grasped as a set of potential narratives in which we might take part, but also through *the semantics of action*, that is, as a meaning-rich sense of possible choices, actions, and their consequences (Ricouer, 1983).

Isak Dinesen, author of *Babette's Feast*, once stated that "all sorrows can be borne if you can put them into a story or tell a story about them" (quoted in Arendt, 1958, p. 104). This statement, often quoted by Ricoeur, highlights the hermeneutic power that narration has against non-being and storytelling as an act of

self-determination (Crowley, 2003). As we tell ourselves our own story, as authors, we appear at the junction between a known past and uncertain future. Courage involves a willingness to dwell in this liminal space, inchoate.

### *3.3 Merleau-Ponty: Becoming Some-Body*

*The body is our general medium for having a world*. (Merleau-Ponty, 1945/2012)

Like Heidegger, one of Merleau-Ponty's (1908–1961) concerns, when considering questions of being, was to situate consciousness in the materiality of the world, rescuing it from abstract introspection. He was a friend of Merleau-Ponty but is perhaps best known for his work on embodiment, arguing that notions of identity and being cannot be separated from the corporeal (Toadvine, 2019). This has significant implications, ushering in the body rather than Freud's dreams as the royal roads to the unconscious. The body, as Reggie Ray puts it, "is the unconscious, not only in the smaller but also in the largest sense. The body is ultimately our largest person" (*Buddhist Review*, 2010, para. 1).

From this position the discovery of identity cannot be done without considering the incarnate nature of subjectivity. Without Descartes' dualism we are left to seek non-dissociative forms of identity which account for the fact that we are inseparable from our skin. Embodiment theory shifts the vantage point from abstraction to materiality. Identity starts with the subjective experience of the body-subject, experientially aware and connected to sensations of the flesh (Merleau-Ponty, 1945).

## 4 Existentialism and Diverse Identities

This brief history of identity formation from an existentialist perspective reveals a shift in focus, from the interiority to situatedness, from mysticism to the contextualization of selfhood in the context of time and narrative, but also the material world of perception, action, and flesh. Courage is conceptualized as resistance, to Church dogma, to the conformity of the masses, and to fragmentation and disembodiment, in favor of an encounter with anxiety, aloneness, and liminality. The identity that emerges is not fixed; it is found in God, hermeneutic, fleeting, narrated, and felt.

It is important to recognize that this classic era of existentialist thought, while radical in its humanism, did not grapple with identity diversity as we now know it. It was primarily a white male endeavor, failing to consider subjectivities of gender, race, sexuality, and their intersection. Many of the thinkers discussed so far, however, did serve as critical starting points for more political existentialisms, willing to develop complete theories regarding oppression and identity (Freeman, 2011). Sartre, of course, influenced Simone de Beauvoir's feminist existentialism, despite her vehement critiques (Simons, 1986). Sartre also influenced Frantz Fanon's black

existentialism, particularly his book *Anti-Semite and Jew* (1948a). Merleau-Ponty also brought the body to identity, opening up existentialism to feminist, black, and gender-nonconforming bodies. Existentialism was to meet politics, and the subject had to reckon with patriarchal, racist, and homophobic forces in the journey towards authenticity (Levin, 2011). Existentialism also met Foucauldian post-modernity, whereby subjectivities created by disciplinary power could be transformed by experimental technologies of the self (McGushin, 2011).

## *4.1 Feminist Identity and the Male Gaze*

It is fascinating that the revolution of second-wave feminism of the 1960s was heavily influenced by Simone de Beauvoir who studied the work of Kierkegaard and Heidegger with Sartre at the École Normale Supérieure (Bair, 1990). Her feminist existentialism was explicated in her near 1000-page opus *The Second Sex* (de Beauvoir, 1949), arguably the most important book of early feminism. For Beauvoir the search for identity involves reclaiming of embodied subjectivity from a patriarchal culture. Women are incidental as opposed to essential, and while the man is the *Subject* or *Self*, the woman can only be the *Other* (de Beauvoir, 1949). A woman is socialized to develop the identity of a doll, passive and timid, aiming to please and lacking in physical strength. These qualities are not her feminine essence but are created by civilization. Central to her thesis is the idea of the male gaze that constructs the objectified identity of a woman. This gaze, once internalized, means the woman continued to produce her body as an object for others. If the identity of a woman is created by patriarchal society, however, it is not predetermined and can therefore be self-fashioned, involving the dismantling of a lifetime of socialization and the challenging of the myth of the woman (Curthoys, 2000; de Beauvoir, 1949).

Contemporary feminist phenomenologists, like Judith Butler, still owe much of their thinking to Beauvoir, including her proposition that gender is performative, built on social practices (Butler, 1990). This view also resonates with the existentialist rejection of a predetermined human nature and the notion of identity as reinvention, self-narrated or emergent. The performativity of identity is established through historical repetition and stylization making the appearance of innate traits (Butler, 1993), rendering other forms of identity as abject or illegitimate. In reality one can resist this false naturalization through critical reflection, identity claims, and new modes of performativity.

## *4.2 Racism and Identity*

> *All colonized people—in other words, people in whom an inferiority complex has taken root, whose local cultural originality has been committed—position themselves in relation to the civilizing language; i.e., the metropolitan*. (Fanon, 1967, p. 2)

Frantz Fanon, the world's leading black existentialist thinker and activist, stated in his most famous book *Black Skin, White Masks* (Fanon, 1967) that Sartre's *Anti-Semite and Jew* (1948a) contained pages that were "among the best I have ever read" (Bernasconi, 2004). Fanon's aim, however, was to decolonize existentialism, given that colonialism was a *total project* which had rendered black identity to the hell of non-being. Non-being occurs through the *epidermalization of inferiority* (Song, 2017) or the internalization of racism. This project of negrification means that the oppressed person must navigate the world through whiteness, struggling for identity through white language, appearance, manners, and habits. For Fanon any recuperation of black embodied subjectivity must be done as resistance to the imperializing dominant culture.

Interestingly Vereen et al. (2017) highlight the many points of departure between humanist white existentialism and black. Sartre, for example, challenged the Descartian notion of "I think therefore I am" with "existence precedes essence." Black theory clearly proclaims, however, that "I am because we are." While black thought still includes the threat of non-being and the impetus for a liberated identity, this can never be separated from the black struggle for wider sociopolitical emancipation. Freedom and black authenticity become a question of justice and black consciousness.

Despite Fanon's credentials as an activist, he has been heavily criticized by feminists. His most prominent investigation of women's lives (Fanon, 1967), an interrogation of the novel *Je Suis Martiniquaise* by Mayotte Capécia (1948), has been accused as being misogynistic (Brownmiller, 1975). Fanon argued that the self-hatred of black women is so marked that they are driven to have sex with white men, seen by feminists as a brutal a critique, involving the policing of black women's bodies.

## *4.3 Gendered Identity*

There have been few contemporary challenges to notions of identity more significant than the dismantling of gender as a biological given. The deconstruction of gender essentialism follows the historical existentialist discourse, given that it takes Sartre's reinvention to the corporeal. Simone de Beauvoir's statement that "one is not born, but rather becomes, a woman" exemplifies the existentialist radical commitment to identity reinvention, providing a philosophical starting point for the separation of gender from biological sex that came to underpin contemporary gender politics.

Judith Butler's seminal book *Undoing Gender* (Butler, 2004) takes up the cause for gender performativity in relation to intersex and transgender individuals, arguing for an anti-foundational *stylistics of existence*. She tells the story of David Reimer, as evidence for the auto-production of gendered self-identity. David, an identical twin born in the USA in 1965, had his penis destroyed during a circumcision. He had a sex reassignment at 22 months and at the age of 14 rediscovered his

masculinity and assumed a male identity. His case demonstrates that gender is free and floating, rather than essential, with social norms only giving the appearance of a gendered ontological core.

Houghtaling (2013) positions sexuality from an existentialist frame as follows: "sexuality through an ontology of becoming that takes into account the diverse, multifaceted nature of sexuality as a series of temporal experiences, attractions, desires, sensations, practices, and identities" (p. ii). This statement places gender firmly within the humanist commitment to emergent notions of identity, unstable and always becoming.

## 5 Synthesis

The story of existentialism approach to identify has followed a shift from Christianity, to humanism and then post-modernity. The self, once found in God, interior, gradually shifts outwards, looking into the material world, through the body, with others, into action. Eventually we arrive at Hannah Arendt's (1998) idea of *amor mundi*, whereby an active life involves breaking free from hegemony, not just in the arena of consciousness but also praxis. The personal has become political.

Despite these differences, however, a number of similarities can be ascertained in respects to the approach to identity, with existentialism serving providing the means through which subjects, historicized, can make sense of who they are. Firstly, identity is not seen as fixed construct or trait, but rather emerges in opposition to such conceptualizations. Identity is the antithesis of essentialism, being found in the spiritual realm, in experience, momentary, narrated, an ontology of becoming. Secondly, essentialist notions are socially defined but positioned by the herd as givens. The human subject, yearning for authenticity, must resist these constructs in order to be free. The specific objects of resistance change within each paradigm. For Kierkegaard this meant resistance to church dogma and religious social conservatism, for Heidegger the world one happens to be thrown into, and then on to the patriarchy, the colonial, the heteronormative. The result, however, is a unique individual, self-created and self-determining.

## 6 Global Dread and Identity

To a large extent the rise of existentialism occurred in direct response to the global trauma of World War 2, given man's search for meaning after atrocity and holocaust (Lalka, 2005). In 1946, Sartre declared *existentialism as a humanism*, with man cast into a brave, new Godless world (Sartre, 2007). The existentialist discourse casts a long shadow, adapting to deal with contemporary problems, building on the canon, but integrated with the post-modern thought of Foucault, given the mutual opposition to structuralism. In contemporary times, however, we are dealing with new

forms of global catastrophes in the form of climate change and Covid-19. What does existentialism have to offer now in terms of the being-in-the-world? What does it mean to have the courage to be oneself in the face of these new existential threats?

### *6.1 Eco-existentialism and Sustainable Biographies*

Albrecht (2012) describes eco-existentialism as a new form of inquiry which responds to the dread we experience in the era of climate change as we fear not our own mortality, but the sustainability of all life on the planet. At its worst we experience pre-traumatic terror, in relation to the potential for eco-apocalypse. He describes this despair as *psycho-terratic*, in that it no longer refers to an intrapsychic state, but rather one that relates to our relationship to the earth. In the existentialist tradition, he describes both inauthentic and authentic forms of existence, one Anthropocene and the other *symbiocene*. The former, similar to Sartre's bad faith, involves an attempt to cope based on climate denialism, planetary-death denial, and the maintenance of an anachronistic identity based on materialism. This form of defense involves the blind following of public denialists, numbing through digital forms of entertainment and even reactionary increases in consumerism. The latter involves self-denial and the reconfiguration of our identity as one that is inherently *biophilic*, or involving the love of nature, or *sumbiophilic*, involving a deeply ingrained love of living in harmony with other species (Albrecht, 2019). Distress is at its most pronounced when one becomes frozen in between, acutely aware of the reality of the climate crisis but unable to shift from anxiety to grief and then the reconfiguration to a symbiocene identity. Like Arendt (1998) this state involves the recreation not only of an identity tied to place but also of direct action in terms of sustainability and activism.

It is important to recognize the significance of this form of identity, one that mirrors Australian aboriginal conceptions (McManus et al., 2014) but is new to the history of existentialist thought. From the wider perspective of European philosophy, it can be best understood as related to a post-human ontology, whereby the human being is no longer central, but one species among an assemblage of many (Wolf, 2010). Let us say we have shifted from Heidegger's being-in-the-world to being-in-the-world-with-all-its-species.

## 7 Covid-19

The Covid-19 pandemic is the perfect storm for existentialist despair, not simply because it elicits a form of global dread but because, while threatening non-being, it simultaneously casts us into physical isolation from each other. If death comes this isolation amplifies, with family members excluded from one's final moments. This dread, or *dis-ease* (French & Monahan, 2020), is elevated to apocryphal myth

through digital hyperrealism (Baofu, 2009), in a century already primed by the semiotics of doom. Roberts and Cremin (2016) name this the Age of Catastrophe, where dystopian dread is already primed 9/11, the GFC, Fukushima, Katrina, and the refugee crisis. While these events caused real suffering, they are elevated to a monolithic myth through media-saturated simulacra (Baudrillard, 1983), including memes, CGI blockbusters, and The Walking Dead. Dread is no longer related to original sin, or the absurd, but a product of a cultural unconscious or semiosphere (Lotman, 2005). It is important to recognize that moral panic and doomsday scenarios have long been a vehicle for social control, from Salem (Reed, 2015) to AIDS (Long, 2004) and Trump's theocracy.

The question remains as to how we can exercise self-affirmation in the face of both a real pandemic and a hyperreal apocalypse and what forms of identities might be possible. What might emerge as we work our way through the fright, grief, and post-traumatic reality of a changed world? What kind of heteroglossic possibilities are there after resistance to freezing effects of a unitary monolithic discourse (French & Monahan, 2020)? Arragui (2020) argues that Covid-19 provides us with an opportunity to reconsider our relationships with multiple species which make up the *viralscape* or *intercorporeal scenery*. As with climate change, we must reject anthropocentrism in favor of a post-humanist identity, demoted to an assemblage that now includes the microbal.

## 8 Conclusion

It has been over 170 years since Kierkegaard wrote *Fear and Trembling* (1848), but the Father of Existentialism introduced the world to a discursive resource that has maintained its relevance to the current day. The individual, faced with threats to his identity, has drawn on this form of philosophical inquiry to inspire self-affirmation in the face of non-being, abandonment, and the transformational potential of dread. The threats have changed, from the dogma and conformity of the Church to the meaningless of war; the erasure of sexism, racism, and gender-role conformity; and contemporary global threats of climate crisis and pandemic. Our response, however, need not, as we resist foreclosure and instead choose the path of self-creation and authenticity.

This is not an intellectual journey, however, but an experiential one, involving uncertainty and loss. Oscar Wilde paid the most terrible price for self-affirmation, in an era that would not tolerate his irreverence and homosexuality, dying in Paris on 25 November 1890 from meningitis brought on by his 2 years in prison. Impoverished and exiled, he spent his last years living in second-rate hotels and wondering the boulevards alone. While we may not have to pay the ultimate price for self-becoming, the costs can still involve pain and suffering. In the end, as Wilde is reported to have stated on his death bed, "this wallpaper and I are fighting a duel to the death. Either it goes or I do."

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# Yet You May See the Meaning of Within: The Role of Identity Concerns and the Self in Psychopathology


**Ayoub Bouguettaya, Tess Jaeger, and Richard Moulding**

**Abstract** Concerns and processes regarding one's identity and "self" are arguably a central component of existential concerns within humankind. This chapter briefly introduces self-related constructs before looking at how they have been applied to specific domains of psychopathology in recent empirical and theoretical works. First, it has been argued that self-construct is a central concern driving obsessive-compulsive disorder (OCD), with those with obsessions having an ambivalent or feared view of self. Second, within the OCD-related disorder of hoarding disorder, it has been argued that perceptions of self and others intertwined with the meaning of objects contribute to the incredible challenge that those with the disorder have in discarding objects. Finally, within depression and eating disorders, the focus has recently been shone on social identity processes, whereby one's sense of self is dynamic and influenced by one's contemporaneous self-categorisation as a group member. In depression, a loss of social identity has been argued to trigger pathology, whereas in eating disorders, it has been argued that social identification with particular groups may increase the risk of pathology.

**Keywords** Self · Social identity · Obsessive-compulsive disorder · Hoarding · Depression · Eating disorders

Considering our own identities and our place in the world is arguably one of the central conceits of humankind. Dale Carnegie (1981) famously proffered the notion that when "we are not engaged in thinking about some definite problem, we usually spend about 95 percent of our time thinking about ourselves" (p. 27). Under this lens, psychology equally has paid a great amount of attention to the role of selves and identity within psychopathology, and identity has arguably always been a feature of models of psychopathology. The idea that identity is a factor in mental health

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is not new; it has long been noted that those with stable self-concepts tend to be healthier generally (Kelleher & Leavey, 2004). Meanwhile, those who have an unstable self-image (Franck & De Raedt, 2007) have a negative self-image (including due to stigma; Makkar & Grisham, 2011; Shimotsu & Horikawa, 2016), or experience a loss of an identity (Seymour-Smith et al., 2017), and are more likely to show signs of psychopathology. Contemporary research suggests that one's identity and associated self-image likely affect the likelihood of developing and recovering from a variety of mental health conditions, and understanding "the self" in psychopathology may lead to improved preventative and treatment options.

Given such a focus on identity, both at a folk-level and within psychology as a science—and perhaps not unusually for the field—this has also led to a proliferation of constructs and understandings of what we are talking about when we are talking about the "self" (e.g. Brinthaupt & Lipka, 1992). In considering this issue, Leary (2004) appealed to a need for clarity in distinguishing clearly between the processes involved in self-awareness; the knowledge, beliefs, or feelings that people have about themselves; and the processes involved in self-agency and self-regulation. The self in all of these aspects is arguably involved in psychopathology. For example, disruptions in the basic sense of self have been noted in recent models of psychosis-related disorders (Nelson et al., 2012, 2019). Meanwhile, the beliefs people have about themselves have been implicated in many anxiety and depressive disorders, such as the anomalous considering of one's social performance and evaluation of self in social anxiety (Clark & Wells, 1995) and body dysmorphic disorder (Veale, 2004). Self-regulation approaches are also implicated, for example, in disorders such as addictions and gambling (Rodda et al., 2016).

Given the preponderance of such self-related constructs and their specific relationship to forms of psychopathology, at best, here we can only hope to touch on some illustrative examples of how self may play into particular disorders (For further depth, see Kyrios et al., 2016). As such, in this chapter we will review a select few from the range of mental health disorders that have been associated with the existential construct of identity. In particular, we will discuss the "self", and several overlapping constructs, as they have been implicated in obsessive-compulsive disorder and hoarding disorder. We then turn to a new, social identity approach, as it has been applied to depression and eating disorders. Through this lens, we hope to illustrate how such constructs can, and we believe, should, be considered in models of these disorders.

## 1 Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterised by unwanted intrusive thoughts, images, impulses, or urges that are typically accompanied by compulsive efforts to alleviate their associated discomfort or distress (American Psychiatric Association [APA], 2013). It is only relatively recently that cognitive theorists have begun to focus on the role of the self and identity in OCD. Guidano and Liotti's

(1983) theoretical model of the aetiology of obsessive-compulsive behavioural patterns is a notable exception. This model focuses on the role of early attachment experiences, where a child predisposed to OCD is argued to experience both affection and indifference from their primary caregiver. This paradoxical pattern of attachment is hypothesised to encourage the development of a fractured self-image, for example, one that is at once lovable and incapable of being loved or demonstrative of both high and low self-worth. These irreconcilable aspects of the self can be viewed as equally compelling explanations of the same experiences and are often supported by the individual's interpretation of external reality. Thus, reconciliation of the self-image and outward reality may become a primary goal. Guidano and Liotti suggest that this tends to manifest in unyielding personal expectations regarding moral or ethical conduct (i.e. adherence to strict rituals or rules). This is strongly linked to negative self-appraisals. "'Intrinsically' valued moral canons become a guide to the elimination (or control) of the 'wicked' part of the self and the fostering of the 'positive' part", which perpetuates "systematic doubt" (Guidano & Liotti, 1983, p. 113). At their core, such appraisals reflect existential concerns regarding the fundamental nature of oneself and potential impact on others.

Bhar and Kyrios (2007) suggested that this self-ambivalence, or fragile sense of self, may exacerbate OC symptoms, as intrusions tend to be viewed as particularly imminent or meaningful when this is the case. For example, it has been argued that intrusions may be interpreted as evidence of personal failings (Guidano, 1987; Guidano & Liotti, 1983; Rachman & Hodgson, 1980). More recent research suggests that moral self-ambivalence may play a role in increasing vulnerability to OC symptoms (Ahern et al., 2015b) and maintaining OC behaviours (Perera-Delcourt et al., 2014). Subtle threats to moral self-perceptions have been associated with activation of OC cognitive biases in OCD-related contexts (Abramovitch et al., 2013; Doron et al., 2012). Also following from Guidano and Liotti (1983), Doron and colleagues (2007, 2008, 2012) have highlighted the role of "sensitive" self-domains—areas in which an individual lacks confidence or self-efficacy—in priming maladaptive appraisals of intrusive thoughts that undermine core self-perceptions. General self-worth contingencies, as assessed in personal domains pertinent to obsessional behaviour, have been associated with OC symptoms in both clinical (García-Soriano & Belloch, 2012) and non-clinical (García-Soriano et al., 2012) samples. The cognitive hypothesis that neutralisation plays a role in the development and maintenance of OCD is supported by findings that indicate such strategies may be enacted in an attempt to restore self-worth (Ahern et al., 2015a). The implicit assumption of constancy in the nature of character and morality (i.e. endorsing an entity theory of morality and character) is associated with OC phenomena and symptoms (Doron et al., 2013). As such, it is conceivable that a belief in the stability of one's own moral or ethical constitution—coupled with the perception of improper personal conduct—may result in feelings of powerlessness and existential angst.

Cognitive appraisal models (CAMs) of OCD focus primarily on the relevance of appraisals to the perpetuation of OC symptoms. For example, Rachman (1998a, b) distinguished haphazard intrusive thoughts from obsessions by drawing attention to the role of appraisals and perceived personal relevance. Specifically, individuals

without OCD are able to disregard intrusions as relatively meaningless and irrelevant, whereas those with OCD interpret these thoughts as revealing hidden aspects of the self that are deeply disturbing. Purdon and Clark (Clark & Purdon, 2016; Purdon & Clark, 1999) postulated that egodystonic intrusive thoughts develop into obsessions because they are perceived as threatening to the individual's sense of self. Rowa and colleagues have demonstrated that more upsetting intrusions contradict an individual's sense of self to a greater extent than less upsetting intrusions in both non-clinical (Rowa & Purdon, 2003) and clinical (Rowa et al., 2005) samples.

In contrast to CAMs, the inference-based approach (IBA) foregrounds the role of vulnerable self-themes in contributing to the development of obsessional narratives and the reasoning processes that maintain them (O'Connor et al., 2005). While appraisals are relevant to these processes, they are not considered central to the maintenance of the disorder. Proponents of the IBA have focused particularly on the role of self-perceptions implying a feared, or harmful, self in the context of repugnant obsessions (Moulding et al., 2014). The *feared-self* construct is an extension of personality and social psychology literature issuing from Higgins' (1987) landmark paper on self-discrepancy theory. In this work, Higgins outlined a process of self-construction that is influenced by a dynamic interplay between three interdependent domains, including (i) the individual's *actual self*, comprising the qualities they ultimately believe they hold; (ii) their *ideal self*, encompassing the qualities they aspire to possess; and (iii) their *ought self*, comprising the qualities they believe they should, or are expected to, possess. The degree to which these domains are incongruent with one another is posited to produce certain emotive responses. Specifically, actual–ideal discrepancies are argued to elicit dejection-related emotions, which are related to a perceived failure to fulfil one's personal expectations, or to achieve positive outcomes (e.g. inability to cease engagement in compulsions). Conversely, actual–ought discrepancies are postulated to evoke agitation-related emotions consistent with a perceived inability to meet prescribed standards (e.g. powerlessness to refrain from engagement in obsessions or compulsions).

Concerns regarding self-knowledge and development are reflected in the work of Markus and colleagues (Markus & Nurius, 1986; Oyserman & Markus, 1990a, b), who introduced the concept of *possible selves*. These are described as "the ideal selves that we would very much like to become … the selves we could become, and the selves we are afraid of becoming" (Markus & Nurius, 1986, p. 954). Thus, possible selves are future-oriented and can be both hoped for and dreaded. *Feared* or dreaded possible selves are regarded with anxiety and apprehension. Feared possible selves are similar to Ogilvie's (1987) contemporaneous conceptualisation of the *undesired self*, which was proposed as a contrasting self-guide to Higgins' (1987) ideal self. Like feared possible selves, the undesired self can be understood as representing unwanted or distressing potential future outcomes. Discrepancies between real (or actual) and undesired selves have been linked to avoidance-based motives, whereby individuals tend to engage in self-evaluations relative to their perceived distance from negative or unwanted states rather than their proximity to ideal or desired states (Ogilvie, 1987). Latent variable analysis has also demonstrated partial support for the role of actual–undesired self-discrepancies in predicting negative

emotional states (Phillips et al., 2007). Carver et al. (1999) found that those whose actual and feared selves were relatively proximal tended to experience anxiety and guilt, which was unrelated to actual–ought discrepancies and conducive to avoidance motives. These findings concur with Heppen and Ogilvie's (2003) conceptual replication, which found that actual–undesired self-discrepancies moderated the relationship between actual–ought discrepancies and anxiety. The theoretical relevance of dangerous, feared, or undesired possible selves to OCD is reflected in the appraisals often accompanying "autogenous", or repugnant, obsessions (Lee & Kwon, 2003).

An emerging body of empirical research has demonstrated a relationship between feared-self beliefs, OC symptoms, and associated cognitive processes. Ferrier and Brewin (2005) tested the cognitive behavioural hypothesis that individuals with OCD tend to appraise unwanted intrusive thoughts as indicative of hidden, unacceptable aspects of the self in a clinical sample. On average, those with OCD drew significantly more negative self-inferences in response to their intrusions than did anxious or non-anxious controls. The authors also conducted a content analysis of the traits encompassing the feared self that emerged from the study. Identified themes included a "depressed/anxious self", which was indicative of symptom-related self-appraisals surrounding feelings of hopelessness and dejection; a "rejected self", which revolved around feelings of loneliness, unworthiness, and being essentially unlovable; a "flawed self", which encompassed undesirable traits that are not directly related to concerns surrounding the possibility of harm to the self or others (e.g. self-centredness, vanity); and a "dangerous self", which involved concerns of potential harm to others or the thought of being crazy or uncontrollable. The OCD group tended to endorse the latter category more often than both control groups. This self-theme was found to be consistent with Rachman's (1998a) clinical descriptions of the character traits often identified by OCD clients in relation to obsessions with repugnant themes—for example, appraisals indicative of the individual being essentially "evil", "dangerous", "unreliable", "uncontrollable", "weird", "insane", "sinful", or "immoral" (p. 211).

Fear of self has been examined in research incorporating both non-clinical (Jaeger et al., 2015; Nikodijevic et al., 2015) and clinical (Aardema et al., 2018, 2019; Melli et al., 2016) samples. Nikodijevic et al. (2015) found that feared-self beliefs and high OC symptoms predicted the believability of OCD-relevant scenarios and fluctuations in doubt regarding these scenarios over time. Results were consistent with a mediation model, whereby feared-self beliefs partially underlie OC symptoms. An extension of this research by Jaeger et al. (2015) was consistent with Nikodijevic et al.'s (2015) findings. Fear of self has since been identified as a substantial unique predictor of unacceptable thoughts and impulses, independent of negative mood states, obsessive beliefs (Melli et al., 2016), and inferential confusion (Aardema et al., 2018) in clinical samples.

Although it is germane to clinical presentations of OCD observed in cognitive literatures for more than 40 years, the role of identity and self-beliefs in OCD has only recently become the focus of consistent research attention. Current findings indicate that negative self-evaluative beliefs may underlie OC symptoms, thus

contributing to the development and/or maintenance of the disorder. As such, these findings are consistent with notions that domains and processes related to self are a central component of OCD (Jaeger et al., 2021).

## 2 Hoarding Disorder

Given that hoarding was, until quite recently, considered to potentially be a symptom dimension of OCD, it is illustrative to compare OCD with hoarding disorder (HD) in terms of the differing role that self and identity may play within psychopathology. HD is characterised by the accumulation and failure to discard possessions to the point where the clutter becomes disabling or distressing for the individual (APA, 2013). While hoarding is a complex phenomenon, with multiple overlapping causal factors, including information processing deficits, unhelpful beliefs about objects, and emotion regulation issues (Steketee & Frost, 2003), one understudied aspect of the disorder is the role of identity. However, even outside of hoarding, as noted by William James (1890), "…a man's Self is the sum-total of all that he can call his…" (p. 291), and notions of self, both individually and in relation to others, are replete within the phenomenology of hoarding (Kings et al., 2017; Moulding et al., 2016, 2021).

One of the aspects that differentiated hoarding from OCD is that in OCD, symptoms are largely egodystonic, whereas in HD, they are ego-syntonic (Rachman et al., 2009). While notions of avoiding a feared self propagate through the OCD literature, in HD there are considerations of how objects can instead substitute positively for self or others, with limited research supporting the relationship between hoarding and underlying deficits in self-structure, with self-ambivalence (Frost et al., 2007) and identity confusion both being linked to hoarding symptoms (Claes et al., 2016). While in the case of OCD this was posited to lead to reactivity to intrusive thoughts or creation of negative self-relevant narratives, in hoarding it has been suggested that alternative pathways operate. Specifically, Frost et al. speculate that underlying dichotomous or ambivalent self-views lead individuals to seek meaning from possessions, resulting in symptoms of hoarding and also compulsive acquisition issues. However, they also note that materialistic desires could in turn interfere with social relationships, impairing the development of an elaborated or fully realised self-concept.

Consistent with the notion that self can become intermingled with identity, studies have pointed to the notion of self-object fusion in hoarding, whereby the "person that has all this stuff, it's theirs, it's a part of them, even ridiculous year old newspapers" (Kellett et al., 2010, p. 146). A measure assessing the extent to which objects and the self overlap was found to differ between individuals with and without hoarding, was related to overall symptoms, and decreased with treatment (Dozier et al., 2017). In a clinical sample, individuals identified as showing self–object fusion endorsed that discarding was like letting a part of themselves go, that they experienced a buzz from acquiring new things, and that they thought about the future use

of objects; and they were the only (albeit small) group within the study to indicate that they drew a sense of companionship from items (Postlethwaite et al., 2020).

Further studies have investigated the multiple ways that identity can function with respect to objects (Kings et al., 2020), reflected in conclusions from qualitative studies that individuals with hoarding "used material possessions to reassemble the fragments of their temporal experience into a unique space where memories, present, and life projects join together" (Cherrier & Ponnor, 2010, p. 14). Items can serve as a source of memory and thus self-identity in hoarding. For example, in a study analysing cases collated from personal organisers, Roster (2015) described "Gloria", who hoarded hundreds of children's books and Girl Scout craft kits, which were said to be the key to her happy memories of her time with her daughter which had revolved around these activities and which fortified her continuing identity as a mother. Roster also gives the case of "Deborah", a recently widowed former librarian who they noted had particular difficulty discarding her books, reflecting her background as a librarian and the component of that identity which reflected a reverence for knowledge (Roster, 2015).

Yap and Grisham (2019) aimed to further unpack the construct of emotional attachment to possessions. In an online questionnaire study with 532 North American participants recruited via Amazon MTurk, they included as one aspect of emotional attachment a specifically developed measure, The Possessions as Memories and Self-Extensions Scale, which contained two subscales: the Possessions as Memories (PAM) subscale aimed to address the extent to which objects represent memories of people and events in the past, while the Possessions as Identity (PAI) subscale examines the extent to which objects signify who they are and would like to be. Such subscales were consistent with past studies such as the findings of Cherrier and Ponnor (2010), that objects impart "the same emotions [from the past] when you physically hold something", and with Roster's (2015) suggestion that possessions impart individuality. Correlational analyses found a moderate-to-strong correlation with overall hoarding symptoms, with regression analyses finding that the PAM scale contributed to difficulties discarding over-and-above anxiety, depression, general hoarding-related cognitions, and object attachment security. They note that the imbuing of value to an object through its links with autobiographical memories may be a significant barrier to treatment.

Most directly, Kings and colleagues (Kings et al., 2020) used photo-elicitation—where participants photographed significant possessions in their home—along with IPA to directly explore identity in people with HD ($N = 10$). Kings and colleagues found three themes, reflecting early life factors, identity, and links to others. In terms of themes related to identity, as previously suggested by Yap and Grisham (2019), objects were found to represent to individuals who they were as people, for example, "not many people have clothes that date back to the 50s, do they? Not many; I do". Objects also conveyed a sense of self-confidence—"I had millions of clothes as a kid, but I used to feel good wearing that. I was teased a lot as a kid, but, even so, I liked that dress"—and were used to defend self, where self-esteem is "kind of fragile … so you justify your specialness in lots of other weird ways—so objects". Finally, objects could become physical extensions of self, such that there

was “A sense of feeling whole if I have those physical things around me. If I do a complete clean out … I’m completely gone, my identity is gone”.

Objects were also linked with others (Kings et al., 2020). Items served to remind individuals of important attachments with others, giving a sense of warmth and closeness. Sometimes those relationships may have been difficult, with grief being apparent, and that sense of non-resolution appeared to function to prevent discarding of the items. Further, while objects have been noted to be physical extensions of self, they could also serve as physical extensions of others; for example, “Nora” described taking almost all her mother’s possessions as she “felt like I was taking my mother with me, almost like parts of her”. Participants described a sense of responsibility to past owners of items, which appeared in addition to the responsibility noted for items by Steketee and Frost (2003). Participants spoke of using items to create new connections with others via caring for them, and conversely, items were kept because they signified that others cared for them. Overall, then, Kings and colleagues found that items seemed to be intimately connected to an individual’s self-concept and also to the position of that concept within their relationship with others. While limited by a relatively highly functioning sample (all participants acknowledged their hoarding and were seeking treatment), a resultant measure is showing promise in relating self to hoarding symptoms (Kings et al., 2021).

## 3 Examining Depression and Eating Disorders via a Social Identity Approach

Finally, we turn to understanding the self in psychopathology through presenting research on depression and disordered eating. In addition to the aforementioned model by Higgins (1987) of actual vs. potential self-guides, perhaps the most famous model of identity and psychopathology is the Beck model of depression (Beck et al., 1983; Wright & Beck, 1983). In this model, Beck posited that depressed individuals developed a negative self-schema or a set of beliefs about themselves that were largely pessimistic. Beck suggested that this negative self-schema manifested in a set of cognitive distortions, such as personalisation (seeing others’ negative feelings as more due to one’s self), magnification (exaggerating negative events as more due to one’s self), and overgeneralisation (negative conclusions about one’s self due to specific, inconsequential events). This model suggests that the tendencies people have in their self-image against the world and the future have strong implications for the development of depression. The Beck model has strong clinical utility, and challenging these views in cognitive behavioural therapy can reduce depressive symptoms (Butler et al., 2006). Furthermore, longitudinal evidence has shown that having a negative self-schema predicts the onset of depression in women, further emphasising the value of understanding identity within psychopathology (Evans et al., 2005).

However, contemporary research has suggested that cognitive models of the self and identity (such as the Beck model) may not fully encompass the social component of depression or other forms of psychopathology. For example, the Beck model does contain a wider triadic component, theorising that depressed individuals also held negative beliefs about the world and the future. Overall, however, these beliefs are intertwined, and all three have social components. Arguably, any sense of self is socially derived (Hogg et al., 1995). Furthermore, the world is a function of social reality (Greifeneder et al., 2017), where even basic perceptual processes and memories can be affected by considering oneself as a group member (Luminet & Curci, 2009; Van Bavel & Cunningham, 2012; Xiao et al., 2016). Beliefs about the future are also strongly linked to social and cultural views (Fischer & Chalmers, 2008), and optimism and pessimism are often derived from social experiences (Higgins et al., 1997; Smith et al., 2013). While cognitive models have therapeutic utility, some have argued that they underestimate and undervalue social psychological models of how people see themselves in context (Haslam et al., 2019). This is not uncommon in psychology; in the biopsychosocial model of health and psychology, social psychology is the least studied component (Suls et al., 2010) but has been suggested to have the largest impact on health (Haslam et al., 2019). Therefore, understanding a social psychology model of the self in addition to a cognitive model may have significant implications for preventative and therapeutic approaches to psychopathology.

One newer theoretical approach (the social identity approach or SIA) has made significant advances in how identity relates to psychopathology. The SIA, which combines social identity theory (Tajfel & Turner, 1979) and self-categorisation theory (Turner et al., 1987), was originally developed to understand how social groups influence people but has been since expanded to understand social psychology and health (Haslam et al., 2018). The core premise of this theory is that an individual's self-concept is tied not just to their *personal* identity (i.e. their attributes that stand in contrast to all others) but also to the categories (groups) that an individual is a part of (Turner & Oakes, 1997). When this group membership is made salient, that membership provides a sense of self—or a social identity—which then affects their behaviours, thoughts, and feelings in a variety of modalities (Reicher et al., 2012). This approach suggests that identity is fluid, constantly being constructed against social contexts, and that social groups are a major source of information on ourselves. Being part of a group, in this approach, also improves one's self-esteem by providing positive distinctiveness (Tajfel & Turner, 1979). Therefore, the SIA suggests that group joining provides an additional sense of self, which in turn improves mental health.

This approach has provided new ways of understanding mental health generally, and it is bolstered by research showing the importance of socialisation to health generally. Generally, research ($N$ = 308,849) suggests that the more socially connected a person is, the longer they live (Holt-Lunstad et al., 2010). SIA research provides a strong rationale as to why; it has found that merely identifying with a group improves one's self-esteem (Steffens et al., 2017). Being part of more *groups* also improves health; research on retirees found that being part of multiple groups

(i.e. having more social identities) improves life satisfaction, and a lack of social identities had reverse effects (Steffens et al., 2016). However, not all groups are equal; identifying with some groups can cause and sustain mental health issues, like substance abuse (Dingle et al., 2015a, b).

The SIA has expanded existing knowledge of the causes of depression. Longitudinal research has shown repeatedly that a lack of social connectedness (i.e. a lack of social identities) predicts depressive symptoms later in life, even after controlling for a number of other factors (Cacioppo et al., 2006, 2010). Similarly, depression is usually triggered by a loss in one's social sphere, such a loss of work, or relationship breakdown—or, in other words, a loss of a social identity (Paykel, 1994). Furthermore, SIA research has found that a lack of social group membership predicts relapse of depression (Cruwys et al., 2013).

More recently, research into disordered eating has shown that social identification has a role in disordered eating formation as well. Decades of evidence has shown that eating behaviour is socially bound (Cruwys et al., 2015; Higgs, 2015; Higgs & Ruddock, 2020; Robinson, 2015), and classic research suggests that being part of certain groups increases disordered eating behaviour (Crandall, 1988). Social identification with particular groups, such as being a cheerleader, may increase disordered eating risks (Greenleaf et al., 2009). In fact, there is likely an interaction effect; low self-esteem is also a prospective predictor for eating disorder development (Button et al., 1996), and joining a group generally is done to improve self-esteem (Tajfel & Turner, 1979). Joining high-status groups is also more desirable than lower-status groups (Ellemers et al., 1988), and it is likely the same groups that display disordered eating have a high status in their context (e.g. cheerleaders). Therefore, it may be that those with a low self-esteem are drawn to groups that increase disordered eating. Overall, however, it is likely that identity and self-esteem play a central role in disordered eating development, with social identity able to explain specific facets of disordered eating pathology (Allison & Park, 2004; Bouguettaya et al., 2019b).

Social identity can also be used to understand recovery from mental illness, especially in disordered eating and depression. A recent meta-analysis showed that these SIA interventions can improve recovery from a variety of illnesses (Steffens et al., 2019). In fact, in one study using both community group (e.g. soccer group) and group therapy samples, researchers found that the strength of identification with that group moderated the recovery from depression; a higher identification was associated with greater recovery (Cruwys et al., 2014). Similarly, multiple studies have suggested that shifting one's social identity from an "eating disordered" self to a recovery self or alternative group is often reported by participants in eating disorder recovery (Bouguettaya et al., 2019b; Dark & Carter, 2019; Ison & Kent, 2010). These studies suggest that when an individual undergoes reappraisals or shifts their identity—including their social identity—their recovery is enhanced.

Furthermore, while it is not a focus of this chapter, understanding the role of identity in therapeutic approaches may improve existing therapies. For example, elements of psychopathology can also be reduced through understanding the social identity approach, including addressing perfectionism in disordered eating.

Perfectionism in disordered eating is notoriously difficult to treat (Soenens et al., 2007), but understanding perfectionism as a drive toward an improved social identity means it is possible to use social identity principles of comparative contrast (i.e. identity content can be shifted depending on the frame of reference). One of our recent studies demonstrated that classic social identity paradigms could be used to accomplish a reduction in a type of perfectionism that predicts disordered eating (Bouguettaya et al., 2019a), although future research in clinical samples is needed.

## 4 Conclusion

This chapter has served as a whistle-stop tour regarding some ways in which identity and psychopathology may be intertwined. We began by noting that "self" is actually a multifaceted construct that is used in multiple ways, from noting that disturbances in basic "mineness" in psychotic disorders to an elaborated discussion of how self-guides and self-structure may make one vulnerable to intrusions and feared-self narratives in OCD. We proceeded to contrast this with the OCD-related disorder of hoarding, where it was suggested that the pathology was an attempt to bolster identity, and that self itself could be imbued within objects, both in terms of individual identity and self-in-context with others. Finally, we noted an exciting emerging approach to identity that holds promise to combine more fully the "psycho-" and the "social-" of the biopsychosocial model. From this approach, how people see themselves and their social groups are intertwined, and the centrality of identity in a variety of mental health conditions, suggests that acknowledging identity processes can lead to improved mental health. It would suggest that existing approaches to the self and mental health (including those of OCD and hoarding) could potentially be supplemented by newer research into social identity.

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# Clarifying Identity and the Self in a CBT Context


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**Abstract** Two important psychological frameworks, self psychology and cognitive behavioural theory, are brought together in this chapter as one way of advancing our understanding of the role that identity and 'the self' play in psychological disturbance and its treatment. Numerous definitions of the self have been discussed across multiple disciplines, and these are referred to either implicitly or explicitly in cognitive behavioural formulations of psychopathology. Researchers have consistently emphasised the complex transactional associations between psychological disturbance and ruptures in self-structures or self-processes such as self- identity, esteem, regulation, stability, cohesion, complexity, incongruence, discrepancy, schemas and ambivalence. Furthermore, early developmental influences are known to impact on the emergence of both the self and a range of psychological disorders, which could also impact on aspects of psychological treatment. Moreover, while cognitive behavioural therapy (CBT) is considered the gold standard treatment for many psychological disorders, efficacy and targets of treatment vary widely from disorder to disorder, with the emergence of the Third Wave of psychological therapies focusing attention on the need to target a broader range of factors in CBT to improve outcomes, inclusive of the self. For instance, the emergence of successful strategies targeting dysfunctional self-processing in disorders such as social anxiety and borderline personality has seen greater interest specifically in evidence-based self-related interventions. Such considerations are important in evolving CBT, inclusive of advancing personalised approaches to psychological treatment, as well as preventative mental health, education and even public mental health policies.

**Keywords** Self · Identity · Cognitions · Psychopathology · CBT · Attachment

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## 1 Introduction: Why Bring Together the Self and CBT Literatures?

This chapter brings together two important psychological frameworks, that of self psychology and cognitive behavioural theory, as one way of advancing our understanding of the role that 'identity' and 'the self' play in psychological disturbance and its treatment. There are multiple reasons for bringing together these distinct areas, inclusive of diagnostic and treatment implications. From a diagnostic perspective, ruptures in the self are seen as important in disorders as diverse as obsessive-compulsive spectrum disorders, personality disorders and psychoses (Kyrios et al., 2016). While evidence-based interventions such as cognitive behavioural therapy (CBT) have transformed how we treat psychological conditions (Hofmann et al., 2012; McMain et al., 2015), there has been a tendency for services, mental health policies and professional training programmes to focus on reducing symptoms rather than on the features of individuals presenting with psychological disturbance. The result of this tendency is that we develop gold standards for treatment that use a 'one-model-fits-all' framework rather than individualising approaches to interventions. Associated with this is the use of evidence that examines group rather than individual outcomes, thus limiting clinical decision-making for discrete presentations.

Clinical acumen and findings from clinical trials support that not all individuals with particular presenting problems respond to gold standard treatments similarly. In fact, efficacy and effectiveness studies for even those conditions that evidence supports are best suited to CBT demonstrate less-than-adequate recovery rates. For instance, a recent meta-analysis of randomised controlled trials (RCTs) for adults with obsessive-compulsive disorder (OCD) concluded that only 32% of patients had recovered at posttreatment and follow-up compared to control conditions where 3% and 21% recovered at posttreatment and follow-up, respectively (Fisher et al., 2020). More positively, meta-analysis of published RCTs targeting anxiety disorders in children and adolescents reported recovery rates of 47.6–66.4% compared to around 21% across waitlist and active treatment conditions; however, recovery rates for individuals with comorbid autistic spectrum conditions were lower at 12.2–36.7% (Warwick et al., 2017). Hence, there is room for improvement in outcomes following CBT across a range of disorders where CBT is often regarded as the gold standard treatment.

Advancing knowledge of self-related factors that maintain dysfunction and predict outcome could help guide which additional factors to target in interventions. For instance, a meta-analysis of the efficacy of interventions that target social identification to improve health and well-being, inclusive of anxiety, depression, cognitive health and stress, found moderate magnitude effects, with greater impact associated with augmented social identification amongst participants (Steffens et al., 2019). Constructs associated with identity and the self are beginning to re-emerge as important factors in understanding and treating psychological disorders (Kyrios et al., 2016).

## 2 What Is Identity and 'The Self'?

The terms 'self' and 'identity' remain ill-defined concepts. From simple characterisations to more complex analyses, the concepts have demonstrated longevity due to their face validity and cross-theoretical embeddedness. Hammell (2006) explains that 'in general, "identity" is used to refer to one's social "face" – how one perceives how one is perceived by others'. 'Self' is generally used to refer to one's sense of 'who I am and what I am' (p. 185). However, terms 'identity' and 'the self' are often used interchangeably, as we do in this chapter, and both are considered transactional outcomes of ongoing social interaction and self-agency.

Historically, the concept of 'the self' has been discussed across multiple disciplines, including psychology, psychiatry, sociology and philosophy. Contributing to discourse is the fact that 'the self' is a complex multidimensional and transactional construct with developmental determinants and outcomes (Baumeister, 1998). For instance, Leary and Tangney (2012) identified 66 self-referential phenomena, acknowledging there is little research examining their interdependence. Katzko (2003) further noted that '…the term "self" is used by too many different theorists in too many different ways…' (p. 84).

Descartes' early statement 'I think therefore I am' (Descartes, 1967) highlights one of the main initial challenges in thinking about 'the self', i.e. disentangling the individual who has a subjective thinking experience from being the object of that thinking. The challenges are reflected in Locke's (1960) late seventeenth-century contention that the 'self' corresponds to the person engaged in the thinking (the 'I') through to the eighteenth-century philosophers such as Hume (2014) who considered the 'self' separately from the individual who was having the experience. Hume considered the 'self' to be akin to a mental construction of the same individual (the 'Me') that could be appraised in relation to various qualities, inclusive of one's possessions or social status and personal characteristics such as moral values. Subsequently, William James (1890) conceptualised the 'self' as comprising *both* subjective ('I') and empirical or observed ('Me') attributes. More recently, Gallagher (2011) emphasised two further features of self: (a) one's basic or core self (selfhood) which comprises implicit awareness of one's experiences or consciousness ('ipseity') and (b) the narrative self, comprising one's external or social experience of self and including constructs such as social identity, self-concept, self-image and other related self-cognitions.

Discourse within the psychopathology arena has seen multiple constructs, processes, structural features and content areas related to the self that have been identified and studied using a range of theoretical frameworks, including psychodynamic, sociological, narrative, neuroscientific and cognitive. There is a complex interaction between various factors in how the self relates to psychopathology, and, while there are some commonalities between some disorders, there are multiple areas that require ongoing research to delineate aspects of self related to specific disorders (Kyrios et al., 2016). Nonetheless, following the recent advent of the post-rationalist and Third Wave of cognitive behavioural therapies, for example, acceptance and

commitment therapy (ACT) (Hayes, 2016) and mindfulness-based cognitive therapy (Segal et al., 2002), there has been ever-increasing interest in constructs related to the self in the CBT field.

The 'self' is imbued with processes, organisational structures, contents and outcomes. It has been described as schema, prototype, cognitive representation, multidimensional hierarchical construct, narrative sequence, linguistic descriptor and elaborate theory, amongst others (Brinthaupt & Erwin, 1992), and is considered to be a summation of who the individual is. To simplify the complexity of the literature on the self, one can focus on two particular factors: (a) *self-structures and related self-processe*s, including terms such as conscious versus unconscious, explicit versus implicit and strategic versus automatic processing; self stability and integration; and self cohesion, complexity, discrepancies, incongruence, ambivalence, contingencies and sensitivities, and (b) *self-content*, inclusive of self-schemas, beliefs and appraisals.

The earlier psychodynamic theories focused mainly on the former, while cognitive behavioural theories and treatments have tended to focus on the latter. An important contribution of psychoanalytic theories is the way in which they initially construed self-structures as underpinning the development of psychological disorder and included both conscious and unconscious elements in their construction of self. Freud (1916) considered that key features of 'self' were often concealed from conscious awareness and that the interplay of the id, ego and superego essentially determined human behaviour. In psychodynamic theories, self-identity is principally considered a representation of the self in relation to others, particularly one's early parental relationships (Westen, 1992).

Psychodynamic approaches brought the social context into sharper focus, with later researchers such as Turner and colleagues introducing social identity theory which proposes that individual's self-concepts are derived from perceived memberships to certain social groups (Tajfel & Turner, 1979). From a social perspective, the self in the form of self-identity or self-concept could change with the knowledge of or emotional attachment to a specific group. Such approaches have not necessarily concerned major therapeutic recommendations within the CBT world but have been associated with approaches to improving health and well-being within broader therapeutic frameworks (Steffens et al., 2019).

To date, despite theoretical underpinnings emphasising the importance of self-constructs in cognitive behavioural theory (Clark et al., 1999), self or identity has not been incorporated *systematically* into CBT. Cognitive models have, however, incorporated self-constructs as phenomena that encompass specific content and mindsets, expectations and judgement biases and attentional or information processing that maintain psychopathology (Oyserman & Markus, 1998). The notion of 'the self' has been featured both implicitly and explicitly in many cognitive behavioural accounts of psychopathology and resulting interventions, with a particular emphasis on self-content and some additional focus on information processing (Kyrios et al., 2016).

While rational emotive therapy (RET), a prototypical CBT, was based on the foundation that psychopathology results from irrational beliefs and thoughts (Ellis,

1962; Ellis & Dryden, 1997), the self was not discussed explicitly; however, RET does implicate the way in which irrational beliefs are pertinent to subject matter relating to the self. An example of a primary irrational belief would be 'I must be successful in order to be worthy', while secondary rational alternative beliefs could include 'Even when I fail in a specific task, people understand and still accept me'.

Later iterations of cognitive approaches were more explicit regarding the impact of self-cognitions on psychopathology. From Beck (1967, 1976) through to post-rationalists (e.g. Guidano & Liotti, 1983; Mahoney, 1974) and schema-based theorists or therapists (Markus, 1977, 1990; Young et al., 2003), the self and, in particular, self-contents and self-processes have been implicated in the aetiology of anxiety, depression and other disorders.

In his foreword to Kyrios and colleagues' book outlining the self in understanding and treating psychological disorders across the diagnostic spectrum, Beck states that the self-concept is '…a unifying feature…of …disorders…The notion that we have something in us that expresses itself in so many ways is puzzling, yet elegant and exciting' (Beck, 2016, p. X).

However, emphasising that we are only at the beginning of an appreciation of how the 'self' impacts on psychopathology and its treatment, Beck also goes on to say that 'Up to now, we have had to dip in and out of the literature to piece together the various perspectives on the self in such disorders…When psychological disorders are understood as disorders of self, clinicians can apply a fresh perspective towards treatment' (Beck, 2016, p. X).

## 3 Selected Self-Constructs, Self-Structures, Self-Processes and Self-Contents

The next section describes a range of self-constructs, self-structures and self-processes of particular interest to understanding and treating psychological disorder, as well as features of self-content.

### *3.1 Self-Contents and Self-Schemas*

Within the cognitive tradition, the self is seen as a representation of information relating to the individual and consists of descriptions about one's identity, beliefs about one's attributes and self-expectations and future forecasts for one's self. While there are aspects of these that can lie outside of one's immediate awareness, conscious or strategic thinking can facilitate self-knowledge. Negative self-appraisals are seen typically across the range of disorders but may be particularly potent if an individual places greater significance on specific perceived deficiencies. For example, placing importance on others' perceptions of one's social performance and

ability to manage or control one's emotional reactions to perceived criticism constitutes vulnerabilities to social anxiety, while having high expectations about one's body shape or weight is associated with perceptions about one's worth in eating disorders. Decreased self-confidence and self-criticism in anxiety is particularly activated in specific situations, while depression is associated with more global and pervasive negative self-views such as poor self-worth and self-blame. Furthermore, negative self-beliefs can also act as a selective filtering or guiding system for self-related information. Moreover, negative or harsh self-critical evaluations, particularly when made in comparison to others, are an integral part of the 'cognitive triad' where negative views of the world or others, the future and one's self form the characteristic basis of the depressogenic individual (Beck et al., 1979).

Theorists within the CBT tradition differentiate three major levels of cognition associated with psychopathology. These three levels can all be applied to the concept of 'the self' – (a) negative automatic thoughts or appraisals, which tend to be situation specific but based on other levels of cognition (e.g. 'I can never express myself clearly when I have to speak publicly'); (b) maladaptive beliefs/assumptions (e.g. 'I can never be as good as others in public speaking'); and (c) maladaptive self-schemas (e.g. 'I am an inherent failure in everything I do') – and all three levels form part of the diathesis-stress framework of psychopathology. For instance, individuals who maintain depressogenic appraisals, beliefs or schemata (i.e. the diathesis) are considered more likely to develop depressive symptoms following negative events (i.e. the stress) (Beck, 1967). In addition, attentional biases add to the encoding of information and responses to situations (Beck & Clark, 1997). What is less clear is the distinctiveness or nature of the relationships between each of these levels of cognition.

While appraisals tend to be situation specific and beliefs/assumptions are generally more easily malleable, schemas are relatively enduring internal repositories of world or self-representations that direct how we process, organise and manage experiential information and how we typically respond to such information (Clark et al., 1999). The evolutionary advantage of schemata is their ability to facilitate information processing and responses, often automatically, efficiently and out of one's conscious awareness or effortless control. The disadvantage of maladaptive schemata is their propensity to be self-perpetuating, even in the presence of disconfirmatory information, by guiding the information to which we attend.

Self-related schemas are considered 'cognitive generalisations about the self, derived from past experience, that organise and guide the processing of self-related information contained in the individual's social experience' (Markus, 1977, p. 64). Self-schematic content can differ from disorder to disorder; for instance, a focus on inherent failure or defectiveness may be associated with depression, while threat and vulnerability relate to anxiety disorders, body appearance and size to eating disorders and defective moral worth to obsessional presentations. While negative self-content in the form of schemas, beliefs and appraisals is known to predict psychopathology (Kyrios et al., 2016), the relationship between the valence of their content and psychopathology is likely to be more complex. For instance, Dozois (2007) and Dozois and Dobson (2001), support the interconnectedness of specific

negative self-schemas with depressive presentations characterised by poorly interconnected positive schema representations. Bryant and Guthrie (2007) reported that negative coping beliefs predicted traumatic distress, while higher prior self-worth ratings were found to protect from post-traumatic stress disorder (PTSD) severity (Yuan et al., 2011). The responses of individuals with negative self-beliefs to trauma differ with their expectations about the impacts of the trauma (e.g. 'I won't be able to manage'), predictions regarding their future (e.g. 'I'll never be able to cope') and self-appraisals ('That I couldn't stop this happening is proof that I'm worthless') facilitating ongoing distress.

A further factor to consider with respect to valence is the dynamic balance between positive and negative self-schema content and individuals' unique interpretive styles when managing specific activating situations. For example, whereas some individuals receiving praise for an achievement might balance out depressogenic schemas relating to failure, in others, the same event may lead to emotional distress due to the perceived pressure by others or the added expectation of future achievement. Furthermore, positive and negative self-beliefs and their balance may have unique impacts on psychological adjustment (Garamoni et al., 1991; Prieto et al., 1992). More recently, the balance between positive and negative affect and cognitions has also impacted on well-being frameworks and interventions (Fava et al., 2017).

Finally, self-schemas, irrespective of their valence, interact with stressful life events in the development of emotional disturbance. Janoff-Bulman's (1989) 'shattered assumptions theory' proposes that the experience of trauma can change how affected individuals view themselves and the world. Three inherent assumptions (the overall benevolence of the world, the meaningfulness of the world and one's self-worth) constitute core schemas, and when traumatic events shatter these, distress and trauma ensue until affected individuals can rebuild a supportable and adaptive assumptive world. In a recent evaluation and extension of the theory, Williamson et al. (2020) examined these processes in the context of perceived perpetration of morally ambiguous or reprehensible acts in cohorts of military/service personnel and the general public. The researchers reported that PTSD severity was associated with having experiences that violated belief systems important to one's identity and for which there was no way to atone for actions that were discrepant with one's beliefs. The authors contend that trauma transpires when individuals tie threats to meaning and self-esteem to the process of identity formation. Singer (2004) commented that '…To understand the identity formation process is to understand how individuals craft narratives from experiences, tell these stories internally and to others, and ultimately apply these stories to knowledge of self, other and the world in general' (p. 438).

### 3.2 Self-Structures and Self-Processes

Such considerations speak to structural and process aspects of self, which also include stability and consistency of self-concept over time. Poor stability of self-views has been a feature of numerous psychological disorders such as borderline personality disorder (BPD; Zeigler-Hill & Abraham, 2006). For instance, Santangelo et al. (2017) reported that BPD patients demonstrated greater instability in self-esteem and affect which were both highly interrelated and associated with symptom severity. Disturbances in self-consistency are also a feature of disorders such as social anxiety disorder, PTSD and BPD (Kyrios et al., 2016), whereby maladaptive regulation of the roles and self-representations that an individual maintains are demonstrated in, for example, erratic relationships, discrepant behaviours, a sense of emptiness or purposelessness and inconsistent goals (Westen & Cohen, 1993).

Research effort has also focused on other specific aspects of structure relevant to psychopathology, including the clarity, cohesion and complexity of self. The term self-clarity refers to the 'extent to which the contents of an individual's self-concept are clearly and confidently defined, internally consistent, and temporally stable' (Campbell et al., 1996, p. 141). If self-views lack clarity, they are prone to downward revisions, particularly if individuals feel they do not meet perceived standards (Pelham & Swann, 1989). Concepts such as self-ambivalence (Bhar & Kyrios, 2007), self-discrepancies (Higgins, 1987, 1989), maladaptive contingencies (Crocker & Wolfe, 2001) or sensitivities in self-esteem (Doron et al., 2008) and feared self (Ferrier & Brewin, 2005; Melli et al., 2016) are aligned with poor cohesion in self-views.

Many theorists regard the self-concept to be a non-unitary construct, with multiple contingencies used by individuals to evaluate self-worth (Crocker & Wolfe, 2001). Self-complexity refers to '…the number of aspects one uses to cognitively organize knowledge about the self, and the degree of relatedness of these aspects' (Linville, 1985, p. 97). Individuals vary in the number of elements that comprise their sense of self (e.g. social roles, traits, goals), as well as the distinctiveness and associative networks of these 'self-aspects'. Individuals reporting greater self-complexity (i.e. a greater number and greater distinctiveness of self-aspects) are considered less at risk of depression and illness following periods of high stress (Hershberger, 1990; Kalthoff & Neimeyer, 1993; Linville, 1987). Self-complexity is thus thought to operate as a resilience or protective factor against the detrimental effects of severe stress. However, empirical support has been mixed, with overly high degrees of self-complexity possibly also associated with poorer cohesion or less integrated core identity (Rafaeli-Mor & Steinberg, 2002). Brown and Rafaeli (2007) found support for the functional advantage of complexity and integration, with a greater number of self-aspects and more overlap amongst self-aspects associated with lower depression levels. Managing variance amongst individuals in the quality of integration with respect to the range of self-aspects into a whole or coherent sense of self is an implicit foundation of many strengths-based approaches to CBT that (a) encourage the development of new attributes that can be more easily

integrated into existing positive personal resources and (b) discourage contingencies that maintain personal limitations.

Additional self-related factors that impact on adjustment and are closely associated with self-complexity include (a) the degree of consistency versus discrepancy in self-appraisals; (b) the degree to which individuals place significance on specific aspects of self, content themes or contingencies; and (c) the degree to which self-definition is cohesive or stable. Along these lines, self-discrepancy theory (Higgins, 1987), which focuses on the consistency between different aspects of self, is a major contribution to understanding the impact of self on psychopathology. Accordingly, individuals vary in how they see themselves currently (i.e. their 'actual' self), how they would like themselves to be (i.e. their 'ideal' self) and how they think they should be (i.e. their 'ought' self). Discrepancies between these aspects of self place individuals at risk of psychopathology, with particular discrepancies associated with specific affective states, i.e. actual-ideal self-discrepancies related to dejection-related emotions (e.g. depression), while actual-ought discrepancies matched to agitation-related emotions (e.g. anxiety). Despite methodological limitations and discrepant findings, studies have supported these relationships (Boldero & Francis, 2000), although the translation of such insights into specific intervention strategies has not necessarily formed part of traditional CBT conceptualisations of existing treatment strategies, at least explicitly.

Recent literature further reflects the specificity or particular relevance of self-construals to distinct aspects of psychopathology. As examples, research has been undertaken in examining ipseity (i.e. the disturbance of the basic sense of self) as a trait marker in schizophrenia (Nelson et al., 2014) and disruptions in attachment and the capacity to mentalise in personality disorder (see Fonagy & Luyten, 2009). Our own research has focused on OCD following on from the clinical and theoretical work of Guidano and Liotti (1983). In order to describe the impact of unwanted, feared or inconsistent aspects of the self in OCD, researchers have used terms such as 'self-incongruence' or 'self-ambivalence' (Guidano & Liotti, 1983) and ego dystonicity (Rowa et al., 2005). Guidano and Liotti (1983) suggest that individuals with OCD are ambivalent about their self-concept, experiencing positive and negative self-evaluations simultaneously regarding their worth, particularly from a moral perspective. The resulting uncertainty generates attempts to find confirmatory evidence for positive self-views through compulsions, predisposing them to attend to threats to self-esteem. Experimental evidence has supported the impact of compulsions on decreasing degrees and confidence in self-worth (Ahern & Kyrios, 2016).

With respect to specific content areas related to OCD, Guidano and Liotti (1983) focused on moral worth, indicating that self-worth in OCD is highly contingent on maintaining perceived high moral standards. Furthermore, Ferrier and Brewin (2005) found that those with OCD were characterised by a 'feared self' which was more likely to comprise immoral characteristics as self-evident in their intrusions. Aardema et al. (2018) reported that participants with OCD and eating and body dysmorphic disorders reported significantly greater fear of self than non-clinical and anxious/depressed controls, concluding that 'fear of possible self' may be relevant for a range of psychological disorders where negative self-perceptions prevail.

In a recent systematic review examining the relationship between select self-constructs and OCD, Godwin et al. (2020) found that both fear of self and self-ambivalence predicted obsessive-compulsive symptoms and argued that interventions for OCD ought to encompass a component to address fear of self and self-ambivalence.

Moreover, Doron and colleagues (Doron et al., 2007, 2008) examined a range of specific self-domains in which they conceptualised individuals with OCD as experiencing 'sensitivity' or vulnerability. Vulnerable individuals place a high value but concurrently feel incompetent in such domains. Using both clinical and non-clinical cohorts, the researchers concluded that obsessive-compulsive beliefs and symptoms are associated with sensitivity in the domains of morality, perfectionism and achievement. There are questions about the specificity of findings to OCD. For instance, neither Bhar and Kyrios (2007) nor Bhar et al. (2015) found differences in self-ambivalence between OCD and anxiety disorder cohorts, signifying that ambivalence may constitute a general vulnerability (Godwin et al., 2020). Nonetheless, there may be particular clinical significance to such constructs in OCD. For instance, Bhar et al. (2015) reported that changes in self-ambivalence predicted recovery status at posttreatment for patients with OCD during CBT. Despite its status as the 'gold standard' treatment for OCD (McKay et al., 2015), with only half of affected individuals with OCD responding to CBT, these findings indicate that an additional treatment focus on self-ambivalence could improve outcomes.

## 4 Developmental Considerations in Delineating Identity and 'The Self'

Self-constructs and their developmental precursors have both been regarded as significant in the aetiology of various disorders (Guidano & Liotti, 1983; Mikulincer & Shaver, 2016). Importantly, developmental factors have been seen to be critical in the development of self-construals. In particular, the concept of 'attachment' impacts crucially on how individuals see themselves and the world. Central to attachment theory is the precept that humans have an 'attachment behavioural system' that activates greater proximity to attachment figures at critical times, such as those where individuals feel uncertain or distressed, in order to facilitate subjective feelings of safety and security (Bowlby, 1988). Over time, humans are able to internalise their attachment figures, although key learning experiences over critical developmental periods may lead to differential states of assumed security. Early experiences of attachment figures as available, supportive and responsive are likely to lead to positive 'working models' or mental representations of others and the world as secure and of oneself as worthy or competent. In contrast, when attachment figures fail to reliably engender security, individuals develop concerns about the trustworthiness of the world, others and oneself in managing threats; hence,

rather than a sense of security developing, humans learn to be anxious or avoid potential threats and ambiguities.

Two attachment style dimensions, attachment anxiety and attachment avoidance, are associated with distinct patterns of relationship quality, emotional regulation and behavioural predispositions (Mikulincer & Shaver, 2004). The avoidance facet is typically associated with distrust and doubts about others and oneself, emotional distancing and behavioural avoidance, while the anxiety factor is accompanied by anxious concerns about others' availability, low confidence and hyperactivating compensatory strategies comprising active attempts to achieve support and love with associated anger and despair if it is not provided (Cassidy & Kobak, 1988). In turn, both attachment anxiety and avoidance are associated with a broad range of psychological conditions (Mikulincer & Shaver, 2016).

Of particular relevance to this chapter, negative attachments impact on self-construals (Guidano & Liotti, 1983). Mikulincer and Shaver (2004) argued that secure attachments allow an individual to develop a cohesive, stable and adaptive self-structure. Insecure attachments inevitably lead to doubts about one's own worth and higher levels of self-criticism, poor self-efficacy and personal styles that defend against perceived social threats, pessimism and worthlessness. Following the work of Hazan and Shaver (1990), Bartholomew and Horowitz (1991) developed a framework that conceptualised adult attachment styles as comprising positive and negative working models of self and relationships with others. Specifically, they defined four archetype attachment patterns comprising various combinations of positive or negative self-construals and positive or negative views of others. Subsequent research has supported this conceptualisation of the interrelationships between attachment, self-aspects and psychopathology.

For instance, our own research in OCD with clinical and non-clinical cohorts supports the associations between adult attachment insecurities and symptom severity, even after controlling for depression (Doron et al., 2009, 2012). Seah et al. (2018) further examined the association of insecure attachment, self-ambivalence and obsessional beliefs as vulnerabilities to OCD severity using an analogue cohort. They supported the impact of attachment anxiety on self-ambivalence and the impact of attachment, self/identity and cognitive factors on OCD severity. While many studies have been undertaken with analogue samples, there is ample evidence from clinical cohorts supporting the association of symptom severity and self-construals across the OCD spectrum (Dunai et al., 2010; Kyrios et al., 2018). The consistency of such findings supports the need to develop interventions that target self-construals and specific beliefs, and to account for the idiosyncrasies of attachment patterns, in treatment. As discussed earlier, while some treatment approaches explicitly target such matters, CBT has tended to be less explicit in its focus on attachment and self-related structures. The following section discusses the literature and provides further suggestions as to how to incorporate matters relating to self and attachment into CBT.

## 5 The Self and Treatment Considerations

There are important therapeutic implications to the quality of an individual's attachments and the nature of one's self-construals. While psychodynamic therapies hold such considerations central to their frameworks (cf. concepts such as transference and countertransference and the structure of the psyche), traditional CBT therapies tend to de-emphasise the importance of the therapeutic relationship and underscore the salience of therapeutic strategies with somewhat of a focus on self-content and completion of homework tasks (Clark, 2016). While much has been written about the role of the therapeutic relationship on psychotherapy outcomes (see Cuijpers et al., 2019 for a recent review), all psychotherapies require a level of alliance, engagement and transactional communication between therapist and client. From a meta-analysis of CBT studies, Kazantzis et al. (2018) concluded that there is strong evidence for the importance of both the therapeutic alliance and the use of homework exercises with respect to outcomes.

The quality of interactions between therapist and client will be impacted at least in part by their respective attachment styles. Therapists use their understanding of clients' current attachment style and sense of self to facilitate adaptive engagement processes in treatment, inclusive of: (a) enabling a sense of security; (b) supporting the development of a 'shared model' that underpins treatment targets; (c) deciding how best to communicate and what 'stance' to take in developing an alliance with the client; (d) motivating clients to undertake required out-of-session tasks; and (e) modelling important values such as self-acceptance and self-compassion. Level of engagement is particularly important as it increases treatment adherence and compliance. To accomplish all this, therapists may need to adjust their interactive style by understanding how the client's sense of self and all its associated phenomena (i.e. content, structure, etc.) have been impacted by the client's developmental and attachment experiences to that point. For instance, in the treatment of BPD, it is imperative to build a strong therapeutic alliance, including the ability to repair ruptures and enable corrective relational experiences, in order to slowly correct the client's attachment disorganisations. Only after a successful therapeutic alliance has been established and ruptures have been repaired can the integration of other interventions aimed at, for example, emotion regulation be initiated (Liotti & Farina, 2016).

Shorey and Snyder (2006) recommend that assessment of client's attachment styles should comprise a standard component of case conceptualisation and treatment planning. Analysis of explicit and implicit self-structures, self-processes and self-contents associated with an individual client's symptoms could help with access to more core or consequential cognitions, behaviours and maladaptive predispositions, as well as strengths and coping strategies. In turn, this could facilitate the development of a case formulation or 'shared model', i.e. a map that is shared between therapist and client linking the self with the relevant phenomena that maintain symptoms and pathology for that individual. The 'shared model' is the cornerstone of CBT and is developed through a process of guided discovery (the 'Socratic

dialogue' is central to this) and collaborative empiricism. Such a model is also imperative for the motivation and engagement process as it addresses issues and goals that are important to the client. However, there is a paucity of reviews on the impact of specific elements of the therapeutic alliance, such as collaborative empiricism and Socratic dialogue (Kazantzis et al., 2018).

As noted by Clark (2016), further to considerations regarding engagement and motivation, determining the impact of implicit and explicit self-structures and self-processes would further be useful in facilitating positive treatment outcomes. For instance, targeting complexity of an individual's self-identity may assist in tailoring cognitive interventions to either reduce or strengthen the importance of certain self-attributes. In OCD, for example, an individual's self-worth often relies on one or two specific overvalued domains (e.g. morality, achievement, control, ought or ideal 'self'), and intrusions frequently challenge the sense of competence in such domains, resulting in distress and maladaptive responses. When targeting the self in treatment, a specific emphasis can be placed on expanding a client's self-concept by exploring and identifying other important domains, developing strategies to increase other skills and challenging the rigidity and importance of that one specific domain (Doron & Moulding, 2009). Alternatively, more adaptive behavioural manifestations of those domains can be practiced. Further, the degree of congruence or interconnectedness of positive and negative self-attributes could be addressed or challenged which may lead to specific attitudes or activities to modify certain elements of a dysfunctional self (e.g. self-compassion). Despite the importance and value of considering incongruent self-aspects and their impact on emotional disturbance in a case formulation, this frequently does not occur in therapy.

While a variety of CBT methods implicitly take the self into account, clinical techniques can be used to target the self specifically; for example, a focus on both broad (e.g. self-esteem) and specific self-related structures (self-ambivalence), contents (e.g. perfectionism) and processes (e.g. self-focused attention) can be used effectively in treatment. Further, traditional cognitive and behavioural techniques could be augmented with ACT-based values exercises, mindfulness strategies and behavioural exercises all of which could be tailored to specific self-constructs. In addition, narrative approaches offer useful pathways to understanding and working with self-construals (Singer, 2004). Regardless, the therapeutic relationship provides the context to address the self strategically using specific strategies, including unconditional positive regard, active listening and a neutral response to negative and maladaptive thoughts and behaviours, as well as graded psychoeducation, to help clients experience a greater sense of security and to develop an assumption of positive regard (secure attachment) to normalise their experiences.

The inclusion of self-based interventions can offer significantly augmented outcomes for specific disorders when compared to traditional treatments. For example, in social anxiety, researchers have found added benefits to the inclusion of self-imagery rescripting, schema-focused interventions, behavioural experiments and modification of processing through attentional training, task concentration training and attentional bias modification procedures (Gregory et al., 2016). In particular, the use of self-based augmented strategies such as the use of video feedback to

facilitate imagery rescripting, behavioural experiments and attentional training has been found to lead to lower attrition, a greater proportion of participants experiencing clinically significant change and significantly higher effect sizes relative to a control treatment without augmentation with self-interventions (McEvoy et al., 2015). Interestingly, attentional bias modifications are being used more broadly in areas where self-focused attention is maladaptive, such as the experience of chronic pain (Liossi et al., 2020).

A further example comes from a recent study evaluating the addition of self-identity components to group cognitive behavioural therapy for hoarding disorder demonstrated larger-than-usual effect sizes for hoarding and depressive symptoms at follow-up (O'Connor et al., 2018). While these studies highlight the importance of understanding the phenomenology associated with dysfunction and targeting relevant self-related factors, further research is needed to investigate the additional effect of addressing self-concepts in treatment. Nonetheless, evidence to date highlights the importance and potential benefits of a deeper focus on the self (Chia et al., 2021).

## 6 Future Directions

There are a number of directions that can be taken in the future with respect to promoting our understanding of the interrelationships between self-constructs and psychological dysfunction and in facilitating the use of that knowledge to develop more efficacious treatments.

Further research is needed to increase our understanding of the self and identity and to develop integrated frameworks that link dimensions of self reliably across disorders or dysfunctions. The self is a complex and dynamic construct and incorporates the experience of objective, subjective and contextual/interrelational characteristics. That complexity is considered a strength of the construct as it allows its incorporation into multiple frameworks; however, the lack of a common language about the self or agreement about its relevant dimensions, particularly those associated with psychological adjustment, has led to imprecision about its very definition and its various facets, undermining multidisciplinary or collaborative research within even the same disciplines. Clarity around operationalisation of the 'self' and/or a consensus language could act as a bridge that facilitates multidisciplinary research.

An additional research direction relates to the developmental prequelae of self-construals. The cognitive behavioural literature warrants further longitudinal research that follows the development of self and its co-relationship with psychological adjustment while also reliably identifying attachment and self-based risk factors for psychopathology in general and for specific disorders. The outcomes of such studies offer the potential to develop self-based taxonomies of psychological function and dysfunction based on attachment and self-dimensions. Such advances could help form a roadmap for integrating existing formulations of psychological

disorders and their treatments or developing new treatments that target key dimensions of self or identity (structures, processes and cognitions).

Given the relatively limited efficacy of existing evidence-based treatments with respect to recovery, there is a clear need for ongoing review of existing interventions and development of new therapies targeting self/identity. Maturing our existing knowledge base of the self in specific disorders into new treatment protocols ought to be a priority. Furthermore, the integration of self-based intervention strategies into existing treatments to augment efficacy is necessary across a broader range of disorders and dysfunctions. Naturally, the ongoing evaluation of the efficacy and cost-effectiveness of self-based interventions is critical, as is the development of effective training programmes and workshops to disseminate skills throughout the mental health workforce and relevant trainees. Finally, given links between self/identity, psychological adjustment and developmental factors, we need to consider early intervention and prevention programmes, either through public mental health or parenting programmes (prevention), self-development courses potentially disseminated through educational facilities (prevention) and self-augmentation strategies for those at risk or in the early stages of onset (early intervention).

As a parting comment, cognitive behavioural theory and its associated treatments have given us a multitude of options for treating psychological disorder, offering hope and recovery to all with the lived experience of a range of conditions and personal challenges. Greater knowledge about the self, identity and attachment and how these factors impact on all of us offers further hope.

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# Section IV
# Freedom

# Freedom, Responsibility and Guilt

**Thomas Heidenreich and Alexander Noyon**

**Abstract** Among the existential concerns that have become relevant for CBT, the three interconnected concepts of freedom, responsibility and guilt play an important role. Freedom, in this context, is understood as the ability to deliberately choose between different (behavioural) possibilities; responsibility (for one's actions or inactions) is a direct consequence of freedom. Rollo May (Freedom and destiny. W. W. Norton, New York, 1981) has emphasised that destiny sets limits to this freedom. This chapter explores the existential concept of freedom and its potential implications for psychopathology and CBT: being free to choose implies that a large number of options (those not chosen) must be ignored. Not taking conscious decisions may look like a safe thing to do at first but will probably lead to ending up in life situations that are arbitrary rather than value-based. Freedom is a prerequisite for responsibility: if humans are free to choose, they are responsible for the choices they make and (in the constraints of destiny) for the course of their lives. Potentials that are not realised due to bad decisions may to lead to "ontological guilt" and regret. We will conclude with a brief outlook on potential clinical implications that will be detailed in the chapters following this one.

**Keywords** Existential therapy · CBT · Freedom · Responsibility · Guilt · Ontological guilt · Behaviourism · Cognitive-behavioural therapy

## 1 Introduction

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I –
I took the one less travelled by,
And that has made all the difference.

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(Robert Frost: The Road not Taken)

The history of philosophy as well as that of literature, music and other forms of art is full of themes that relate to the topics of freedom, responsibility and guilt: from seemingly trivial decisions such as "Should I stay or should I go now" (The Clash) to Hamlet's famous monologue "To Be or not to Be..." – decisions between different forms of behaviour (based on the freedom to choose between them) play a major role in human lives. The aim of this chapter is not to attempt an exploration of the extent of freedom people have in the face of a deterministic world – rather, we will try to elucidate how (a) people are able to choose between different, and often incompatible, life options and what the consequences are (*freedom*), (b) how the choices people make during their life are related to *responsibility* and (c) how freedom and responsibility are related to *guilt* and regret.

## 2 Freedom

Freedom is just another word
for nothing left to lose.
(Kris Kristofferson: Me and Bobby McGee)

Writing a chapter on freedom for a book on "Existential concerns and cognitive-behavioural procedures" has several potential starting points: first, the exploration of freedom as an existential concern, and second, the history of freedom in the history of CBT. We will start with a broader overview of freedom in a philosophical and political sense and then turn to freedom in existential psychotherapy and will finally address the history of freedom in behaviourism, cognitive therapy and new "third wave" CBT approaches. As will be demonstrated, early behaviourism and existential philosophy did not see eye to eye on the topic of freedom. Yet, freedom and its relevance for therapy have gained influence within the CBT tradition in the works of A.T. Beck and Albert Ellis.

### *2.1 Freedom as a Concept in Philosophy and Politics*

Man is condemned to be free.
(Jean-Paul Sartre, 1943/1956)

The question "Are human beings free to choose whatever option they want or is life pre-determined by religious fate or natural determinism" – sometimes called the problem of free will or free-will problem – has haunted philosophy and psychology for centuries if not millennia, and it is highly unlikely that a definitive answer will be found in the near future. Historically, there are a large number of philosophical (e.g. O'Connor & Franklin, 2020), political (e.g. Arendt, 1961) and psychological (e.g. Skinner, 1971; May, 1981) publications on freedom and its relation to other

topics. Dating back at least to the Stoics of ancient Greece and Rome (Bobzien, 1998), the question of how much freedom humans have in a potentially predetermined or deterministic world has been discussed intensely – a discussion that continues to this day (O'Connor & Franklin, 2020). With his *Philosophical Inquiries into the Essence of Human Freedom*, the German idealist philosopher Schelling (1809/2006) has paved the way for the understanding of freedom in existential philosophy (Heidegger, 1971) and later existential psychotherapy (Yalom, 1980).

**Freedom in Existential Philosophy** In existential philosophy, freedom is one of the major themes for a number of authors (e.g. May, 1981, Yalom, 1980; see Noyon & Heidenreich, 2012, for an overview). As mentioned above, Heidegger, in his *Being and Time*, interprets freedom as the "[f]reedom to choose and grasp oneself" (in the German original: "Freiheit des Sich-selbst-wählens und -ergreifens") (Heidegger, 1927/1962, 1967, p. 188).[1] As is well known, Heidegger's language is highly idiosyncratic und thus hard to read, but the basic concept is easily grasped: humans have the potential to imagine what they could be ("Seinkönnen"), and they have a choice to either follow the call of what Heidegger terms "conscience" to this "could-be" or stick to what everybody (the "Man", which has nothing to do with the current use of the English term "man") does and expects. The state of not living up to one's potential is termed "Uneigentlichkeit" by Heidegger – again, a word that is often translated as "authenticity" (Varga & Guignon, 2020). Varga and Guignon's sophisticated analysis of the term "Eigentlichkeit" and its translations are as follows (online document without page numbers):

> The most familiar conception of "authenticity" comes to us mainly from Heidegger's *Being and Time* of 1927. The word we translate as 'authenticity' is actually a neologism invented by Heidegger, the word *Eigentlichkeit*, which comes from an ordinary term, *eigentlich*, meaning 'really' or 'truly', but is built on the stem *eigen*, meaning 'own' or 'proper'. So the word might be more literally translated as 'ownedness', or 'being owned', or even 'being one's own', implying the idea of owning up to and owning what one is and does (…). Nevertheless, the word 'authenticity' has become closely associated with Heidegger as a result of early translations of *Being and Time* into English, and was adopted by Sartre and Beauvoir as well as by Existentialist therapists and cultural theorists who followed them.

Freedom is also a central concept in the philosophy of Jean-Paul Sartre (most famously in *Being and Nothingness*, 1943/1956; see also Baggini (2002) for an analysis of Sartre's Essay "Existentialism is a Humanism") and Karl Jaspers, who introduced the concept to psychiatry and psychotherapy (Bormuth, 2013).

**Freedom in a Political Sense** In the context of this book, including an analysis of the concept of freedom in a political sense is not possible. We will thus only mention a number of political authors who have become influential for existential con-

[1] 1967: year of publication of the German edition used for this article; 1927: year of publication of the original version in German; 1962: year of publication of the English translation of the original.

Please note that for all works originally published in a language other than English, both the original and the translated version will be cited (e.g. 1927/1962), the first year indicating the original version (e.g. 1927), the second the English translation used (e.g. 1962).

cepts: Hannah Arendt, a former student of Martin Heidegger's, wrote a famous chapter on "Freedom and Politics" (Arendt, 1961, p. 191), where she proposed an understanding of freedom based on social interactions:

> ... by freedom I do not mean that heritage of humanity which philosophers define in a variety of ways and isolate, to their own satisfaction, as one of the inherent attributes of man. (…) Basically, whether I enjoy freedom or suffer the reverse depends upon my intercourse with my fellow men and not on my intercourse with myself.

It should be noted that this intersubjective stance towards freedom is in line with Sartre's thinking (existentialism is a humanism). The political consequences of psychological freedom were described by Erich Fromm in his book *Escape from Freedom* (1941). Based on his empirical work in Germany in the late 1920s and early 1930s (before fleeing the Nazi system), he argued that freedom is a frightening process and that a potential escape from freedom is to fall back into autocratic thinking.

**Freedom and Decision Making** As the material discussed so far shows, freedom (or its opposite) manifests itself in the choices people make. We will not be able to discuss this in detail here, but both the literatures on decision theory (Peterson, 2017; Resnik, 1987) and on judgement under uncertainty (Kahneman et al., 1982; Pisano & Sozzo, 2020) would be interesting to explore against an existential background.

## *2.2 Freedom as an Existential Concern*

**Freedom and Its Connection to the Other Existential Concerns** Death, freedom, isolation and meaninglessness are the four existential concerns that Irvin Yalom describes in his seminal book *Existential Psychotherapy* (1980). We will not explain these concepts in our contribution because they are dealt with in other chapters of this book (see Dar-Nimrod in Chapter "Existentialism and Its Place in Contemporary Cognitive Behaviour Therapy" of this book on the role of death and death awareness, Helm and Greenberg in Chapter "Existential Isolation: Theory, Empirical Findings, and Clinical Considerations" of this book for isolation and Kuperis in Chapter "On the Need for Meaning" on meaning), but it is crucial to note that there are important links of freedom to the other three existential concerns of death, meaninglessness and isolation: death is a natural boundary to life – this means that humans can't postpone decisions infinitely but rather that sooner or later it will be too late for some actions. Simone de Beauvoir developed a highly interesting thought experiment in her novel *All Men Are Mortal* (de Beauvoir, 1946/1992) where an Italian count is made immortal. While enjoying some aspects of this early on, his life becomes more and more meaningless since he can take all decisions without real consequences (because he could choose the other way round during his next cycle of life) – for a more Hollywood-style treatment of the same issue, see

"Groundhog Day" with Bill Murray. Similarly, there is a close connection between freedom and meaning: making healthy choices in life will lead to experienced meaning, whereas failing to choose or choosing wrongly will lead to meaninglessness. May (1981, p. 6) has argued that "[f]reedom is thus more than a value itself: it underlies the possibility of valuing; it is basic to our capacity to value. Without freedom there is no value worthy of the name". The link between freedom and isolation is multifold: decisions taken with personal freedom will very often involve other people and therefore have the potential of interpersonal isolation. Similarly, intrapersonal isolation (dissociating from personal experiences and potentials) and existential isolation (Yalom's assumption that there is an unbridgeable distance between individuals) can be linked to the concept of freedom.

**Freedom as a Topic in Therapy** The complete second part of Yalom's *Existential Psychotherapy* is devoted to the concept of freedom, and, rather than starting with a theoretical or philosophical essay on freedom, Yalom relates clinical case examples that show the practical meaning of freedom for therapy in a variety of situations. One example is that of a patient who tells her therapist that her behaviour is controlled by her unconscious, and another is that of a therapist who has a "can't bell" that he always rings when a patient uses the word "can't". An example that might be encountered nowadays is a patient who tells his therapist that his "addiction centre" had been triggered and that his "dopamine kick" had caused a relapse (notably, a similar example from Yalom features "the unconscious"). The therapist's answer "And did your dopamine also buy the bottle of whisky?" puts it in a nutshell. Yalom argues that even these seemingly trivial instances can point to deep existential issues. Identifying the existential roots of these different therapeutic situations is of uttermost importance, and Yalom uses the works of both Martin Heidegger (1927/1962) and Jean-Paul Sartre (1943/1956) as a foundation for his reasoning.

Among the existential psychotherapists, Rollo May, who was a close friend of Yalom's (Yalom, 2017), has dealt with the topic of freedom extensively. In his book *Freedom and Destiny* that appeared one year after Yalom's *Existential Psychotherapy*, he – like Martin Heidegger – relates to the work of Schelling (see above) and describes freedom and its interrelation to destiny in the following way:

> This personal freedom to think and feel and speak authentically and to be conscious of so doing is the quality that distinguishes us as human. Always in paradox with one's destiny, this freedom is the foundation of human values such as love, courage, honesty. Freedom is how we relate to our destiny, and destiny is significant only because we have freedom. In the struggle of our freedom against and with destiny, our creativity and our civilizations themselves are born. (May, 1981, Foreword)

A few pages later (May, 1981, p. 5), he specifies:

> What, then, is the nature of freedom? It is the essence of freedom precisely that its nature is not given. Its function is to change its nature, to become something different from what it is at any given moment. Freedom is the possibility of development, of enhancement of one's life; or the possibility of withdrawing, shutting oneself up, denying and stultifying one's growth.

May distinguishes two kinds of freedom: freedom of doing vs. freedom of being. Freedom of doing is defined in the following way: "Freedom is the capacity to pause in the face of stimuli from many directions at once and, in this pause, to throw one's weight toward this response rather than that one" (May, 1981, p. 54). In contrast, freedom of being is described as "Whereas the 'freedom of doing' refers to the act, the 'freedom of being' refers to the context out of which the urge to act emerges. It refers to the deeper level of one's attitudes and is the fount out of which 'freedom of doing' is born" (May, 1981, p. 55).

Also, Viktor Frankl[2] (1946/1995) has explored freedom and its relevance for psychotherapy. He uses the term "pandeterminism" to characterise the (in his opinion incorrect) assumption that all freedom is an illusion because everything can be explained causally. On a psychological level, this means that humans are puppets on a string rather than active agents and don't have any influence on their life courses. Thus, in a predetermined world, there can be no responsibility for one's actions. Equally misleading, according to Frankl (1946/1995), is the so-called psychologism – the assumption that there is no fate at all and that everything that happens is a direct consequence of one's thoughts or behaviour. Thereby, psychologism negates the existence of fate or coincidence since everything can be explained causally. Consequently thought through to the end, pandeterminism means that people have no freedom of choice but only an illusion of it ("Everything is fate – you are not responsible for anything"), while in the psychologistic world view, everything depends exclusively on the inner world of the person ("Anything goes – you are responsible for everything").

Overall, existential approaches to psychotherapy tend to take a middle ground: while conceding that there are facts that can't be influenced by individuals/that fall outside the realm of individual freedom (termed "destiny" by Rollo May, 1981), there is still plenty of room for free decisions. Following Sartre on a philosophical level and Yalom in existential psychotherapy, we assume that the reality of human life includes parts on which human beings can decide themselves ("freedom") as well as events that enter life randomly and uncontrollably ("destiny"). Independent of the exact amount of freedom that is attributed to humans, there is one major consequence: responsibility (at least to some degree) for one's actions. We will explore this in the next section.

Also, some clinical disorders such as depression are closely linked to the theme of freedom: regret over not having lived the potentialities of life may play an important role in depression (see Chapter "Failed Potentialities, Regret and Their Link to Depression and Related Disorders" of this book).

[2] Exception to [1]: The year mentioned second does not indicate the year of publication of the English version but that of a more recent German edition.

## 2.3 *Freedom in Behaviourism, Cognitive Therapy and New Developments in CBT*

Current CBT has come a long way since the first behavioural publications, and the discussion of freedom, free will and the like has changed tremendously over the decades. We will address each of these phases in turn.

**Freedom in Behaviourism** Historically, the first works of behaviourism came after the first philosophers that are considered to be "existential" (e.g. Kierkegaard, who published *The Concept of Anxiety* in 1844), but some of them (e.g. Watson, 1913) appeared earlier than important existential philosophical works (such as *Being and Time* in 1927 and *Being and Nothingness* in 1943), and many of the influential works of existential psychotherapy appeared during a time when behaviourism was the dominant psychological philosophy of science.

From Watson's early work (Watson, 1913, p. 163), the aim of behaviourism was to eliminate all references to consciousness: "The time seems to have come when psychology must discard all reference to consciousness; when it need no longer delude itself into thinking that it is making mental states the object of observation". Since "freedom" as defined in a psychological sense is not empirically observable ("mentalist"), it is part of what Watson calls "absurd terminology" (p. 166f) and should therefore be eliminated from psychology.

About 40 years after Watson's manifesto of behaviourism, B. F. Skinner wrote a highly influential book that carries the word "freedom" in its title – as can be expected, this word is not used in affirmative sense but rather as something to be overcome: *Beyond Freedom and Dignity* (Skinner, 1971). Skinner puts all emphasis on the environment and rejects the idea that a mentalistic concept of freedom is useful. Rather, he places freedom in the realm of operant conditioning:

> Freedom is an issue raised by the aversive consequences of behaviour, but dignity concerns positive reinforcement. When someone behaves in a way we find reinforcing, we make him more likely to do so again by praising or commending him. (Skinner, 1971, p. 45)

And, on the next page:

> Man's struggle for freedom is not due to a will to be free, but to certain behavioural processes characteristic of the human organism, the chief effect of which is the avoidance of or escape from so-called 'aversive' features of the environment. (Skinner, 1971, p. 46)

Consequently, the emphasis of the analysis shifts from what Skinner terms the "autonomous man" to the control of the environment:

> By questioning the control exercised by autonomous man and demonstrating the control exercised by the environment, *a science of behaviour also seems to question dignity or worth*. […] A scientific analysis shifts the credit as well as the blame to the environment, and traditional practices can then no longer be justified. These are sweeping changes, and those who are committed to traditional theories and practices naturally resist them. (Skinner, 1971, p. 26)

> The struggle for freedom and dignity has been formulated as a defence of autonomous man rather than as a revision of the contingencies of reinforcement under which people live. A technology of behaviour is available which would more successfully reduce the aversive consequences of behaviour, proximate or deferred, and maximize the achievements of which the human organism is capable, but the defenders of freedom oppose its use. (Skinner, 1971, p. 124)

In spite of Skinner's refutation of "autonomous man", only one year after the publication of Skinner's book, Ryback (1972) argued that existentialists and behaviourists failed to see their "common ground" which he sees in the underlying humanistic assumption. One reason could be the language used in behaviourism: "However, Behaviourists still lack the semantically 'warmer' language with which to communicate their increasingly broadening scope of activities" (Ryback, 1972, p. 53). As we will see, this "warmer language" entered the historical scene not from the Skinner box but from a new development called "cognitive therapy". It should be noted that despite the contemporary preponderance of "cognitive-behavioural therapy", these used to be two different approaches to therapy back in the early days: behaviour therapy with its emphasis on Skinner boxes and the like and cognitive therapy as the work of two psychoanalysts who were dissatisfied with the practice of their traditions.

**Freedom in Cognitive Therapy** When A. T. Beck and his colleagues published *Cognitive Therapy of Depression* (Beck et al., 1979), it stood in sharp contrast to the rejection of mentalist concepts by Skinner and other behavioural writers. While "freedom" as a topic is not mentioned explicitly in this book, it is one general assumption that cognitive content such as thoughts can be changed more or less freely. In 1970 already, Beck defined cognitive therapy as a set of operations focused on a patient's cognitions (verbal or pictorial) and on the premises, assumptions and attitudes underlying these cognitions.

The second founding father of cognitive therapy, Albert Ellis, wrote a text that deals with the very topic of freedom: in a response to a paper by Lucien Auger ("Are Human Beings Free?", 1987), he describes his position in the following way: "I tend to be, however, a little more in favor of free choice or free will than he is" (Ellis, 1987, p. 54). He continues (p. 55) by stating that "human freedom seems to have some degree of reality –especially when it is backed by reflective thinking. For men and women are future-oriented as well as stuck in the conformist past and they can therefore choose to go through present pain for future gain (as when they give up smoking or fight to the death against political tyrannies so that their children may live in freedom)".

> (…) [H]umans – as rational-emotive therapy particularly emphasizes – can change their cognitions and interpretations. This very ability, I (along with George Kelly) would say, gives them at least some measure of freedom or "free will". Limited yes but still existent. (Ellis, 1987, p. 56)

**Freedom in ACT: Freely Chosen Values** As for acceptance and commitment therapy (ACT) and other new developments in CBT (sometimes termed "third

wave"), freedom in the sense of this chapter is most prominent in the work with values. The term "values" has a very specific meaning in acceptance and commitment therapy. Wilson and Dufrene (2009, p. 64) define values as

> freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioural pattern itself.

In our context, the words "freely chosen" are of course paramount. Since the definition above is quite technical, we will briefly examine Fletcher and Hayes' (2005, p. 321) elucidation of the term "values":

> Values differ from goals in that they are not objects to be attained, but rather are directions that integrate ongoing patterns of purposive action. In the case of values, language is useful in that it serves to link actions in the present into a coherent pattern of effective action. ACT exercises use the processes of acceptance, defusion, present moment awareness, and so on to clear the way for clients to identify valued domains of life (e.g., family, relationships, work). In choosing life directions that are meaningful, clients are able to disengage from the verbal processes that drive behaviours based on social compliance, avoidance, or fusion, and shift toward more appetitive forms of behavioural regulation.

It should be noted that in this paragraph, the expression of "choosing life directions that are meaningful" has a definitive "existential ring" to it – both choice (rooted in the possibility of freedom) and meaning are two of the most central concepts of existential psychotherapy.

It would be beyond the scope of this chapter to examine the role of freedom in other new developments in CBT such as mindfulness-based cognitive therapy (MBCT; Segal et al., 2013), dialectical behaviour therapy (Linehan, 1993) or behavioural activation (Jacobson et al., 2001). Nevertheless, it should be noted that freedom (of choice) tends to play a major role in these newer developments. In MBCT, for instance, it is one of the major aims to inhibit dysfunctional ruminative processing associated with low mood – the freedom to refrain from action is very important. Behavioural activation, like ACT, emphasises the role of choosing values (and engaging in them through actions).

Taken together, freedom in the sense provided by existential psychotherapists was refuted by early behaviourists as being mentalistic – however, it is highly compatible with the cognitive therapy approach, and it plays a major role in modern "third wave" CBT approaches.

## 3 Responsibility

> Can you take responsibility for this?
> (Fritz Perls)

Similar to the concept of freedom, responsibility is a concept that is relevant in a variety of contexts – from moral responsibility in philosophical ethics (Talbert, 2019) to political responsibility (e.g. Tholen, 2018). Having discussed the concept

of freedom in great detail, we will deal with the concept of responsibility in a much more concise way as most of the issues related to the existential concern "freedom" are closely related to responsibility. Leaving aside the philosophical debate on compatibilist vs. incompatibilist accounts of the relationship between determinism and free will (and resulting responsibility of an individual; see Talbert, 2019), we may assume that freedom (in whatever amount) is a prerequisite for responsibility: if all actions are predetermined, it is impossible to make an individual responsible for their deeds.

**Responsibility in Existential Philosophy** In existential philosophy, Sören Kierkegaard (1844/2015) has placed great emphasis on the responsibility for one's actions and the resulting anxiety because making choices means deciding against all other options. Similarly, other existential philosophers have stressed the responsibility resulting from free will (see Noyon & Heidenreich, 2012).

**Responsibility in Existential Psychotherapy** Much of what has been discussed in the context of freedom also applies to responsibility: Yalom (1980) places an emphasis on patients' avoidance of responsibility (and, thus, the denial to accept the idea of freedom). Drawing on the work of Kaiser (1955), he discusses clinical case examples and literature that deal with avoidance of responsibility. In his view, it is important for patients to take responsibility for those facts in life they can control but also to be aware of "destiny" that is uncontrollable.

What are the clinical implications for failure to take on responsibility? Yalom (1980) describes a prolonged delay of decisions rooted in a deep form of existential anxiety towards taking responsibility for one's actions. This anxiety is much deeper than a single pending decision. A phenomenon closely related to responsibility is certainty: some clients don't move forward in the decision process because they want to achieve some kind of "absolute safety" to take the right decision. This very often goes hand in hand with the idea that the "right decision" will make everything possible and thus will have no negative consequences. This illusion is a misinterpretation of the existential fact of responsibility: there is no choice that does not come with the fact that it is a decision against all other options. The things that are not chosen are associated with non-existence, nothing, not-being (*Le néant*; Sartre, 1943/1956). Rejecting responsibility can be understood as a dysfunctional reaction to the anxiety that is inherent in freedom. Trying to avoid this kind of anxiety is highly dysfunctional because even the decision not to choose is a choice and is regularly associated with the avoidance of action. On the other hand, taking on responsibility for things that are not controllable (e.g. a diagnosis of cancer) can be quite harmful.

In summary, responsibility rests on the assumption that humans are free to choose their actions at least to some degree – in psychotherapy, a major task is to find out which actions are under the control of patients and which are not.

## 4 Guilt

The years rolled slowly past
And I found myself alone
Surrounded by strangers I thought were my friends
I found myself further and further from my home, and I
Guess I lost my way
There were oh-so-many roads
(…)
(Bob Seger: Against the Wind)

Just as responsibility is a direct consequence of freedom, the possibility to be guilty is a direct consequence of responsibility: being guilty is only possible when at least two conditions are met – (a) there is responsibility for one's actions (meaning that somebody is able to freely choose between alternatives), and (b) the harm caused (to others) was done intentionally. This is echoed in legal systems all over the world where there is a distinction between killing somebody intentionally vs. accidentally.

### *4.1 Three Forms of Guilt According to Yalom*

Yalom (1980) proposes a distinction between three forms of guilt: neurotic, actual and ontological guilt. Since ontological guilt is of paramount importance in the context of this chapter, we will deal with the other two forms of guilt only briefly.

**Neurotic Guilt** In Yalom's psychodynamic approach to existential psychotherapy, neurotic guilt is conceptualised in a psychoanalytic way. Phenomenologically, neurotic guilt in this sense characterises a number of mental disorders: in major depressive disorder, for example, one criterion is "Feelings of worthlessness or excessive or inappropriate guilt nearly every day" according to *DSM-5* (American Psychiatric Association, 2013). Similarly, guilt may play a role in obsessive-compulsive disorders (Shapiro & Stewart, 2011).

**Actual Guilt** As stated above, actual guilt implies intention of one's action (or inaction) and an ability to choose this action among other options. Guilt is something that is unavoidable in life (even though humans can try to minimise their negative impact on other people and nature). For Frankl (1946/1995), guilt is one part of the "tragic triad" (together with suffering and death). For him, not experiencing guilt is a sign of psychopathology rather than health (i.e. in antisocial personality disorder).

## *4.2 Ontological Guilt*

The form of guilt most relevant in the current context is what is called ontological guilt (or sometimes existential guilt). In contrast to guilt resulting from harming others (actual guilt), ontological guilt refers to falling short of one's possibilities. We will briefly consider the existential philosophical background of ontological guilt and then turn to therapeutic implications as discussed by Yalom (1980).

**Ontological Guilt in Existential Philosophy** Although a large number of existential philosophers have written on this topic, it is Heidegger's classical account (in paragraph 58 of *Being and Time*) (Heidegger, 1967, p. 280; 1927/1962) that has remained influential to this day (Elgat, 2020). The respective section in *Being and Time* is titled "Anrufverstehen und Schuld" (Summons and Guilt), and it describes the summons (by conscience) to a more authentic way of life and the ontological guilt that inevitably grows from the impossibility of ultimately bridging the gap between realising all of our "ownmost" possibilities for relating to our existence. In Heidegger's own words (original version):

> Das Anrufen des Man-selbst bedeutet Aufrufen des eigensten Selbst zu seinem Seinkönnen und zwar als Dasein, das heißt besorgendes In-der-Welt-sein und Mitsein mit Anderen. (Heidegger, 1967, p. 280)

We will not try to provide a translation but rather to highlight some central points: "Anrufen des Man-selbst" means that an everyday person is called (by conscience) to actualise her/his innermost self (in the German original, "eigensten" is the superlative of "own"). This actualisation is not in some speculative cosmos but rather within the world and in the being with others.

Karl Jaspers (1932/1969) is more concerned with the ontic aspects of guilt (those related to life in the world) than with the ontological. He conceives guilt as one of the "boundary situations" that are characteristic for human life. Just by grasping life and its possibilities, humans restrict others. Even trying to do nothing doesn't solve this problem because this too has consequences.

**Ontological Guilt in Existential Psychotherapy** Yalom (1980) draws from the above passage by Heidegger and specifies what he calls "existential guilt" as the failure to live life as fully as possible. This feeling of guilt is of course uncomfortable, but it may be very constructive in helping people overcome this impasse and move in a direction that is more in line with the authentic self. Breitbart (2017, p. 510), in a more recent paper, summarises this basic idea in a clear way:

> This responsibility to create a life involves creating a unique life (one only we could have lived – authentic to us), and to live this life to its fullest potential, thus creating a life of meaning, purpose, direction, growth, and transformation, and becoming valued members of a culture and the world with meaning. Most, if not all of us, fail at this impossible task. Falling short of this responsibility leads to what existentialists describe as existential guilt, the notion that I could have done more, and that I missed opportunities or failed in some ways.

Clinically, working with ontological guilt can be rewarding as well as challenging. As a rule, the more options patients have in their lives, the easier it is to mine therapeutic gold from the mine of ontological guilt – consider the lyrics by Bob Seger at the beginning of this paragraph: assuming that he is still at an age where he can change things, we might ask questions such as "what did you neglect during these last years" and will try to activate some of these things. Other life circumstances make working with ontological guilt more challenging: this is especially true in end-of-life care and terminal illness, where there are only limited options to change. Again, in Breitbart's words (Breitbart, 2017, p. 511):

> Ultimately, it comes down to the singular choice of forgiving yourself for being an imperfect, vulnerable human being. Forgiving yourself for merely being human—all too human.

One can see an interesting parallel here to Erikson's eighth and last stage of psychosocial development – a successful completion of this stage is associated with "a sense of coherence and wholeness" (Erikson, 1982, p. 65), while the opposite is described as despair.

## 5 Regret

> I'd rather be sorry for something I've done
> Than for something that I did not do.
> (Kris Kristofferson and Rita Coolidge)

After taking a close look at freedom, responsibility and (ontological) guilt, we have arrived at a potential everyday consequence of these: regret. As we have seen, to authentically realise all potential aspects of one's personality is impossible, so life will very likely always contain regret over unlived potentials to a smaller or larger degree. Nevertheless, the amount of regret over this will vary greatly between people (and in individual people at different times of their lives). We will not explore regret in more detail at this point (see the next two chapters of this book) but rather want to stress the fact that expectations of people (and what they are supposed to do in a "successful" life) are shaped by the cultures they live in as well as their "authentic" self – one example is a study published by Orna Donath, an Israeli sociologist, on regret of women associated with raising children (Donath, 2015): while many western societies proclaim that raising children has to be highly rewarding (especially for women), some seem to feel different. Similarly, many people devote most of their time to pursuing money and job success – very often at a very high cost for other areas of life.

It should also be noted that societies (and in part commercial interests) shape expectations of what people think they should do during their lives (and, in this way, avoid regret): so-called bucket lists consisting of things people want to do or experience before "kicking the bucket"; some of these bucket list items tend to be commercially available (go skydiving), while very often, interpersonal aspects (like re-engaging in the relationship to an alienated family member) are much more

important. Morgan Freeman and Jack Nicholson (in the movie with the same title) beautifully exemplify this shift from commercially available items to relevant personal ones.

## 6 Conclusions

This chapter has delved into the basic concepts of existential philosophy and existential psychotherapy. In a book titled *Existential Concerns and Cognitive-Behavioural Procedures: An Integrative Approach to Mental Health*, this might seem a bit out of place and far removed from CBT procedures. But we believe that the opposite is the case: dealing with these philosophical roots enables therapists to see the deeper aspects of seemingly irrational behaviour. For example, a student who enters therapy with a diagnosis of mild depression and who shows difficulty deciding on potential job offers can be understood in a "narrow" sense where we as therapists do the usual decisional balance and motivational stuff. Having the background of existential thinking may enable us to see some of the real depth of a seemingly simple decision. This becomes especially prominent when we meet clients who have taken (in retrospect) unwise decisions or who have tried to refrain from deciding. These more clinical aspects will be explored in the two following chapters by Ross Menzies: His first chapter deals with "Failed Potentialities, Regret and Their Link to Depression and Related Disorders" and shows direct links of these ways of reasoning to CBT constructs such as a ruminative response style and post-event rumination, while his second chapter deals with "Reframing the Past and the Treatment of Existential Guilt and Regret".

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# Failed Potentialities, Regret and Their Link to Depression and Related Disorders


**Ross G. Menzies**

**Abstract** A variety of studies have linked mood disorders to a ruminative style of thinking, particularly involving events and happenings from the past. When an individual's early expectations of life are not met, depression may follow. In existential terms, depression may be linked to an individual failing to embrace the potentialities afforded by freedom. Post-event rumination, usually involving shorter time frames, has also been linked to social anxiety disorder, with individuals thinking over social encounters and how these were interpreted by others. Finally, regret and shame over early happenings can be involved in a range of pure obsessions, illness anxiety disorder and related conditions. It will be argued that all of these phenomena can be understood in existential terms and that this analysis is more in keeping with the way clients express their difficulties than typical cognitive and behavioural formulations.

**Keywords** Rumination · Depression · Social anxiety disorder · Obsessive-compulsive disorder · Existential freedom · Maximising · Existentialism · Metacognition · Health anxiety

## 1 Freedom, Failure and Depression

As we have seen in Chapter "Freedom, Responsibility and Guilt", the freedom to make choices is one of the existential givens that all humans must confront. Although it might superficially seem to be a positive aspect of living, freedom presents us all with great challenges. Many writers have argued that making choices comes with tremendous responsibility. As Menzies and Menzies (2021) point out in their summary of the work of Sartre and the French existentialists, in choosing actions you

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are signalling your decisions to the broader community. Others may fairly assume that you see your choices as good ones for a person to make (see further Sartre, 1999). For example, if you refuse to get a COVID-19 vaccination, you might, unfortunately, influence others to do the same (Menzies & Menzies, 2021).

In addition, there is a seemingly infinite number of lives from which to choose. As Nietzsche (1974) suggests, the death of God, at least in terms of popular influence, has opened up these possibilities by eliminating a simple set of rules to obey. You must create your own path, and in creating it you will have defined yourself and fashioned your essence. It is for this reason that Sartre (1999) famously declared that 'existence precedes essence'. Accordingly, the decisions and directions of our life are not to be taken lightly. Freedom is, in many ways, a heavy weight that we must drag through our entire lives. Sartre (1999) declares that we are 'condemned to be free' with decisions to be made at every turn. As Menzies and Menzies (2021) remind each of us, we are mortal and will get only one shot at living truly and authentically. Each of us has only one chance to define oneself. Bravery will be needed if we seek authenticity, as Gerard Kuperis (2018, p. 49) demonstrated with the following simple, but compelling, example:

> Let's say I go to college, since all my friends go to college, my teachers have been preparing me for this step, and it's very clearly the expectation of my parents, who have never even mentioned the possibility that I do anything else. For Sartre, this kind of pattern shows us exactly how we deal with our freedom: while we could choose to work and travel the world, build a cabin in the woods, or pursue some other dream, we typically do not do it, precisely because it would be our own choice, and thus our own responsibility. If I do choose my own actions and I, for example, run out of money in a remote part of China, if I break an arm, or if I fail to save money for my retirement, I can only blame one person: myself.

With decision-making, regret inevitably may arise. Of course, regret is not necessarily a negative thing. Several studies have shown that regret may promote learning. Making mistakes and regretting them may positively influence planning for the future (e.g. Epstude & Roese, 2008). Bailey and Kinerson (2005) demonstrated that past behaviours that elicited regret were less likely to be repeated. Further, Shani et al. (2015) found that individuals who feel responsible for missing future opportunities experience increased feelings of regret. These findings, taken together, suggest that regret may play an important role in driving growth, maturation and adaptive change in behaviour. However, it is also well established that regret and rumination about perceived mistakes in the past are linked to the severity of depressive episodes (Roese et al., 2009). How do we reconcile these competing findings?

One possibility is that regret is activated by multiple psychological processes, some of which are adaptive while others are not. Along these lines, decision justification theory (DJT; Connolly & Zeelenberg, 2002) suggests that there are two components of decision regret: self-blame for making a bad choice and comparative evaluation of the outcome. On the face of it, this model allows for the possibility that regret could be adaptive or maladaptive, depending on which process dominates in any individual. If regret is largely driven by a rational comparison of outcomes that could inform future choices, growth would be expected. On the other

hand, if regret is driven by self-blame for the past decision, deterioration in self-esteem, self-efficacy and mood might be expected.

Kraines et al. (2017) were the first researchers to examine DJT in the context of depression. Sixty-five participants (27 never depressed, 24 formerly depressed and 14 currently depressed) read two scenarios designed to elicit regret and rated the degree to which they experienced self-blame, comparative evaluation regret and overall regret. The two scenarios are described below:

Scenario 1

> Imagine that you are leaving a party where you were drinking alcohol. A friend suggests that you call a cab but you decide to go ahead and drive yourself home. You arrive home safely, but in the morning you realize that you had been too drunk to drive. You drove through an area of town that usually has many pedestrians and quite a bit of traffic and you realize that things could have ended in disaster.

Scenario 2

> Imagine that you are deciding whether or not to vaccinate your 1-year-old child against a serious disease. The disease can have serious, negative long term effects on your child's health and can even end in death. The vaccine is reliable and quite safe. Only 1 out of every 10,000 children given the vaccine have the bad side effect (complete blindness). You consult doctors, vaccine experts, and friends who all agree you should vaccinate your child. You consider carefully and decide to vaccinate. You are unlucky and your child suffers the side effect of blindness.

After reading each scenario, participants were asked to rate how much they would regret the decision they made (i.e. overall regret), how much they wished the results had turned out differently (i.e. comparative evaluation regret) and how much they would blame themselves for their decision (i.e. blame regret). Few differences were reported between groups, with no differences observed in overall regret or comparative outcome regret. Notably, however, currently depressed participants demonstrated greater self-blame regret compared to the never depressed group. The authors concluded that major depressive disorder is associated with increased self-blame regret, but not comparative outcome regret.

Other explanations for the data are, of course, possible. For example, the failure to find differences between groups in comparative evaluation regret may have been due to floor and ceiling effects. Wouldn't every participant, regardless of mental health status, have given the highest possible rating to desiring another outcome than blindness in Scenario 2? The findings need replication and extension in other experimental and quasi-experimental designs and in other research laboratories. Still, the difference in blame regret between depressed and never depressed participants is an important finding that is consistent with considerable research on rumination in depression.

## 2 The Problems of Rumination

A central feature of depression is rumination and often about the past (Nolen-Hoeksema et al., 2008; Papageorgiou & Wells, 2004). Rumination is a maladaptive process since it is not goal directed. It involves repetitive thinking, typically about the perceived causes (i.e. antecedent events) of the sufferer's depressed state, and does not involve active problem-solving (Nolen-Hoeksema et al., 2008; Papageorgiou & Wells, 2004). Importantly then, as Joormann and Stanton (2016) point out, it must be differentiated from adaptive cognitive strategies such as problem-solving or reappraisal, in which the individual reframes or reinterprets their circumstances. Since the focus of rumination is so often about the choices and behaviours that have led to the depressed state, rumination and regret often go hand in hand.

A ruminatory style of thinking has been shown to be a prognostic indicator of depression proneness (for a review, see Nolen-Hoeksema et al., 2008). In controlled, single-session laboratory settings, individuals with a tendency toward rumination have been shown to experience longer episodes of psychological pain following a mood induction trigger (e.g. sad music) (see Watkins, 2008 for a review). The extension of the depressed state that occurs with rumination may be one of the ways in which it acts as a maintaining factor in the mood disorders. Longer bouts of sadness following any negative trigger give greater opportunities for the depressed mood state to further influence negative appraisal, driving ever deeper depression (see Lyubomirsky & Tkach, 2004, for a review).

Given the negative consequences of rumination, why would anyone engage in it? Wells (2019) argues that stable, incorrect metacognitive beliefs about rumination lead some individuals to maintain the practice in a futile attempt to self-regulate emotion. These faulty metacognitive beliefs (e.g. 'ruminating helps me to cope') motivate the individual to ruminate which, as Nolen-Hoeksema et al. (2008) have shown, increases and maintains emotional distress. According to Wells (2019), these faulty metacognitive beliefs are causal factors in psychiatric disorders, a position that is supported by considerable experimental evidence (see Sun et al., 2017 for a review).

Not all metacognitive beliefs involved in depression are positive. Papageorgiou and Wells' (2003, 2004) metacognitive model of depression emphasises positive and negative beliefs about rumination that are typically found in the depressed person. Positive beliefs focus on the claimed utility of rumination (e.g. 'It will help me find answers to my problems'; 'It helps me cope'). These positive beliefs motivate the individual to begin rumination in the face of an internal or external trigger. Once stuck in a ruminatory cycle, negative metacognitive beliefs may take over (e.g. 'rumination about my past is uncontrollable'), reducing the individual's self-efficacy to exit the ruminatory process. The negative beliefs drive an ever-increasing hopelessness in the individual, stuck in a loop exploring the regrets of the past, the pain of their present and the futility of their future. The ruminatory process increases the accessibility of negative emotions and thoughts, thus maintaining depressive symptomatology. The model has intuitive appeal and considerable face validity. It is

usually well received when explained to depressed clients who typically have clarity about their metacognitive beliefs about rumination. Evidence from a range of studies has shown that positive and negative metacognitive beliefs are strongly related to both the ruminatory style of thinking and depression (Kraft et al., 2019; Kubiak et al., 2014; Papageorgiou & Wells, 2003, 2009; Roelofs et al., 2007; Weber & Exner, 2013; Yilmaz, 2016).

In sum, positive and negative metacognitive beliefs drive the individual to more and more rumination that maintains the depressed state. For our purposes, however, it is the content of the depressed individual's thoughts that is most instructive. As we have seen, most of the thoughts do not involve problem-solving, reframing or other adaptive strategies. On the contrary, the depressed ruminator becomes locked in the regretted actions and moments of their past that bring them further down (e.g. 'why did I leave England?', 'if only I'd told her I loved her before it was too late', 'I chose the wrong career – I could have achieved so much more'). Regret about the past dominates the depressed mindset (Beck et al., 1987) and arises from the consequences of existential freedom. Choosing the 'wrong' forks in the road can lead one into a cycle of rumination about failed potential that can dominate years of a person's life. After all, as one client recently pointed out, 'The choice I made has changed my life forever. I don't get a second chance at life'. The combination of freedom and the inevitability of death makes the choices of a life seem even more critical to many who reflect negatively on their life's story (Menzies & Menzies, 2019).

Regret has even been linked to suicidality, particularly among the middle aged and elderly. Bruine de Bruin et al. (2016) examined the relationships between individual differences in maximising (i.e. striving for the right decision), levels of regret, negative decision outcomes and suicidal ideation and behaviours in an elderly sample with depression and a group of controls. They found that scores on the three individual-difference measures (i.e. maximising, regret and outcomes) were worse for psychiatric patients than for nonpsychiatric controls. Further, these scores were significantly correlated to clinical assessments of depression, hopelessness and suicidal ideation. Several other findings are notable in this interesting study. First, maximising was associated with depression, even after controlling for life decision outcomes. That is, the very act of striving for the right decision was linked to depression. Second, repetitive regret (or what we might describe as rumination about perceived mistakes of the past) significantly mediated the relationship between maximising and measures of depression and suicidality. Taken together, the findings suggest that individuals who seek perfect decisions could be at risk for clinical depression and suicidality because of their proneness to regret. The authors conclude by arguing that 'regret regulation' should become the new target for treatment of late-life depression.

## 3 Social Anxiety Disorder and Post-event rumination

While much has been written about depression driven from regret over earlier life events and choices, minor social actions in everyday life can become the bane of the daily existence of those with social anxiety disorder (SAD). Post-event rumination involves excessive reliving of minor aspects of social situations that have passed. The individual becomes consumed by self-evaluation of their social performance, going over the choice of words in a sentence, the amount that they spoke, their answers to questions and a range of related social phenomena. Much of the time taken up in post event rumination is spent exploring the things that the individual believes, in hindsight, that they should have said or done differently. In essence then, one can conceive of post-event rumination as an expression of the pain that comes from existential freedom.

There is now a large body of research demonstrating that, unsurprisingly, the frequency of post-event rumination predicts how negatively an individual assesses their social performance (Abbott & Rapee, 2004; Dannahy & Stopa, 2007). Further, the very act of ruminating tends to guarantee a negative perspective. After all, how many social encounters, if closely scrutinised, could be said to be free of any social error or imperfection? Given that the process of post-event rumination inevitably leads to a negative view of one's social performance, again one can fairly ask why individuals with social anxiety disorder would engage in it? Clark and Wells (1995) argue that the effort to find social errors relates to beliefs that the individual holds about social performance and its consequences, e.g. 'If I make mistakes, then others will reject me'. Unfortunately, as Clark and Wells (1995) point out, the process of ruminating on negative social behaviours makes these more salient, dominating the memory of the social encounter. This produces a biased and negative record of social performance that may increase social anxiety in similar, future encounters. In this way, post-event rumination plays a critical role in the maintenance of social anxiety disorder.

The psychological pain produced by post-event rumination among those with social anxiety disorder may be partly responsible for the high use of alcohol in this condition. Considerable research has shown dramatically increased odds of having an alcohol use disorder (AUD) among those with SAD, compared to non-anxious controls (see Oliveira et al., 2018 for a review). Alcohol use can lead to a decrease in post-event processing for several reasons, none the least of which is that memory impairments mean there is little to process. Ogniewicz et al. (2019) have shown that alcohol-induced decreases in post-event processing predicted intoxication in following social encounters but only for those who are high in social anxiety. Thus, individuals with social anxiety disorder may inadvertently learn to use alcohol as a strategy to reduce negative cognitive processes. While this may work, the emergence of an alcohol use disorder is a significant price to pay for reduced rumination.

Of course, there may be more direct existential reasons for AUD and other drug problems. The inevitability of death, the truth of my existential isolation and the inherent meaninglessness of one's life may drive substance use problems. Menzies

et al. (2019) have shown strong positive relationships between death anxiety scale scores and the severity of alcohol use disorders. Menzies and Menzies (2021) argue that:

> The inevitability of my decline and decomposition is a fate beyond the skills of western medicine. Some people turn to substances to sedate themselves from the truth with the soma of their choice – a 'holiday from the facts' – be it alcohol, hallucinogens, or literal pain killers for their existential aches. p. 278

## 4 Regret and Obsession

The existential theme of freedom seems to be particularly prominent in obsessive-compulsive disorder (OCD). Indecisiveness has long been seen as a hallmark of the disorder, with many individuals depending on others to make choices for them (Krochmalik & Menzies, 2003). Even small decisions, like choosing which size can of butter beans to buy or choosing a recipe from a cookbook to prepare, can become impossible. Some individuals with OCD attempt to avoid choice altogether by applying simple rules that remove the sufferer from the decision-making process (e.g. opening a cookbook at random and preparing whatever recipe appears). Others just get stuck in indecisiveness, unable to move forward in any meaningful way.

Menzies and Menzies (2019) interviewed individuals with OCD with themes of existential freedom emerging in their analysis of transcripts. As one participant starkly put it:

> … if I went to my dad tomorrow and said, "Dad, I want to travel the world," he'd book me a flight in an instant. That pisses me off even more, the fact that I know I can do anything, and I choose not to because I'm worried about it. That upsets me more than anything in the world. When I have all these options, everything, and I fucking choose not to do them, for one reason or another. I could go travel the world, see everything, do all these beautiful things, but I wouldn't enjoy it. It upsets me, it really upsets me. p. 252

Menzies and Menzies (2019) point out that this man's response reveals the dual nature of freedom that existentialist philosophers and contemporary existential psychotherapists (e.g. Irvin Yalom) describe. First, the seemingly infinite number of behavioural choices before us creates anxiety for fear of regret ('I know I can do anything, and I choose not to because I'm worried about it'). Second, the feared regret so limits the individual's freedom that they are unable to pursue anything meaningful ('That upsets me more than anything in the world'). In the case described above, the sufferer certainly appears, as Sartre put it, 'condemned to be free'. Freedom seems a punishment to him rather than a prize. How can one proceed in the face of these pains? Menzies and Menzies (2019, p. 253) argue that it is about achieving balance:

> As part of our existence in this world, we must all find a balance between the two: to live as freely as possible, unburdened by the restrictive baggage of our worries, but also to navigate the overwhelming number of choices we could make and still continue to act. If we want to

> make the most of our time on earth, we can neither succumb to the terror of our paralysing freedom, nor can we inadvertently lock ourselves into prisons of our own making.

While the most common forms of OCD relate to cleaning/contamination and harm-checking, an extraordinary range of obsessions exist, many of which are directly related to the existential theme of freedom. In particular, the form of the condition typically referred to as 'real-event' OCD involves scrutiny of an action or actions that the individual has taken in the past and an exploration of what these may mean about the person and their worth/value (de Silva, 2003; Einstein & Menzies, 2003; Marks, 2003). The events involved in real-event OCD are many and varied, although most commonly they have occurred in adolescence or early adulthood. In general, the critical factor is that the sufferer experiences horrific shame and regret and judges the event to speak to a fundamental flaw in their character that renders them forever worthless. They may ruminate endlessly about the event, attempt to work out why it occurred and consider what people in the general community would think of them if they found out (Menzies & Menzies, 2021). Events described in case reports and chapters focusing on clinical descriptions include:

> Stealing underwear from an aunt's bedroom
> Punching someone in a schoolyard argument
> Pouring an alcoholic drink for a friend who was already intoxicated
> Stealing money from a parent's purse
> Sleeping with a friend's partner
> Noticing, but not looking away, the underwear of a friend while playing a game

Typically, real-event OCD is accompanied by poor or limited insight. The individual fails to see the event in the context of their age and maturity at the time. Instead, the sufferer argues that the chosen action reflects a failure in the person's make-up that renders them worthless, not deserving of the support and care of others. Unsurprisingly, secondary depressions are common in real-event OCD, as the rumination leads to increasing regret and shame that drives self-esteem lower and lower over years or even decades (see further Menzies & Menzies, 2019).

The existential theme of freedom relates to a second class of obsession. In aggressive obsessions individuals fear that they may suddenly act out in a violent way, causing harm or death to loved ones, strangers or even the self. Typically, their fears are triggered by intrusive thoughts or images of the violent action. There are many different arguments that sufferers mount in defence of their fear. First, the mere presence of the thought is seen as threatening: 'why would I have the thought if it's not a possibility'. Second, the individual may point to aspects of their past that they believe reveal a vulnerability to violence, e.g. 'Maybe this is why I learned martial arts when I was young – I must like to hurt people' (see further Menzies & Menzies, 2019). Third, some will argue that even good people can just 'snap' and cause havoc. They will point to news reports of seemingly balanced people who suddenly shoot people in their workplace or others who walk out of their home one day and suddenly leap in front of a train. Finally, some fear that the mere repetition of the thoughts in consciousness will make them dangerous: 'I'm not a bad person, and I don't want these things to happen. But if the thoughts keep coming I could just

find myself doing it without even thinking'. Unfortunately, as in many forms of OCD, the individual with aggressive obsessions typically tries to supress their thoughts which only increases their frequency, increasing the individual's belief that the feared outcome is likely (Marks, 2003; Salkovskis & McGuire, 2003).

All presentations of aggressive obsessions can be seen through an existential lens. In essence, the central threat rests on the idea that one could do the behaviour in question. That is, the sufferer is physically capable of lifting a baby and throwing it off a balcony, or pushing someone in front of a car, or jumping in front of an oncoming train. What's more, as we have seen, the obsessional patient may point out that some individuals do engage in such behaviours (Einstein & Menzies, 2003; Menzies & Menzies, 2019). So, once again, this form of mental health problem comes down to distress related to existential freedom. Each of us is capable of an alarming range of behavioural choices. Not all of these choices have positive outcomes.

## 5 Health Anxiety and Related Disorders

Some classes of disorders seem more logically linked to death than freedom, but the latter theme may also be involved. This appears to be true for the health-related anxiety problems. Menzies et al. (2019) found strong relationships between death anxiety and severity of several mental health problems including illness anxiety disorder, panic disorder and somatic symptom disorder. This is not surprising given the fact that these conditions typically involve concern about serious medical illnesses. However, in addition to fears of death, these disorders also confront the sufferer with constant decision-making about whether to seek medical assessment or ignore their worries and perceived signs and symptoms. In fact, concern about this decision-making can become as debilitating as the core symptoms themselves.

The *DSM-5* (American Psychological Association, 2013) identifies two subtypes of illness anxiety disorder, namely, care-seeking and care-avoidant. The care-seeking subtype overuses medical assessments and testing as a means of reassurance-seeking. The care-avoidant subtype, fearful that their worries could be confirmed by medical assessments, generally avoids doctors. Of course, many sufferers do not fit neatly into these categories, and most individuals with illness anxiety disorder are constantly consumed by the freedom to see a doctor or ignore their concerns. Many express a desire for rules to aid the decision-making process (e.g. if a symptom remains for two weeks, I will see a doctor). In essence, this strategy amounts to an attempt to bypass existential freedom by taking the choice out of the hands of the sufferer (see Scarella et al., 2019 for a review).

Interestingly, decision-making regarding medical appointments may be influenced by reminders of death. In this way, existential freedom and death anxiety may be acting in concert in health-related disorders but also in other disorders. Menzies et al. (2021) used a mortality salience design to examine the effect of reminders of death on body scanning behaviours and the decision to seek medical assistance. A

total of 128 treatment-seeking participants with either a body scanning disorder (i.e. panic disorder, illness anxiety disorder or somatic symptom disorder) or a non-scanning disorder (i.e., depression) were randomly allocated to either a mortality salience or control condition. Mortality salience was achieved by the insertion of two innocuous questions about death in a large battery of questionnaires, ensuring that the purpose of the study was disguised. Following this, participants were presented with a series of images of various body parts, which purportedly predicted particular life outcomes, and asked to check their own body and select the image that most closely matched their own. As hypothesised, mortality salience produced an overall increase in body scanning, as measured by the time taken to select the image that they believed matched their own body part. However, this only occurred for participants with a body scanning disorder and only if they were told the image predicted a health-relevant outcome (e.g. allergic reactions). When participants were told that the body images predicted other outcomes (e.g. personality characteristics), no increase in scanning occurred. More importantly, from an existential freedom point of view, mortality salience increased intention to visit a medical specialist across both groups of participants. That is, regardless of one's disorder, subtle reminders of death increased the desire of those with a mental health condition to seek medical assessment.

## 6 Summary

Sartre (1999) saw humankind as condemned to be free. I must choose, and have been choosing right across my life, from an infinite number of forks in the road in terms of the actions that I take, the actions that I reject and the words that I say. Superficially, this may be seen as a positive aspect of life, but, as we have seen, it can cause crippling pain, disabling indecision and a lifetime of regret dominated by a sense of failed opportunities. This chapter has explored several disorders through the lens of existential freedom. The disorders were chosen as exemplars of the problems of freedom, but the reader should be assured that they are not the only conditions in which this existential theme is critical. For example, in eating disorders the choice to eat or reject a food item can be occasioned by tremendous pain, indecision and fear of later regret and shame. The sufferer of body dysmorphic disorder must choose between remedial action (e.g. surgery) and the safety (but accompanying sadness) of inaction. The pathological gambler must decide to ignore their encouraging thoughts ('I can win it all back tonight') or risk further loses and ever-declining financial resources. It is fair to say that existential freedom is riddled through the bones of most of the mental health disorders in one form or another. It is the goal of therapy to help the sufferer navigate these forks in the road toward adaptive choices that lead the individual out of their stuckness and toward a functional existence focussed on the present moment.

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# Reframing the Past and the Treatment of Existential Guilt and Regret

**Ross G. Menzies**

**Abstract** Regret over past actions can haunt sufferers with a range of disorders. At the heart of the CBT response, to regret is the Stoic practice of letting go of things beyond our control. Stoic philosophers from Greece and Rome argued that desires for outcomes beyond our control are at the centre of human pain and suffering. They urged us to limit our desires to activities and outcomes that fully rest in our own hands. This chapter will explore contemporary CBT for regret and shame through the lens of applied Stoicism. In addition, a range of specific techniques borrowed from the treatment of obsessions will be shown to have potential in battling regret. Finally, the use of self-compassion, mindfulness and novel approaches for regret regulation will be explored.

**Keywords** Regret · Stoicism · Self-compassion · Mindfulness · Obsessive-compulsive disorder · Rumination

## 1 Regret and Its Role in Mental Health

For so many individuals who enter psychotherapy, it is the events of their past, near and far, that they wish to discuss. Missed opportunities, foolish mistakes and the cost of these errors can occupy the mind for years or even decades. Menzies and Menzies (2019) argue that Shakespeare's tragedies have remained popular over centuries largely because they focus on being defeated by our own weaknesses of character or momentary decisions, an experience familiar to many. Clients in psychotherapy regularly discuss such experiences (Beazley, 2004; Kyle, 2014): 'If only I'd told her I loved her', 'if only I'd seen the signs', 'if only I'd taken him seriously'.

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The desire to get decisions right, to optimise outcomes in all our actions and choices, is referred to as 'maximising'. Unfortunately, the characteristic is not as positive as it might superficially sound. 'Maximising' has been linked to mid-life and late-life depression, but the relationship appears to be heavily mediated by one's proneness to regret (see Chapter "Failed Potentialities, Regret and Their Link to Depression and Related Disorders"). The effect is so marked that Bruine de Bruin et al. (2016) suggest that 'regret regulation' should become a new target for treatment in late-life depression, although the authors offer few suggestions about what this might include, and few clinical trials for regret exist. This is surprising, because the management of regret is not new, with teachings on the topic going all the way back to the early Stoics.

## 2 Stoicism and the Principle of Desire

Stoicism is a Hellenistic school of philosophy founded by Zeno of Citium in the third century BC. Informed by its system of logic, Stoicism proposed that the practice of virtue is both necessary and sufficient to achieve eudaimonia – happiness or 'good spirit'. By living an ethical life, and practising the cardinal virtues (i.e. wisdom, courage, justice and temperance), the Stoics believed one could shed the negative emotional experiences that dominate the lives of so many (see further Pigliucci, 2017).

In its original Greek form, Stoicism centred on logic, physics and ethics. Those that studied with Zeno were to begin with logic, and this formed the basis of the philosophy. As Irvine (2009) argues, the emphasis on logic was a natural consequence of Stoicism's emphasis on man as a rational being. However, by its adoption in the Roman world, the focus had shifted to the search for tranquillity, heavily derived from the field of ethics in Zeno's original conception (Irvine, 2009). Stoicism, at least in theory, offered its followers a life free of the negative emotions, including regret.

The possibility of a contented life rested largely on the Stoic argument that negative emotional experiences were driven largely by the interpretation of events and happenings rather than by the events themselves. As Epictetus (2014, p. 54) famously put it, 'Men are disturbed not by things but by the view they take of them'. This perspective lies at the heart of cognitive behavioural therapy (CBT) as it emerged in the 1960s and 1970s. Notably, early CBT leaders, particularly those writing on cognition, regularly cited Epictetus as the basis of their ideas. Beck's (1976) overview in *Cognitive Therapy and the Emotional Disorders* and Ellis's (1977) opening in *Anger: How to Live With and Without It* both include Epictetus's famous quote. Rational living, as Beck and Ellis argued, involves adopting perspectives on events that can be said to be both logical and adaptive. Since our emotional state is largely determined by our perceptions of the world, the Stoic position, and that of contemporary CBT practitioners, rests on the idea that we need to reframe

maladaptive thoughts, beliefs and attitudes in order to achieve a positive experience of living (see further Irvine, 2009).

A central idea of Stoicism relates to desire or more specifically what it is appropriate to desire. The early Stoic scholars argued that desire aimed at things beyond our control is the chief cause of anxiety and other negative emotional experiences (see Pigliucci, 2017 for a review). In contrast, if desire is placed only on outcomes completely within one's control, one can achieve a state of lasting contentment. For example, if I desire a cheese sandwich, and have both cheese and bread in my home, no anxiety will arise. I can control the outcome, and therefore there is no probability of my desire being thwarted. But if I desire another person to like me (or even love me), my potential employer to select me for a job or to pass a difficult and unseen examination, anxiety will *necessarily* arise. The desire of things that are beyond my complete control logically implies that I may, or may not, achieve my desired outcome. Since the possibility exists that I will not meet my desire, anxiety *must* occur.

Desire for things beyond one's control sets up an endless, lifelong pattern of craving followed by either relief (when the desire is achieved) or disappointment, anger, envy and regret (if the desired outcome is not met). This, of course, is the lifelong experience of so many people. Following this logic, I can only overcome the negative emotions if I shed desire for things that are beyond my complete control. That is, for objects or events that are beyond my control, the Stoics taught us to aim for a state of indifference.

Of all the Stoic philosophers, Epictetus makes the point most forcefully. He counsels us to note carefully the things that we desire and categorise these into things that are within and beyond our control. He declares:

> The chief task in life is simply this: to identify and separate matters so that I can say clearly to myself which are externals not under my control, and which have to do with the choices I actually control. When then do I look for good and evil? Not to uncontrollable externals, but within myself to the choices that are my own. (Epictetus, 2014, p. 57)

Chief among the matters that are outside of our control are the actions and happenings from our past. It is indisputable that the events of the past are, by definition, not within my current control. One may be able to take new decisions to deal with the after-effects of past choices, but the past choices cannot be unmade. Regret about the past, from a Stoic point of view, makes no sense at all, and since a central goal of Stoicism was applying our rational abilities, regret (or even interest in the past) is to be rejected. The idea is echoed in the opening words of Eckhart Tolle's (1997) bestseller *The Power of Now*, 'I have little use for the past and I rarely think about it' (p. 1). And so, to the practising Stoic, the goal is to achieve indifference to the choices that one has made, regardless of the consequences that have followed them.

While the Stoic position seems logical, how can someone feel unmoved by 'bad' happenings once they have occurred? Don't regret and despair after the events seem understandable, if not warranted? Who would not regret driving a car when intoxicated, if it resulted in a death? As Irvine (2009) points out, the solution of Epictetus to such events was to consider them unavoidable – to believe in 'the Fates'. In Greek mythology, the Fates were a group of three weaving goddesses who were said to

assign individual destinies to mortals at birth. And so, regret about our own past choices, and anger at the choices of others that have harmed us, makes no sense. The tragic events of our past were always going to happen.

Fatalism was important in Stoic thinking but seems out of place in a modern world. We no longer believe in mystical sisters weaving the thread of our lives. However, one additional technique that can prove useful is borrowed from the anger literature in what amounts to an argument against free will. Laurent and Menzies (2013, pp. 175–176) tell us:

> The angry speak a lot about the 'choices' people make (mostly the bad ones), and are loathe to 'excuse' wrongful behaviour. But there is something fundamentally unscientific about anger. Logically speaking, if you believe someone *should* have acted differently, presumably you believe they *could* have acted differently. But being who they were, and seeing things as they did, at that moment in time there's strictly only one thing they ever *would* have done.

These authors urge us to accept who we have been at each moment in our past and do the same for others around us. In an argument similar to that raised by Carol Dweck in her work on the growth mindset (see Dweck, 2006), Laurent and Menzies (2013) point out that while we are ever-changing organisms that can grow and develop, our past actions and choices are simply a reflection of our thoughts, beliefs, attitudes and habits at the time:

> The decisions we believe we're making freely are all in fact determined by a dense thicket of crisscrossing cogs and causes – biographical, physiological, cultural, psychological, neurological and environmental. They don't come out of nowhere. We are incredibly complex creatures, entwined in incredibly complex situations, which makes our choices often seem baffling and unpredictable; but we are nonetheless, ultimately, *biological machines* that obey the laws of physics just like everything else. p. 177

The outfielder who drops the catch was doing his best. He could train more and learn new techniques for the future. But feeling guilt at who he was, and the operation of his visual and motor systems at the moment of the dropped catch, makes little sense. And so it is with our choices and actions over time. Acceptance that they were a reflection of the operation of millions of neuronal connections and calculations is an important part of letting go of regret.

## 3 Amor Fati

Some authors go further than simply accepting the events of the past. Many have argued that we need to embrace the life that has arisen from the collective decisions of the past. This notion relates to Nietzsche's (1994, p. 32) notion of loving the fates:

> My formula for greatness in a human being is *amor fati*: that one wants nothing to be different, not forward, not backward, not in all eternity. Not merely bear what is necessary, still less conceal it – all idealism is mendacity in the face of what is necessary – but love it.

The brilliancy in Nietzsche's stance lies in what it achieves. First, the individual who adopts it becomes the master of regret and also shame. In embracing all things past, in truly loving them, shame, humiliation, regret and all emotional pain simply melt away. The supposed missed opportunity for love is embraced. The violent acts of one's youth are embraced. The mistreatment of an ageing parent is embraced. It is who I was at the time. It is my truth as I developed. In wanting the past to be a different one is wanting to have been a different person. But if I see myself as a developing machine, all the moments of my past are part of that development. The supposed mistakes become moments in which I have been able to develop or grow. From this point of view, they do not need to be lamented.

Amor fati relates strongly to the willing acceptance expressed in acceptance and commitment therapy (ACT). Hayes and Smith (2005) describe acceptance as a willing embracing of the things that have happened in a life and the emotions that we have felt. Like Nietzsche, ACT does not promote a begrudging acceptance of circumstances. On the contrary, Hayes and Smith (2005) call for an enthusiastic acceptance that arises from the disarming view that one wouldn't change it even if one could. Only then has one achieved genuine acceptance.

## 4 Learning to Live with Doubt

As the treatment of regret is in its infancy, many of the relevant concepts and constructs will likely be borrowed from other areas of clinical psychology. A key concept in the contemporary management of obsessive-compulsive disorder, which may prove useful in the battle with regret, is learning to live with doubt (de Silva, 2003). Individuals with OCD have been shown to be intolerant to uncertainty (Salkovskis & McGuire, 2003). This intolerance, in combination with an elevated need to control outcomes, may lead to continued checking (of locks, gas stoves, etc.) to ensure that the desired outcome is achieved. Testing, to gain certainty, may occur right across the spectrum of OCD problems. For example, the individual with sexual obsessions may spend hundreds of hours over years or decades testing and retesting their sexual response to same-sex individuals they see on the street as a means of gaining certainty about their heterosexuality (Einstein & Menzies, 2003).

According to the cognitive model of OCD (see Salkovskis & McGuire, 2003), sufferers must come to accept that seeking certainty reinforces the condition by rewarding checking behaviours that become rituals over time. Only by learning to live with doubt can the sufferer cease to test and thereby reduce and eliminate their checking behaviours. The checking has lost its purpose, and the sufferer drops their caring over establishing 'the truth'. The same approach has been taken in illness anxiety disorder and panic disorder. The sufferer is encouraged to live with doubt. Perhaps I will have a heart attack today? Perhaps that throbbing in my temple is a brain tumour? Perhaps there is something fundamentally physically wrong with me that has been missed in medical examinations in the past? The battle to establish the truth is ended as the sufferer is encouraged to recognise that the emotional pain of

seeking certainty is greater than any benefit that would emerge from continued testing. After all, establishing that one pain is benign is typically quickly followed by another pain arising (Menzies & Menzies, 2019).

This approach can be used with regret over missed opportunities and 'mistaken' actions. Let's consider supposed missed opportunities for romantic attachment. One depressed patient revealed hundreds of hours of rumination over more than a decade about not speaking up about his romantic feelings for a co-worker. Subsequently she was asked out by a colleague, whom she dated for more than a year before she left the company to take a job overseas. His pain continued, ruminating on the question of what would have happened 'if only I'd spoke up earlier, before he asked her out'. He was consumed by what might have been and what had become of his lost love since that time. From a 'learning to live with doubt perspective', the individual is left with no need to ruminate about the hundreds of opportunities when they could have spoken up, re-examining and exploring each scene. Online checking of her current activities and imagining how good it could be to have become a part of her life are also parked by this approach. Rather than trying to establish the truth or otherwise of what they fear, the sufferer accepts the outcome. Maybe a life with her would have been amazing? Maybe it would have collapsed? Perhaps she would have said yes if I'd asked her out earlier? Perhaps she wouldn't have? Living with doubt counters regret in many situations because it demonstrates that we can't know what outcomes would have arisen from our decision in the first place. In combination with Stoic indifference to things beyond one's control, and Nietzsche's embracing of our history, we have a powerful set of emerging tools in battling regret.

## 5 Self-Compassion

Other transdiagnostic concepts and therapy approaches have been used in dealing with regret, shame and the rumination that may arise from them. In Beazley's (2004) popular work on regret, the notion of self-compassion is an important one. He asks his readers to understand that they should treat themselves fairly, considering all the contributing factors at the time of any decisions that they have taken. Beazley gives the example of Joan, a researcher in a small drug company, who stole a colleague's idea and developed a patent for it. She amassed a fortune in royalties and considerable acclaim from her peers. But Beazley (2004) tells us that, even as she spent her money, she became progressively lonely and unhappy. Friendships were lost, and she declined into a pattern of seeking more and more success. She became isolated from people who had previously supported her.

Treatment for Joan's regret, which was dominating her waking hours, emphasised the need to look at her behaviour with more compassion and understanding. Beazley (2004) tells us:

> As Joan struggled to make sense of what she had done, she thought back to the way she had been at the time of her betrayal and at the beginning of her regret. She was not trying to excuse the betrayal or minimize it, but she was trying to understand how she could have

> committed what she now considered a despicable act. She remembered how insecure she had been growing up in a poor family and how desperate she was to make money, to become famous, to do anything that would fill the emptiness inside her. She recalled how often her father had told her that she was foolish to get a graduate degree and that she would never make it in the man's world of medical science. She remembered how driven she had been to prove him wrong, to impress him with her money and her success, and to gain approval. She also recalled how selfish she had been in those days, how singularly concerned she was with herself, and how little she had counted friendships except as contacts to further her career. (p. 24)

Beazley (2004) tells us that as Joan began to process who she was at the time, she began to develop compassion for herself. Joan was able to put her behaviours in their appropriate context rather than judge them from her more mature stance that had involved decades of growth and experience. She came to realise that to have done 'better' at the time was simply not possibly being who she was.

Neff and Germer (2018) describe self-compassion as a process in which we learn to be a good friend to ourselves. In essence, it asks us to offer the same loving care to the self that we would offer to another who had made mistakes and was struggling with them. They argue that self-compassion consists of three core elements that are to be depended on when we are in pain: self-kindness, common humanity and mindfulness. Self-kindness is likened to 'putting a supportive arm around our own shoulder' (p. 10). It amounts to showing the same support to the self that we might hope from a loving friend. Common humanity refers to the recognition that we are human and that, like all humans, we are capable of significant mistakes and weaknesses. That we all share the experience of failure and misjudgement is an integral part of their Mindful Self-Compassion (MSC) programme. How can we expect standards that are inconsistent with being human? Mindfulness involves being aware of the present moment in a non-judgemental way. Importantly, Neff and Germer (2018) emphasise that self-compassion emerges from mindfulness rather than being separate to it:

> Mindfulness invites us to *open* to suffering with loving, spacious awareness. Self compassion adds, '*be kind to yourself in the midst of suffering*'. Together, mindfulness and self-compassion form a state of warmhearted, connected presence during difficult moments in our lives. p. 2

Their 8-week Mindful Self-Compassion (MSC) programme consists of a myriad of practical exercises relevant to overcoming regret. These include exercises to (1) identify how I treat others as a friend; (2) identify how I treat the self in difficult circumstances or in the face of failure or misjudgement; (3) identify differences in these two ways of relating; (4) mindfully experience the pain of regretted actions by describing and recording the feelings experienced; (5) identify erroneous assumptions that might be driving this pain (e.g. 'no one would make such a stupid mistake'); (6) emphasise our shared humanity in facing such mistakes; (7) write responses to the self, in a gentle and compassionate way, as if writing to another self (e.g. 'It's okay to make mistakes. I'll be here to support you whatever happens'); (8) reflect on the experience of MSC and how it differs from the previous responding with regret and shame; (9) measure one's growing sense of self-compassion; (10)

journal examples of self-compassion; (11) identify core values; (12) practise self-appreciation; (13) and touch the present moment.

Clinical trials of the MSC programme are still in their infancy. Neff and Germer (2013) report the findings of two small trials with encouraging results. Study 1 was a pilot study that examined change scores in 21 adults from pre- to post-treatment with the MSC programme. Significant improvements on self-compassion, mindfulness, depression, anxiety and stress were reported. Unfortunately, no measures of guilt and regret were taken. Study 2 was a randomised controlled trial with 52 participants allocated to either MSC or a waitlist control group. Compared with the control group, intervention participants reported significantly larger increases in self-compassion, mindfulness and well-being. Gains were maintained at 6-month and 1-year follow-ups. Again, measures of regret, shame or guilt were not taken. Despite this, gains in mindfulness and mood do suggest that MSC may be effective in reducing backward-in-time thinking with a regret-driven, ruminatory style. More research on the programme is clearly needed.

Self-compassion has been lauded as a critical component of narrative gerontology. Stevens (2019) has argued persuasively that self-compassion is needed to enable the elderly to process the 'dark stories' of their lives rather than simply narrate inauthentic accounts of their experiences. To the present author's knowledge, no trials of this approach exist at the present time. Finally, several authors have suggested that the MSC programme could be used for the guilt and shame experienced by veterans of military service (McKinney, 2021) and those with a history of trauma (Gladstone, 2021). Again, no trial evidence is available at the present time.

## 6 Touching the Present Moment

Integral to MSC is mindfulness practice, defined as awareness of the present experience with acceptance. The concept and practice of mindfulness proposed by Neff and Germer (2018) does not differ, in its essentials, from that suggested by Williams and colleagues in mindfulness-based cognitive behavioural therapy (MBCT) or similar exercises in acceptance and commitment therapy (ACT). Essentially, all of these therapies involve 'touching of the present moment' which logically should be integral to managing regret. After all, to regret necessarily involves sending the individual into their past. As we saw in Chapter "Failed Potentialities, Regret and Their Link to Depression and Related Disorders", much of the experience of those with a ruminatory style of thinking is backward in time.

## 7 Future Directions in Regret Regulation

Recent reviewers of this field (e.g. Schwartz & Ward, 2004; Västfjäll et al., 2011; Zeelenberg & Pieters, 2007) suggest that additional strategies offering promise in preventing or dealing with regret include (1) eliminating maximising, in order to make decisions easier and reduce their psychological costs; (2) choosing not to track the performance or outcomes of non-chosen options once a decision is made, so as to prevent regret; (3) promoting gratitude, by focusing on ways that life could have been worse; and (4) recognising the role of chance and external factors in decision outcomes, so as to reduce self-blame. While each of the strategies has merit, some are very difficult to achieve clinically. For example, tracking the outcomes of jobs or investments not taken, or the activity of unrequited or unfulfilled or rejected love attachments, seems particularly difficult to stop. Regret, bitterness and jealousy can haunt individuals for decades after relationship failures or false starts. Baumeister, Wotman and Stillwell (1993) explore the psychological consequences for being rejected, either in a relationship or before one ever formed. The impacts are many and complex and centre on humiliation and lowered self-esteem. They argue that a common pattern of one-sided romantic love involves a less attractive person becoming infatuated with a more attractive person who does not reciprocate the feelings:

> The reason for the rejection may lie in the fact that people are generally not attracted to less desirable others. If this is generally recognized, however, then the rejection carries the symbolic message that the would-be lover lacks sufficient desirable qualities to be a suitable partner for the rejector. p. 390

Romantic rejection before, or even during a relationship, can become a symbolic evaluation of one's deficient worth. Unsurprisingly, this may create a sense of humiliation and significantly impact self-esteem. The effort to restore self-esteem may drive individuals to check on previous partners or would-be lovers, seek assurance that they have not 'outperformed' them in life's journey and drive regret about the ways in which the sufferer approached the potential relationship (e.g. 'I should have spoken earlier'). In any event, choosing not to track one's forgone choices and options may be difficult to resist. It is suggested that increasing motivation to stop checking might be achieved by examining the pain occasioned by the internet and social media searches.

Baumeister et al. (1993) make the interesting point that it is not just the rejected individuals that suffer in cases of unreciprocated romantic attraction. Those who reject, expressing their existential freedom by actively choosing to leave an established relationship or reject a new one on offer, have also been shown to suffer. The decision to reject can lead to the same regret that can occasion any decision at a later time point. This may occur because of later failed relationships or rumination about the reasons for the rejection in the first place. Baumeister et al. (1993) report that in unrequited love, would-be lovers looked back with both positive and intensely negative emotions, whereas rejectors are almost uniformly negative in their narrative accounts. Rejectors may feel guilt at hurting someone and, as stated above, may

regret their decision. Again, rejectors may also engage in checking behaviours to see how their would-be lover has fared across time, although ruminating and brooding following unrequited love are more common among those rejected.

Of course, humiliation and the hit to self-esteem of rejection will lead some to more than brood. Coleman (1997) explored the other impacts of these emotions, finding that violence and abuse often follow rejection, particularly if leaving a former romantic attachment. 141 female undergraduates completed questionnaires examining violence and threatening behaviours in former heterosexual relationships. Participants were placed in control, harassed or stalked groups based on their responses. Unsurprisingly, women who had been more verbally and physically abused during relationships were more likely to be stalked after relationships. Anger and violence are linked to narcissistic tendencies in men, who are particularly affronted by the possibility of rejection (Hamberger & Hastings, 1986; Laurent & Menzies, 2013). Violence against women in relationships remains one of the modern scourges of all societies around the globe (see Ellsberg et al., 2014 and Ali et al., 2016 for reviews).

## 8 Concluding Comments

Regret is a transdiagnostic construct that arises from existential freedom. Individuals must choose directions throughout their lives, effectively ruling out alternative choices as they go. We are, as Sartre (1999) declared, 'condemned to be free'. Unfortunately, for many individuals, rumination about past choices can dominate the present and drive depressive illnesses, particularly from the mid-life onwards (see further Chapter "Failed Potentialities, Regret and Their Link to Depression and Related Disorders"). The management of regret has been neglected in clinical psychology, potentially because it has been seen as just another construct that can be tackled with standard approaches in cognitive therapy. However, given the importance of freedom in existential philosophy, regret deserves a closer examination. It is suggested that future research, at the very least, seek to (1) examine the presence of regret across the full range of mental disorders, (2) explore its role as a potential mediator and maintaining factor in mental health disorders and (3) build an evidence base for the variety of treatment procedures and approaches that have been suggested. To date, there is a paucity of studies that have specifically targeted this common emotional experience.

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# Part VI
# Meaning

# On the Need for Meaning


**Gerard Kuperus**

**Abstract** Sartre (*Essays in existentialism*. Carol Publication Group, 1999, p 34) famously declared that "man is nothing else but that which he makes of himself." Using the central tenet of existential thinking "existence precedes essence," Sartre claims that a person must determine themselves through their choices and actions. This chapter examines the claim that man's search for meaning is a critical part of dealing with the existential confusion that comes from being thrust into an inherently pointless world. Existentialism can be exciting but also utterly confusing. The chapter seeks to explore some ways in which one can break out of our crust and find new perspectives.

**Keywords** Meaninglessness · Meaning · Nietzsche · Sartre · Sailing · Danger · Creativity · Life · Existentialism · Responsibility

## 1 Introduction

Comet "Neowise" is flying over us, about 100 million kilometers away from the earth. An icy space rock flying at a speed of 231,000 km per hour, followed by a tail – it is a magnificent sight. The next time the comet will be visible from earth will be 7000 years in the future. Who will be around then? The rock doesn't care if anyone will be around to watch that event. Either way, it will just carry on in its pointless task of circling around the sun, indifferent to spectators. Neowise confronts us with our own position and makes us feel small, irrelevant. The comet has no meaning and seems so meaningful. The earth, life, humanity: it all seems rather insignificant as this comet is flying over. Is there any meaning aside from the temporary meaning we provide it in this moment?

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Sartre (1999, p. 34) summed up existentialism in the form of the sentence "existence precedes essence." We start with existence, without any given meaning or purpose. For Sartre, and most existentialists, God does not exist. If there is no design, no reason, no meaning to existence, then what? Our lives are perhaps as pointless as that of a comet, and a lot less glamorous! Should we despair, celebrate, create meaning, accept the absurdity of our existence, or…? Certainly, existentialism as a philosophical movement includes thinkers who emphasize the crisis that a lack of meaning can bring, such as Schopenhauer, Kierkegaard, and Heidegger, whereas others, such as Nietzsche, have emphasized the opportunities this presents. Again others, especially Sartre, present us with the responsibility that the absolute freedom of existentialism casts upon us. All these philosophers provide us with ideas that challenge a traditional conception of existence, namely, that our existence has some kind of purpose and meaning. In a world without a God who designed purpose and thus meaning to our existence, we are left in a rather pointless and meaningless world. Needless to say, in a secular society this existential insight that there is no designed purpose to our existence is recognized widely but difficult to accept. It can be met with a sense of anxiety, a false sense of freedom, or a combination of both. Either way the insight has significant consequences on all of the factors that influence who we are and should be: from the conception of ourselves to the relation with others and our social and natural environments.

What is meaning in an existentialist context? How would one reconcile the meaning we attribute to a comet circling the sun? The short answer is that there is only meaning in so far as it is constituted by humans. This definition of meaning created by humans can often become confused with the notion of truth. As Nietzsche points out in the essay *On Truth and Lies in an Extramoral Sense*: "What is the truth? A moveable host of metaphors, metonymies, and anthropomorphisms: in short, a sum of human relations which have been poetically and rhetorically intensified, transferred, and embellished, and which, after long usage, seem to a people to be fixed, canonical, and binding. Truths are illusions which we have forgotten are illusions" (Nietzsche, 2001, p. 67). The meaning of words has become truths, in which we forget that those words, including all the concepts used in the natural sciences, are indeed generated by humans. As Nietzsche reminds us: "After all, what is a law of nature as such for us? We are not acquainted with it in itself, but only with its effects" (Ibid. p. 68). Indeed, the fact that concepts such as "gravity" are human constructions is mostly forgotten. We accept these concepts and theories as facts and forget they are one of many possible approaches to explain phenomena. Since we build theories on other theories, we find in fact multiple layers of truth. Thus, Nietzsche (2001) claims that science becomes a scaffolding of concepts, which we are holding up to avoid the collapse of science, and most of all ourselves. Because beyond those theories and concepts no meaning exists. There is no truth, and meaning does not exist beyond the one we humans provide it, and this meaning does not only become engrained in our conception of reality. It *is* our conception of reality, and we are (rightfully) worried about the nothingness that lies beyond it.

## 2 Language: Scaffolding or New Meaning?

Famously, for Schopenhauer (2020), nihilism leads to suffering. As we are constantly trying to find meaning in a world without any absolute meaning, we are living in a constant tension of that contradiction. Yet, different from Schopenhauer, for Nietzsche (2001) the meaninglessness of the world is a fact to be celebrated. His existentialist philosophy led to a re-evaluation of all values and a joyful science. He argues that if there is no meaning, no truth, and thus no absolute values, we can create our own. This is where nihilism and the lack of meaning become a powerful and positive tool for existentialism. Indeed, we do not have to stick to the given values and meanings, but rather we can generate new ones and reinvent ourselves and our society. However, this is not easy, and Nietzsche points out the difficulties of this endeavor. We easily feel homesick and lost in a world without any direction. Embracing the meaninglessness of existence by creating meaning for ourselves is far from "a walk in the park." Yes, we should laugh and create a joyful or gay science, since life is without meaning, and thus we should laugh at all those who take it so seriously. Yet, if there is nothing to hold on to, we can become lost and without any direction. We might indeed crave those strict rules of the church, because we know what we should and should not do. Or we hold on to the "scaffolding" provided by the concepts of our scientific discipline. Without those concepts humans can feel lost: this fear of the unknown is often what drives individuals to hold on to strict meanings and hold on to them as truths (Nietzsche, 1976). This is where Nietzsche challenges us, and he challenges himself, by writing in a new language, a language of "spring weather" as he suggests in the preface to *The Gay Science*. Yet, even that language itself worried Nietzsche, as they might become truths. This is his worry, expressed at the end of *Beyond Good and Evil*: "what are you after all, my written and painted thoughts. It was not long ago that you were still so colorful, young and malicious, full of thorns and secret spices – you made me sneeze and laugh – and now? You have already taken off your novelty, and some of you are ready, I fear, to become truths: they already look so immortal, so pathetically decent, so dull!" (Nietzsche, 1998, p. 236).

This comes from one of the best and certainly most powerful writers in the history of philosophy. Dull and decent? Those are not exactly the words that come to mind when reading Nietzsche. Yet, this is the curse of language: anything committed to language to some degree solidifies. It is well known that Nietzsche eventually collapsed, and while the true cause of Nietzsche's illness will never be known, it has been speculated that the ultimate consequences of his philosophy became unbearable.

Existentialism defies the idea that there is any absolute meaning or truth. Yet, that does not mean there are no meanings at all. In fact, Nietzsche speaks of perspectives (a variety of different meanings one could say) and strongly suggests we need as many as possible. He argues that all philosophers who have approached truth with awkward and improper methods have led to a "narrowing of our perspective" (Nietzsche, 1968, p. 292). Thus, he proposes what can he called a "perspectivism,"

which suggests that all "truth" is an interpretation from a particular perspective and that there is no limit to the number of possible perspectives. The lack of any absolute truth will not necessarily devalue the significance of humans striving to recognize and search for truth. Nietzsche's philosophy is not simply a relativism, as he admits that "there would be no life at all if not on the basis of perspective estimates and appearances" (Ibid. 236). Truth in an absolute sense does not exist, yet without any "truth," the human race, nor any other form of life, could survive. It is within this context that he proposes that a perspective is the "basic condition of all life" (Ibid. 193). To say it differently: we constantly need to find meaning. Indeed, how could we possibly live without something to hold on to? While the lack of truth can be overwhelming, Nietzsche's philosophy is an optimistic one especially because it empowers humans.

Part of Nietzsche's existentialism is the attack on dualistic thinking, which tries to solidify meaning into truths. Nietzsche replaces the "or" often into a "beyond." Famously, the choice between "good and evil" becomes the attempt to move "beyond good and evil." This is an entirely different ethical approach that challenges the history of Western Ethics. Instead of working with just these two categories, Nietzsche asks us to rethink ethics and morals. In the Christian system of good and evil, an abortion is evil. Period. When that value system disappears, we actually have to ask questions, such as about the value of life, the rights of women over their own bodies, or what to do if a severe disorder is detected in a fetus. The overarching question then becomes which of those values is to be prioritized. Instead of the dualistic either/or, we find now many gray areas between, or beyond, good and evil. Likewise Nietzsche (2001) is critical of the mind and body dualism, set up by Descartes, and challenges the idea that we can think without a body. The body is emphasized over reason, as his language constantly emphasizes that we are animals, driven by our bodily desires and instincts.

Nevertheless, he points out that in philosophy a belief in a specific perspective is required. Nietzsche's own position (his belief) is that a *true* philosophy does not exist, but that there "is *only* a perspective seeing, *only* a perspective 'knowing'" (Ibid. 555). This perspectivism is necessary for life and for the intellect or philosophy. We cannot do away with it. Moreover, perspectivism does have meaning and can become more meaningful: "the *more* affects we allow to speak about one thing, the *more* eyes, different *eyes*, we can use to observe one thing, the more complete will our 'concept' of this thing, our 'objectivity' be" (Ibid.).[1] For Nietzsche perspectivism as meaning can, thus, be more or less complete. In other words, perspectivism challenges black and white definitions of truth and value. In that it moves beyond dualistic thinking.

If there is no absolute meaning to life and we can (and even should) create our own meaning, how do we go about this? One answer can be identified in how Nietzsche and Heidegger emphasize the significance of language. The point of language, in Heidegger, is that, as he puts it himself, it opens up the world to us. In

[1] (Ibid.).

doing so it can either limit us or expose us to new perspectives. Language and the words we use show the world in a particular way. It is how meaning is constituted. For those who speak more than one language, this is easy to recognize: certain expressions and words are not translatable from one language in the other. This is especially clear when it comes to feelings and emotional ways of connecting to the world. While most of the languages we are familiar with have minimal discrepancies, indigenous languages often provide an entirely different reality. Robin Kimmerer discusses how in Pottawatomi, the language of her native people, a bay is not named with a noun, but with a verb: "to be a bay" (Kimmerer, 2020, p. 55). An entity such as a bay is considered as a dynamic and living thing, not as a dead object (as, e.g., the English language does), she argues. Even without going into the details of that particular example, it is fascinating to think about the meaning that such an indigenous language provides, as it allows one to express and recognize the natural world as animate, whereas languages such as English make such animateness difficult to express. Heidegger (1962) suggested that the German language fails to grasp the meaning of being and thus uses both Ancient Greek and a redetermination of the German language to create a new kind of language to bring being out of oblivion. He is certainly not alone in such efforts.

Languages themselves are dynamic, and within each language new meanings constantly emerge. Medical terms are a good example of this. Learning disabilities or attention deficit disorder has existed long before their medical definitions were actually established, that is, since they got an official name. The name of a disability, disease, or illness makes it possible for medical professionals to diagnose it in the first place. There are also many illnesses, such as Alzheimer's or dementia, that lack precision and should probably be divided into several different ones.

Thus, we see that language has a significant role in creating meaning and either generating, averting, or distracting attention. Certain words are avoided, because of their negative meaning. During the COVID-19 crisis, my wife overheard a person describing symptoms (cough and fever) of a friend or family member. The person added "well, let's not call 'it' by it's name." In Camus' novel *The Plague*, the medical doctors and the town officials initially refused to use the words "pest" or "plague" even among themselves because of the horrific connotations the word has. We see that by accepting or refusing a particular name (such as "COVID-19" or "pest"), reality is changed. The refusal to accept that we are in the midst of a pandemic does have actual consequences. Likewise diagnosing a patient correctly is crucial in the treatment of the patient and to, for example, prevent further infection. In summary, language is forming the world as it is instrumental in how humans view the world and how they relate to it, act in it, and feel about and understand themselves.

Heidegger and Nietzsche continuously struggle with language, and their own use of language correlates directly to their respective philosophies. When reading Nietzsche (1968, 2001), we find something very powerful in that language. Yet, we should not be deceived by that language: behind the power lies uncertainty and great complexity. When encountering the language of Heidegger, the opposite feeling might quickly set in: his language is complex and might seem clumsy and forced,

until one gets into it and starts to speak that language. It is an interesting transformation that I have encountered in many of my students.

Heidegger (1962) as a thinker who wants to open up our approach to reality presents us with a new language. He uses existing terms in unconventional ways, for example, by using the word *Dasein* (literally "being-there") for the human being. Truth itself is described as "opening up," which suggests that there is a multitude of ways in which things can open up, depending among other things on the words we use. Instead of a single truth, we end up with a multiplicity of truths.

Nietzsche's (1968, 1998, 2001) "perspectivism" highlights the value that multiple perspectives provide. This means, for example, that we do want the perspective of the natural sciences, that of the philosopher, the poet, the villain, and the priest. Likewise we want the perspectives from different cultures, in which one is not more true than the other, but truth is this multiplicity. Indeed, we want as many perspectives as possible, and this translates into Nietzsche's "dynamic" writing style. As he writes in the preface to the *Gay Science*, it is a book to "experience." Indeed, the reader moves through Nietzsche's moods, emotions, and styles. Those themselves can be considered perspectives.

Yet, Nietzsche also points to the danger of his philosophy: his own philosophy, including perspectivism, can become a truth. As we have seen earlier, these are indeed the challenges of existentialism: the lack of meaning and truth itself becomes a truth. Or perspectivism itself can become the absolute truth of all perspectives. If we accept relativism, anything goes, and we can end up in an existence that does not provide any kind of fulfillment. Can we live in a world without direction? More importantly, does such a philosophy in which we move away from traditional values open the door for chaotic behavior of violence and oppression? It is well-known that Nietzsche's thought has been mutilated and used as anti-Semitic Nazi propaganda and that Heidegger has been associated with the Nazis. While the first is clearly an abuse of Nietzsche's thinking, and the second is a complicated issue, the question of what exactly warrants against such a development should be asked. In a world without meaning, we can create our own values, and anything is possible. Yet, anti-Semitism, sexism, or racism are not the result of existentialism. These xenophobic tendencies do exist independently of existentialism. Even more, we can suggest that in existentialism, any kind of oppression is the result of a life that is not lived well.[2]

Indeed, the fact that anything is possible leads Sartre to a moralistic path. Even while there is no meaning to life, that does not mean there are no consequences to our actions. What we do and do not do matters. For Sartre we have to take full responsibility for not only our own actions but also those of others. After witnessing the violence of WWII and the holocaust, Sartre critically assesses his generation and urges us to take responsibility. I might not be able to stand up against an armed

[2]This point is arguably made in *The Stranger* by Camus (1989) in which the main character, Meursault, wastes his life away with an attitude of indifference. Nothing matters to him, whether he loves or not, hates or not, and he never makes any choices. Things just happen to him, including him shooting another human being, an Arab. The underlying racism is a result of indifference to one's own life and the inability to love and make choices.

soldier, or a soldier has to follow commands. Yet, both are acts of bad faith, cases in which one seeks an excuse for either action or inaction, by suggesting there is no choice. Not acting is, however, not passive. It is an active choice. For Sartre there is always a choice and thus a responsibility. I can choose to not risk my own life in order to save another life, but the point is that it is still a choice. In summary, the lack of meaning, for him, presents a great difficulty.

## 3 Leaving the Land Behind

Existentialism thus provides us with an ethics, a demand to create a meaningful life, i.e., a life that will be worth living. Of course, many of us are, like Tolstoy's Ivan Ilyich, living insignificant lives following paths already carved out for us. I will now discuss a few people who have undertaken extraordinary endeavors. Without suggesting that we all should do something similar, I want to think here about ways in which we can break out of the mold.

The two main people I want to discuss are solo circumnavigators Bernard Moitessier and Ellen MacArthur. Sailing around the world is no small feat, certainly not when it is non-stop and done single-handedly. To provide a sense of the challenge, it involves rounding Cape Horn, a place to fear, with its tremendous heavy waves (up to 100 ft high or 10-story buildings), strong winds, strong currents, and the occasional iceberg to keep things interesting. Around 800 ships have wrecked here, and an estimated 10,000 lives of sailors have been lost. It is estimated that since Mount Everest opened in 1957, more people have climbed to the top of Mount Everest than people have sailed around Cape Horn. About 60 people have ever sailed around the world solo non-stop. Sailing by oneself around the cape is a tremendous challenge, because one is indeed by oneself. When part of a non-stop circumnavigation, one is already exhausted from being at sea for several months, having dealt with all kinds of weather, breakdowns, difficult repairs, navigating, while constantly trying to sail as fast as possible.

Why use this example of the challenge of sailing solo around the world? Besides my personal interest, Nietzsche does mention crossing oceans frequently. Take for example what in *The Gay Science* is called "In the horizon of the infinite." Nietzsche writes: "We have left the land behind and boarded the ship!" (Nietzsche, 2001, p. 124). Leaving the land is here a metaphor for leaving the meanings and values provided by the church and society. Where does that lead us however? "Now, little ship, watch out! By your side lies the ocean; true, it does not always roar, and sometimes it lies there like silk and gold and daydreams of kindness. But the hours are coming when you will recognize that it is infinite, and that there is nothing more terrifying than infinity" (ibid). Endless possibilities without any guidance present themselves here. It is first appealing yet ultimately terrifying. As Nietzsche continues: "Oh, the poor bird that felt itself free and now collides with the walls of this cage! Alas, when homesickness for the land comes over you, as if there had been more *freedom* there – and there is no longer any 'land!'" (Ibid). This is the great

contradiction existentialism reveals: freedom itself is terrifying even to such a degree that strict guidance and clear rules can appear to provide more freedom.[3] We are – in Sartre's (1999) and Heidegger's (1962) words – forlorn, lost and afraid of our own freedom. Nietzsche uses here the notion of "homesickness," presumably an implicit reference to the early romantic thinker Novalis, who wrote that all philosophy starts in homesickness. Indeed, all philosophy up to now has for Nietzsche been a farce, a sickness that is trying to cure itself by constructing truths. Thus, Nietzsche suggests we have to leave this behind and face and embrace our homesickness to become who we are.

What now if we take the metaphor of the ocean literally. Such a move is generally speaking a poor idea at best, but we find some interesting similarities in the ideas of actual ocean sailors. The two people, already mentioned, are MacArthur and Moitessier. Starting with the latter, in 1969 Moitessier participated in the first ever non-stop solo race around the world. While many people wonder why anyone would want to sail non-stop around the world, Moitessier reversed the question: why return to land? After sailing around the three capes, he could not bring himself to return to Plymouth even while he possibly might have won the race. It would have been sailing "from nowhere to nowhere" (Moitessier, 1975, p. 142). Instead he rounded Good Hope and Leeuwin one more time, before he finally returned to land in Tahiti.

Moitessier (1975) describes how he and his boat *Joshua* "wanted to be left alone with ourselves." What he finds in the sea is "the rediscovery the Time of the Very Beginnings, where each thing is simple" (p. 105). He realizes that it would be hopeless to explain why he does not want to return and finish the race: "How can I tell them that the sounds of water and the flecks of foam on the sea are like the sound of stone and wind, and helped me find my way? How can I tell them all those nameless things…leading me to the real earth?" (Ibid. 156). Moitessier has actualized his place and himself in this place; he is truly here, and he is repulsed by the thought of returning to a place where no one seems to be in one's place. He makes an attempt to explain his decision, by using Steinbeck's metaphor of the monster in the *Grapes of Wrath*. This is first of all the tractor that "rapes the earth" after the bank has taken over the land. Indeed, for Steinbeck the bank is the other monster, yet Moitessier mostly focuses on the machinery that determines our pace and way of living. While anchored in Tahiti, he witnesses the construction of roads and parking lots, killing trees and the soul of the place. "Lots of people believe that the bulldozer and the concrete mixer don't think. They're wrong: they do think. They think that if they don't have any work to do, they won't earn any money, and then their slaves won't be able to buy the fuel and oil they need to go on living and go on thinking serious

[3] Indeed, thinkers such as Immanuel Kant (2001) point out that in a society without rules, civil freedom is not even possible. I can only be truly free, Kant argues, within the context of restrictions that protect me. The freedom that Nietzsche and the other existentialist envision is a more radical freedom in which societal and individual freedoms are opened up completely. The way we live together can be radically altered. The meaning of everything, including society and life, is entirely open.

thoughts" (Ibid. 177). How can one return to the monster, after having spent months at sea at the pace of a sailboat? A simpler, slower, fuller life is what he envisions through a reflection on bicycles: "we would ride bikes in the city, there wouldn't be those thousands of cars with hard, closed people all alone in them, we would see youngsters arm in arm, hear laughter and singing, see nice things in people's faces; joy and love would be reborn everywhere, birds would return to the few trees left in our streets and we would replant the trees the monster killed. Then we would feel real shadows and real colours, and real sounds; our cities would get their souls back, and people too" (Ibid. 164). It is a beautiful reflection on our tragic situation, the cause of which is centered in the car, the bulldozer, and all the other monsters that have destroyed the soul of the places in which we live. Moitessier has found his own soul back in the sea and cannot bring himself to return to "the monster."

Ellen MacArthur has several records on her name. In 2002 she nearly won the Vendee Globe, a very competitive race around the world, non-stop and single-handed. While the race is brutal and dangerous (fatalities are not uncommon, and in the most challenging years only a third of the sailors have been able to finish), she describes the experience of the sea as one of absolute freedom and a feeling of space and timelessness. After completing the Vendee Globe MacArthur had a similar experience to that of Moitessier. She did not want the journey to end, and she describes how the most difficult moment of the circumnavigation and the race was leaving her boat after finishing. She embraces Moitessier's insight that "People who do not know that a sailboat is a living creature will never understand anything about boats and the sea" (4). Furthermore, like Moitessier, she became an environmental activist. She founded the MacArthur foundation, an organization that promotes circular economies, which promote to "use things rather than use them up" (MacArthur, 2012) (TED talk). Her turn to promoting a more sustainable economy is based on an insight she gained from sailing around the world: "All we have out there, is everything we have and we have no more (TED talk)." While this is first of all a reflection on the food and other supplies she brought for being months at sea, it is moreover an insight that relates to the earth that sustains us.

What is interesting in this regard, too, is that Moitessier realized that no one would understand his decision to not finish the race and return to land. He knows that his insights are pure madness to others. Like Nietzsche he has to use metaphors in order to express the freedom offered by the sea. MacArthur doesn't have to explain because she returns to shore and finishes the race, but what the welcoming crowd does not understand is that this very moment is the hardest of the whole race.

As I wrote above, I am not suggesting we should do something as extreme as Moitessier and MacArthur. Their journeys don't have to be repeated (which would just create another herd). Yet, their insights provide us ways to open up our eyes as well as a new perspective on the lives we are living. What they realized at sea, away from the daily craziness, is that we are not truly choosing our lives ourselves. The lives we live are not our own and are ultimately lacking authenticity. Both Moitessier and MacArthur come to similar realizations that led to a motivation to do something else. Nietzsche speaks about a homesickness, which indeed can lead one to a change in attitude; to act differently; to find, or rather *create*, purpose; and so forth. In order

to establish a new home, one could say, one first needs to be lost. This obviously takes courage, not only to set out to sail on the ocean (literally or metaphorically) but moreover to challenge the existing world, its economy, values, morals, and its truths. Yet, that is exactly the existential challenge we all face: there is no set path; we have to create our own, sail around obstacles, and face challenges head on.

## 4 Conclusion

One interesting aspect about approaching existentialism through sailors is that Nietzsche, in many ways the founder of existentialism, made an abundance of references to the sea as a dangerous place. Luce Irigaray (1997) in her work *Marine Lover* even argues that Nietzsche's use of the sea is an indication of his fear for the feminine. I will leave that argument aside, but indeed Nietzsche always seems to regard the sea as a dangerous place, one to cross, in order to reach another place, yet not a place for him to reside. Seas are dangerous indeed, and Nietzsche precisely argues to live dangerously.

Indeed, to give up on absolute truths and values is dangerous, and it is a risk. A society that departs from the church can go into all kinds of directions. No meaning is guaranteed. Yet, as Nietzsche always emphasizes we need meaning, the more the better. That does not mean we should use meaning as a crutch or scaffolding to hold up truth. Crossing a sea, literally or metaphorically, can help us to gain new perspectives in that regard.

In this light, existentialism is an exciting but dangerous philosophy. It encourages us to become who we are, to break with the tradition and out of the mold that has been provided to us: new truths, new values, new meanings. And it is for such reasons that thinkers such as Sartre (1999) point to the responsibilities that come with freedom. By stepping away from our daily lives, we come to reflect on it and re-evaluate who we are and want to be. That might not be easy, and it will be a lot easier to not challenge ourselves. If we choose not to, we will ultimately have to confront ourselves with the question of whether we have really been living a life worth living. When we discover the groundlessness of meaning we can either despair or generate new ones. The latter is the path existentialism encourages.

Neowise, as any rock, cannot generate meaning, but we can. Perhaps we are as pointless as a comet circling around the sun; yet, we can reflect on comets, on our own existence, and on the endless possibilities our lives present to us. The comet does not care about anything it encounters, but we do. Our existence, as a free one, is, thus, marked by responsibility. We can sail the oceans, or look up to the sky, and feel small and lost. Out of that feeling, we can then truly be free and generate meanings that are worthwhile to dedicate ourselves to.

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# Meaninglessness, Depression and Suicidality: A Review of the Evidence


**Adrian R. Allen**

**Abstract** Drawing from existential philosophers, life meaning has been proposed as an important resource to general well-being and psychological health in particular. However, the definition of life meaning has been somewhat variable. The current chapter provides a narrative review of life meaning and its connection to depression and suicidality. Brief review of life meaning as a construct and its working definition are provided, as well as its conceptual link to depression and suicidality. Drawing from recent research, life meaning is proposed as a state of seeing one's life as having purpose, coherence and significance. The current chapter proposes that life meaning may be linked to these conditions, in part, through its association with hope. Evidence for the association between life meaning and each of depression and suicidality is presented, drawing from cross-sectional and longitudinal correlational research, mediation/moderation studies and treatment/intervention research. Research reviewed shows that lower levels of subjective life meaning are associated with depression, a higher depressive symptomatology and a higher suicidality across samples of varying age, cultural background and psychiatric status. Moreover, life meaning appears to play an important role in medicating, or at least buffering, the impact of stressful life events and psychological symptom load on depressive symptoms and levels of suicidality. That is, higher levels of life meaning may reduce the impact of stressors upon these experiences. As such, life meaning may be a helpful target for assessment, treatment and prevention of mental ill health. Directions for future research are also noted throughout.

**Keywords** Depression · Suicide · Suicidality · Meaning · Meaninglessness · Psychopathology · Mental health · Assessment · Mood · Affect · Treatment · Psychotherapy

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## 1 Introduction

In diagnostic terms, depressive disorders are characterised by features of disturbed affect (enduring low mood, sadness, loss of pleasure, guilt), behavioural change (reduced motivation, withdrawal), neurovegetative features (sleep disturbance, reduced energy, disturbed concentration, indecisiveness) and cognitive changes (reduced hope, reduced self-esteem) (American Psychiatric Association, 2013; World Health Organization, 2018). However, those experiencing one of the depressive disorders often report additional concerns. Previous authors have noted concerns around subjective deficits in life meaning as common and often central to the subjective experience of people with depression (Fernandez, 2014), possibly causal (Seligman et al., 2006). Indeed, clinicians are often presented with depressed clients reporting a sense of pointlessness, futility and hopelessness, which can be associated with suicidal thinking and action in extreme cases. This prompts the question about how central a role life meaning plays in the phenomenon of depression and suicidality. This chapter provides a narrative review of evidence for the association between life meaning and each of depression and suicidality. Such evidence is taken from cross-sectional, longitudinal, moderation/mediation and treatment-based studies. In doing so, the functional role for life meaning in these phenomena is outlined and the implications noted.

## 2 Conceptual Proposals for the Importance of Meaning to Mental Health

Drawing on the work of existential philosophers, several theorists have proposed the importance of life meaning to sound mental health and implicated its loss in psychopathology. Frankl (1962/2004) placed life meaning as central to the theory on which he based logotherapy, a meaning-centred psychotherapy. In brief, he proposed that people are motivated by a will to meaning – a drive to find personal meaning in life. Within the theory, such meaning is found in serving something outside the self (such as a social cause or another person) and is referred to as 'self-transcendence of human existence' (p. 89). Obstruction of this will to meaning ('existential frustration') can result in 'noogenic neurosis' and experience of the existential vacuum, with depression as a possible outcome. As Wong (2014) noted, Frankl's meaning-seeking model assumes 'that the person is embedded within a wider context of relationships to other human beings, to the world and to some higher power' (p. 160). It follows that loss of access to such sources of finding meaning could prompt depression. This accords with research showing that losses or stressful events within these life areas can be risk factors for depression (Monroe et al., 2009).

Similar to Frankl, Yalom (1980) has drawn on proposals from existential philosophers such as Sartre and Camus. In developing existential psychotherapy, he proposed meaninglessness (in, and of, life) as one of the key existential concerns

that can adversely affect mental health. In his view, such meaninglessness can erode mental health when people, born with a requirement for meaning, recognise there is no inherent meaning in the universe. Recognising this existential concern can be prompted by experiencing significant life stressors (which he referred to as 'boundary' or 'border' situations).

More recently, Seligman (2006), Wong (2010, 2014) and Steger (2012a) have also noted the importance of meaning in life to mental health. In developing well-being theory, which underpins his positive psychology approach to human flourishing, Seligman (2011) included meaning as a contributing element. Likewise, and partly drawing from Frankl and Seligman, Wong's (2010) meaning-centred counselling and therapy (MCCT) emphasises the importance of life meaning to individual well-being.

Given the above proposed conceptual importance of life meaning to depression, and to mental health more broadly, it follows that life meaning would be negatively affected in cases of poor mental health. To this end, subsequent sections in this chapter review the evidence for the association between meaninglessness, depression and suicidality. Before doing so, the construct of meaning is defined.

## 3 Life Meaning

### *3.1 What Is Meant by Life Meaning?*

Rather than investigating meaninglessness per se, most research on this construct has examined life meaning. Reflecting this, the remainder of this chapter refers to life meaning rather than meaninglessness and does so on the basis that these are ostensibly referring to the same construct. That is, high meaninglessness is the equivalent of low life meaning and vice versa. In general terms, life meaning is typically considered to be a subjective judgement of the importance of one's life and actions, embracing components of individual life purpose, a comprehension that the events in one's life are integrated, coherent and 'make sense' and that the individual and their actions are important (Heintzelman & King, 2014). However, there is no universal agreement on a conceptual or operational definition of life meaning, with multiple models of the construct proposed (e.g. Antonovsky, 1993; Baumeister, 1991; Baumeister & Vohs, 2002; Martela & Steger, 2016; Reker & Wong, 1988, 2012; Steger et al., 2006; Steger, 2012b; Wong, 2010). In part, this variation may reflect 'definitional ambiguity' due to the role of unconscious processes that inform subjective judgements of life meaning, which can appear as an 'intuitive feeling state' (p. 471; Heintzelman & King, 2013). Attempting to unify the field, multiple reviews have noted convergence between models and definitions of life meaning. In particular, they note commonality between theorists in proposing the following components as central to life meaning: *purpose*, i.e. identification and pursuit of personally important goals; *coherence*, i.e. a personal sense that one's life and

experiences 'make sense', are comprehensible and characterised by regular, predictable patterns; and *significance*, i.e. appraising one's life and experiences as important and having value (Heintzelman & King, 2014; Hibberd, 2013; Martela & Steger, 2016; Steger, 2012b). Understood in this light, life meaning can be defined as 'the extent to which people comprehend, make sense of, or see significance in their lives, accompanied by the degree to which they perceive themselves to have a purpose, mission, or overarching aim in life' (p. 684; Steger, 2012b).

Finally, a distinction between presence of life meaning (recognition that one's life has meaning) and search for life meaning (motivation to seek life meaning) has been noted (Steger et al., 2006). Many of the standardised measures of life meaning noted below (see Sect. 3.2) do not have a separate subscale for search for life meaning. As such, in reviewing the association between life meaning and each of depression and suicidality, this chapter focuses on subjective estimations of the presence of life meaning. However, readers may refer to helpful reviews on search for life meaning and its association with markers of mental health (e.g. Costanza et al., 2019; Park, 2010; Steger, 2012b; Wong, 2014).

## *3.2 Measuring Life Meaning*

Studies examining the association between life meaning and each of depression and suicidality have typically measured life meaning through use of standardised self-report instruments, which contain items that probe at least one of the above key aspects of life meaning (i.e. coherence, purpose, significance). As such, instruments with items that probe at least one of these aspects, or overall subjective life meaning, are therefore considered to reflect subjective life meaning, though it is acknowledged that a single measure may not necessarily tap all of the above aspects of life meaning (Martela & Steger, 2016). The studies reviewed in this chapter have typically used at least one of the following psychometrically validated measures of life meaning, many of which can be broken into subscales: the Meaning in Life Questionnaire (MLQ) (Steger et al., 2006), which produces an overall score of life meaning and contains separate subscales for presence of life meaning and search for life meaning, with items probing coherence and purpose; the Life Attitude Profile (LAP; Reker & Peacock, 1981), probing purpose and coherence; the Sense of Coherence Scale (SOC; Antonovsky, 1993), probing coherence; the Purpose in Life Test (PIL; Crumbaugh, 1968), probing purpose; the revised Life Regard Index (LRI; Debats, 1998), probing purpose and significance; the Personal Meaning Profile (PMP; Wong, 1998), probing purpose; the Schedule for Meaning in Life Evaluation (SMILE; Fegg et al., 2008), providing an overall level of idiographic subjective life meaning; the Perceived Life Significance Scale (PLSS; Hibberd & Vandenberg, 2015), probing significance; the Meaning in Life Scale (MIL; Krause, 2004), probing purpose and overall life meaning; and the Shift and Persist Questionnaire (SAPQ) (Chen et al., 2015), with a subscale probing purpose. While these scales contain items probing at least one of purpose, coherence and significance, they also

contain items probing other aspects of life meaning determined as theoretically important by their authors. Where studies below examined life meaning utilising other measures or means, this is noted as relevant.

## 4 The Association Between Life Meaning and Hope

Feldman and colleagues (Feldman et al., 2017; Feldman & Snyder, 2005) have proposed a central role for hope in life meaning. They defined hope as the perceived capacity both to develop plans to pursue goals (which they term 'pathways thought') and to take action on these plans (which they term 'agentic thinking'). So defined, they proposed that hope underpins the planning and pursuit of personally relevant goals – this converges with the above description of the purpose component of life meaning. Hence, hope may be seen as supportive of life meaning through its proposed role in supporting purpose. Moreover, it follows that a higher hopelessness and a lower life meaning may be experienced when there are low estimations of the perceived capacities of pathways thought and agentic thinking. This has been shown empirically on both a cross-sectional (Feldman & Snyder, 2005; Hedayati & Khazaei, 2014; Karaman et al., 2020; Mascaro & Rosen, 2005) and longitudinal basis (Mascaro & Rosen, 2005). Furthermore, Feldman and Snyder (2005) conducted exploratory factor analysis on a measure of their conceptualisation of hope (The Adult Hope Scale (AHS); Snyder et al., 1991) and measures of life meaning (the SOC-S, LRI and PIL) and found that a single factor best explained variance between their measures, suggesting hope is part of life meaning. They also found that the positive association between each of hope and life meaning with depressive symptoms was attenuated when statistically controlling for one in the presence of the other.

Feldman and colleagues' conceptualisation of hope converges partially with Abramson's et al. (1989) definition of hopelessness within the hopelessness theory of depression. This theory proposed that negative inferential styles (to attribute negative events to internal, stable, global causes) are the conduit through which proximal negative life events can produce hopelessness and subsequent depression and suicidality. He defined hopelessness as '(a) negative expectancy about the occurrence of highly valued outcomes (a negative outcome expectancy), and (b) expectations of helplessness about changing the likelihood of occurrence of these outcomes (a helplessness expectancy)' (p. 359). On the basis that changing the likelihood of expected outcomes relies on adequate perceived capacity to develop and enact plans for goal pursuit, Abramson's helplessness expectancy converges with Feldman and colleagues' above definition of hope. As recently noted by Haeffel (2017), each element of hopelessness theory has at least partial support (but see Liu (2015)). This overlap in definitions of hope/hopelessness suggests a possible association between life meaning and measures that probe aspects of hopelessness beyond that defined by Feldman and colleagues, such as the Hopelessness Scale (Everson et al., 1996) and the Beck Hopelessness Scale (BHS; Beck et al., 1974), each of which probes

aspects of hope about the future not related to personal action. Indeed, lower life meaning is related to higher hopelessness in adults in the general population when using the Hopelessness Scale (Harris & Standard, 2001). Complementing this, Braden et al. (2017) found higher self-reported life meaning as predictive of lower hopelessness on the BHS 4 months later in a sample of depressed military veterans. Similar findings come from a Spanish mixed psychiatric sample in which life meaning (on the PIL) was inversely associated with hopelessness on the BHS (Marco et al., 2016). Furthermore, Marco et al. (2016) found that the meaning and life satisfaction subscale of the PIL (which does not specifically probe purpose) was inversely associated with hopelessness on the BHS. Complementing this, a recent study found that engagement in a meaning-centred group intervention for men transitioning to retirement was associated with significant reduction in hopelessness on the BHS (Heisel et al., 2020). Taken together, this suggests that life meaning is associated with aspects of hope outside of personal action.

To summarise, the above findings show not only the positive association between hope and meaning, but the possibility that hope is central to life meaning. As deficits in hope have been well shown to be associated with suicidality (e.g. Beck, 1986; Beck et al., 1985, 1990; Brezo et al., 2006; Edwards & Holden, 2001; Hawton & van Heeringen, 2009; Johns & Holden, 1997; Joiner & Rudd, 1996; Klonsky et al., 2012; Marco et al., 2016) and depressive symptoms (Beck et al., 1993; Dyer & Kreitman, 1984), it suggests that life meaning would be negatively associated with depressive symptoms and suicidality. This proposal is addressed later in this chapter. However, before proceeding, the above-noted components of life meaning are elaborated to show their conceptual connection to depressive features and suicidality.

## 5 Life Meaning's Conceptual Link to Depression and Suicidality

The above components of life meaning (purpose, coherence and significance) can be understood in cognitive, motivational and affective terms. Reker and Wong (1988) proposed a model of personal meaning with interrelated cognitive, motivational and affective faculties. The cognitive faculty is the cornerstone of the model and captures the individual's values and beliefs about the self and the world. This motivates goal selection and striving (the motivational faculty), which lead to satisfaction and fulfillment (the affective faculty). They further proposed that these faculties are mutually reinforcing. Understood in this way, coherence and significance can be regarded as cognitive in nature, with purpose as motivational. Following Feldman and colleagues (see Sect. 4), hope can be seen to fit within the motivational faculty. As these faculties support the subjective sense of meaning in life and given that individuals with depression display deficits in these faculties, it follows that subjective life meaning would be reduced in depression. Furthermore, as deficits in

hope are implicated in depression and suicidality (Beck, 1986; Beck et al., 1985, 1990, 1993; Dyer & Kreitman, 1984) and hope has been proposed as integral to life meaning as noted above, it follows that life meaning would be inversely related to suicidality. Evidence for the association between life meaning and depression is presented first, followed by evidence of its association with suicidality.

## 6 Evidence for the Association Between Life Meaning and Depression

### *6.1 Evidence from Correlational and Group Difference Studies*

Initial support for the association between life meaning and depressive symptoms comes from correlational studies. Such studies with cross-sectional designs have found an inverse relationship between self-reported life meaning and depressive symptoms on standardised self-report measures across various age groups including adolescents (Dulaney et al., 2018; Mascaro & Rosen, 2005; Steger et al., 2006) and young adults up to older adults (Braden et al., 2015; Gross et al., 2019; Heisel et al., 2015a, b; Kleiman & Beaver, 2013; Lester & Badro, 1992; Psarra & Kleftaras, 2013; Scharer & Hibberd, 2020). Though these researchers conducted studies with Western samples, similar findings have been found in other cultural groups including those from Asian cultural backgrounds (Chow, 2017; Datu et al., 2019; Huo et al., 2019; Zhang, 2019), Middle Eastern backgrounds (Fischer et al., 2020; Hedayati & Khazaei, 2014), Indian backgrounds (Thakur & Basu, 2010) and Latin American backgrounds (Schnell et al., 2018). Furthermore, meta-analytic findings have found an inverse association between purpose in life and depressive symptoms (Pinquart, 2002). Though the aforementioned research used samples undiagnosed for depression, the same inverse association has been found in those with depressive disorders. For example, Volkert et al. (2019) found a negative relationship between self-reported life meaning (on the SMILE) and the presence of a depressive disorder (dysthymia or major depressive disorder) in the past month.

Results from longitudinal studies provide further empirical support for a connection between depression and life meaning. For example, in a study of 797 adults (not diagnosed for depressive disorders) from multiple countries, a higher self-reported life meaning on the Meaning in Life Questionnaire (MLQ) predicted lower self-reported depressive symptoms at 3-month and 6-month follow-up (Disabato et al., 2017). Similarly, a higher self-reported life meaning predicted lower depressive symptoms in adolescent samples at follow-up periods of 2 months (Mascaro & Rosen, 2005) (using PMP and the Framework subscale of the LRI) to 7 months (Dulaney et al., 2018) (using the Persist subscale of the SAPQ). Further, in a sample of military veterans diagnosed with a depressive disorder, there was an inverse association between life meaning and recovery (based on structured clinician interview) 4 months later (Braden et al., 2017). However, these latter researchers did not find

life meaning predictive of self-reported depressive symptoms 4 months later. As these authors noted, life meaning may predict clinician-determined change in depressive symptoms in clinical samples, though not change in self-reported depressive symptoms. Interestingly, they found that baseline levels of depressive symptoms were not significantly predictive of life meaning 4 months later after accounting for baseline levels of life meaning. That baseline life meaning was associated with subsequent depression, but not the other way around, suggests the possibility that levels of life meaning may be causally related to depression.

Supporting the above evidence, group difference studies have shown a lower meaning in life in those with diagnosed depressive disorders versus those without. Thakur and Basu (2010) found a significantly higher self-reported presence of life meaning on the MLQ in adults diagnosed with major depressive disorder versus those without the diagnosis. Furthermore, Seligman et al. (2006) found a significantly lower life meaning (the measure used was not reported) in a sample of clinically depressed young adults compared to non-depressed individuals with another psychiatric diagnosis and those without any diagnosis. Similarly, another study found that meaning in life (on the SMILE) was significantly lower in adult psychiatric inpatients with depressive disorders versus those without (Volkert et al., 2014). Importantly, the findings by Seligman et al. (2006) and Volkert et al. (2014) suggest that a low life meaning may be specific to depression rather than being a general characteristic of psychopathology. However, none of these studies detailed how diagnosis was determined. Thus, while these group difference studies lend prima facie support to the above-noted correlational data for the inverse relationship between life meaning and depression, replication would be helpful to determine the robustness of these findings.

## *6.2 Evidence from Moderation/Mediation Studies*

Evidence from moderation and mediation studies not only supports the inverse association between life meaning and depression but also suggests that life meaning may be an important link between stressful events and depressive symptoms. Life meaning (on a standardised measure of life worth) has been shown to mediate the connection between knowledge of stroke in elderly Chinese stroke survivors and depressive symptoms (Chow, 2017). Life meaning (on the MLQ) has been shown further to mediate the link between surviving sexual trauma and subsequent depressive symptoms in military personnel (Gross et al., 2019). Complementing these mediational results, Dulaney et al. (2018) found life meaning (on the Shift subscale of the SAPQ) moderated the impact of life stress on depressive symptoms 7 months later in an adolescent sample. Similarly, life meaning (using a self-report measure probing purpose) buffered the association between traumatic life events and depressive symptoms in an older sample on a cross-sectional basis (Krause, 2007). Interestingly, these latter authors reported a pattern of findings that showed that greater life meaning was associated with reduction of depressive symptoms over

time, but not the other way around. Similarly, Mascaro and Rosen (2005) found that while a higher baseline life meaning negatively predicted depressive symptoms 2 months later in a sample of undergraduate students, depressive symptoms were not predictive of subsequent life meaning. Taken together, these findings suggest that life meaning may be an important factor through which life stress exerts influence over depressive symptoms and an important resource that may protect against, or at least buffer, such an impact.

## *6.3 Evidence from Treatment/Intervention Studies*

Evidence for an association between subjective life meaning and depression is supported further by treatment studies that have shown reduction in depressive symptom with interventions that include elements that aim to enhance (at least one element of) subjective life meaning. For example, Seligman et al. (2006) reported two studies examining the impact of positive psychotherapy (PPT) on depressive symptoms. In brief, PPT is a structured intervention aimed partially at enhancing life meaning, along with life engagement and positive emotion. In one of these studies, they examined the impact on depressive symptoms from participating in a six-week group PPT program in mild to moderately depressed young adults. Treatment was associated with significantly lower depressive symptoms immediately following treatment compared to non-treatment controls, a difference preserved through 12-month follow-up. Their second study investigated the impact of individual PPT on depressive symptoms in severely depressed young adults with diagnosed major depressive disorder compared to medicated and non-medicated treatment-as-usual control groups. They found that PPT produced significantly greater reduction in depressive symptoms and more remission from depression following treatment compared to each control group. Meta-analytic findings have further found that positive psychology interventions are associated with reduction in depressive symptoms in both depressed and non-depressed individuals (Bolier et al., 2013; Chakhssi et al., 2018; Sin & Lyubomirsky, 2009).

Complementing the above, evidence has shown that participation in acceptance and commitment therapy (ACT) is associated with reduction in depressive symptoms. In part, ACT encourages engagement in actions that fit the individual's personally held life principles as a means of living a fulfilling life, which includes goal identification and pursuit. This fits notionally with the earlier proposed idea that pursuing life purpose is a component of subjective life meaning. Seen this way, ACT can be considered to target subjective life meaning. Reviewing evidence for ACT, Hayes and co-workers (2006) found that ACT was associated with a significant reduction in depressive symptoms when depression was the primary problem focus and that it did so to a larger extent than other active treatment. Moreover, evidence for the utility of ACT in reducing depressive symptoms has been replicated (A-Tjak et al., 2015; Hacker et al., 2016), though recent meta-analytic

findings suggest it may have more utility for people with mild depression compared to those with moderate or severe depression (Bai et al., 2020).

Studies examining change in life meaning and depressive symptoms from psychotherapy or that have examined the impact of meaning-focused interventions on depressive symptoms further support the connection between these constructs. Volkert et al. (2014) found significant increases in life meaning (on the SMILE measure) in psychiatric inpatients (the majority of whom were diagnosed with a depressive disorder) who self-reported reduced depressive symptom severity over the course of mixed individual and group psychodynamic psychotherapy. Similarly, two studies by Heisel and co-workers are relevant here. In one (Heisel et al., 2015a, b), these researchers found that interpersonal psychotherapy was associated with a significant improvement in clinician-rated and self-reported depressive symptoms in a sample of older adults, along with increased life meaning (assessed with the Perceived Meaning in Life subscale of the Geriatric Suicide Ideation Scale) (Heisel & Flett, 2006a, b), with continued improvement in life meaning at 6-month follow-up. In the second (Heisel et al., 2020), they examined the utility of a 12-week meaning-centred group intervention for a community sample of men around the life stage of transitioning to retirement. They found a significant reduction in depressive symptoms and increases in life meaning (on the Experienced Meaning in Life Scale (Heisel & Flett, 2006a, b), which measures overall life meaning and its components) from pre- to post-treatment. (It should be noted that neither of these studies by Heisel's group contained a control group, so causality of program participation could not be determined.) Furthermore, a randomised controlled trial (RCT) of meaning-centred group therapy (MCGT) for advanced cancer patients found significant reductions in depressive symptoms at post-treatment and at 2-month follow-up (versus supportive group psychotherapy) (Breitbart et al., 2015). Complementing this, van der Spek and co-workers (2017) conducted an RCT and found that cancer survivors participating in MCGT showed significant increases in life meaning (on the Dutch version of the Personal Meaning Profile; (Jaarsma et al., 2007) from post-treatment through to 6-month follow-up (compared to care as usual), with depressive symptoms lower at 6 -month follow-up. These findings converge with meta-analytic findings that engagement in meaning-centred existential therapies is associated with significantly increased life meaning and significantly reduced depressive symptoms with generally moderate effect size (Vos et al., 2015). Finally, another study examined change in life meaning (based on coding responses on a sentence completion questionnaire) following psychotherapy and its association with depressive symptoms (Westerhof et al., 2010). That study conducted a randomised controlled trial (RCT) of a life review program on depressive symptoms in older adults with depressive symptoms but not depressive disorders. It found that depressive symptoms were significantly reduced, and life meaning significantly increased, at post-treatment in the intervention group compared to non-treatment controls. Further, increased life meaning predicted subsequent reduction in depressive symptoms and mediated the impact of the intervention on depressive symptoms. This pattern of results suggests the potential of life meaning to act as a mechanism of change in depressive symptoms from psychological intervention,

converging with the aforementioned studies showing a mediation/moderation role of life meaning on depressive symptoms (Chow, 2017; Dulaney et al., 2018; Gross et al., 2019; Krause, 2007).

To summarise, results from treatment studies further implicate an inverse connection between life meaning and depressive symptoms. This is shown in reduced depressive symptoms from participation in interventions that include meaning-focused components, concurrent increases in life meaning and reduction in depressive symptoms from participation in various psychotherapeutic interventions and evidence that life meaning mediates the reduction in depressive symptoms from intervention. It is noted that these findings come from disparate study types, samples and treatment approaches. As such, well-controlled studies that examine the impact of interventions containing meaning-focused elements in both depressed and non-depressed samples would be helpful to robustly determine the role of life meaning in addressing depressive symptoms. Further examination of the moderating/mediating role of life meaning would also be helpful.

### *6.4 Summary*

Evidence from correlational and longitudinal studies in normal and clinically depressed samples supports the proposal that life meaning is depleted in the presence of depressive symptoms. Further, clinically depressed samples have been shown to be lower on life meaning than people without a depressive diagnosis, and moderation/mediation studies suggest that levels of life meaning may be critical in transmitting, or protecting against, the impact of life stressors on depressive symptoms. Consistent with this, treatment studies show reduction in depressive symptoms and increases in life meaning after intervention and suggest a possible mediating role for life meaning, though further research is required here.

## 7 Evidence for the Association Between Life Meaning and Suicidality

### *7.1 Evidence from Correlational and Group Difference Studies*

As with the investigations on its association with depressive symptomatology, much of the empirical work on life meaning's association with suicidality has been correlational. Findings have typically indicated that a higher subjective life meaning is associated with a lower suicidality, though there is variation depending on the aspect of suicidality measured. Schnell et al. (2018) found that crisis of meaning (i.e. distress at low life meaning) was associated with elevated suicidality in a sample of Ecuadorian high school students. Similarly, Lester and Badro (1992) found that low

life meaning (measured on the PIL) predicted current and past suicidal ideation and past suicidal threats in an undergraduate student sample. These findings converge with another study of undergraduate students in which a low life meaning (on the PIL and SOC-S) was associated with suicidal ideation and self-reported likelihood of future suicidal behaviour (Edwards & Holden, 2001). That study also found that a lower life meaning was associated with past suicide attempts for women in their sample. This general pattern of low life meaning to be associated with increased suicidality has further been found in adolescents (Aviad-Wilchek & Ne'eman-Haviv, 2018; Harlow et al., 1986)), Western and non-Western adults (Chan, 2018; Chen et al., 2020; Lew et al., 2020; Liu et al., 2020) and military samples (Braden et al., 2015; Gross et al., 2019).

Longitudinal data further indicate an association between life meaning and suicidality. Bjerkeset et al. (2010) observed that low life meaning prospectively predicted later suicide in a large Norwegian sample (they did not detail how life meaning was measured), and Kleiman and Beaver (2013) found that the presence of life meaning (on the MLQ) predicted reduced suicidal ideation eight weeks later and reduced lifetime odds of a past suicide attempt. However, Braden et al. (2017) found no association between baseline life meaning (on the LRI) and suicidal ideation 4 months later in a chronically depressed sample of military veterans, after accounting for baseline depressive symptoms and hopelessness.

Group difference data further implicate life meaning in suicidality. These findings come from studies noted above. In one, Aviad-Wilchek and Ne'eman-Haviv (2018) found a significantly lower life meaning (on the PIL) and a higher suicidality in a group of disadvantaged adolescent girls versus non-disadvantaged counterparts. Further, in the earlier noted study by Edwards and Holden (2001), participants who had attempted suicide showed a significantly lower life meaning (on the SOC-S) than those who had not attempted suicide.

## *7.2 Evidence from Moderation/Mediation Studies*

Data from moderation and mediational analyses further implicate life meaning in experience of suicidality and suggest a possible instrumental and/or protective role. Mediational analyses have shown that life meaning provides an explanatory connection between various factors and suicidal manifestations. Life meaning has been shown to mediate the connection between life stressors and suicidal ideation. This has been shown for each of life event load (Schnell et al., 2018), morally injurious events (Corona et al., 2019), sexual trauma (Gross et al., 2019) and significant work stress (Liu et al., 2020). Moreover, life meaning also appears to mediate the link between factors proposed as suicide risk factors (such as ostracism, thwarted belongingness to others and perceived burdensomeness to others) and suicidal ideation (Chen et al., 2020; Kleiman & Beaver, 2013). Further, life meaning has been shown to mediate the connection between symptom load and suicidality. For example, Sinclair et al. (2016) found that presence of life meaning (on the MLQ)

explained the connection between depressive symptom severity and progress from suicidal ideation to suicide attempts in a military sample. Similarly, Lew et al. (2020) showed the same role of presence of life meaning (on the MLQ) in linking hopelessness and suicidal behaviour in a Chinese adult sample. Moderation analyses complement these mediational findings to show a buffering role for life meaning. For example, life meaning (on the PIL) attenuated the association between baseline eating disorder psychopathology and suicidal ideation 7 months later in a sample of patients with eating disorders (Marco et al., 2020). Life meaning (on the MLQ) has also been found to similarly attenuate the connection between depressive symptoms suicidal ideation 6 months later in HIV outpatients (Lu et al., 2019).

## *7.3 Evidence from Treatment/Intervention Studies*

Finally, evidence from treatment studies further implicates life meaning in suicidality. For example, participation in an interpersonal therapy (IPT) intervention was shown to significantly reduce suicidal ideation and enhance life meaning (both measured on the Geriatric Suicide Ideation Scale; Heisel & Flett, 2006a, b) in a group of older adults with mood disorders (Heisel et al., 2015a, b). Complementing this, a recent study (Heisel et al., 2020) found that a meaning-centred group intervention was associated with pre- to post-treatment reduction in suicidal ideation and increase in life meaning (on the Experienced Meaning in Life Scale, which measures overall life meaning and component subscales and is based on Frankl's model of meaning). Similarly, Lapierre et al. (2007) found substantially greater reduction in past-week suicidal ideation 6 months later in an older sample after participation in a personal goal intervention compared to controls.

## *7.4 Summary*

Taken together, the above findings support a role for life meaning in suicidality. The above combination of findings from longitudinal, group difference, mediation/moderation and treatment studies suggests that this role may be instrumental. It appears that life meaning may provide a buffering or protective role in the experience of suicidality. Importantly, it appears that this may be true for both the impact of life stressors and the load imposed by symptoms of psychopathology. This converges with a recent systematic review on the association between life meaning and suicidality, which found presence of (though not search for) life meaning as a protective factor against suicidal ideation, suicide attempts and death by suicide (Costanza et al., 2019). While it is likely that other factors may also play such a role, the current data suggest that probing life meaning may be an important component of assessing suicidality and that enhancing life meaning may have utility in managing

suicidal manifestations and reducing suicide risk (Costanza et al., 2019; Gross et al., 2019; Sinclair et al., 2016).

## 8 Summary and Conclusion

Life meaning has been proposed as important to human well-being and is implicated in states of degraded psychological health. The evidence reviewed in this chapter supports this proposition in general and specifically identifies its role within depression and suicidality. Life meaning appears to be reliably lower in the presence of depressive symptoms and heightened suicidality, across cultures, age groups and sample types, such as civilian, military and psychiatric and non-psychiatric samples. While some have proposed a causal role for lack of life meaning in depression (e.g. Seligman et al., 2006), further research in both clinical and non-clinical samples is warranted to confirm this and support to extant findings. Notwithstanding, current research indicates a buffering/protective role for life meaning. Life meaning appears to protect against the impact of life stress and symptom load on subsequent depressive symptoms and suicidality and against other mediating factors between depression and suicidality, such as hopelessness. As has been noted by other researchers, probing life meaning may be a useful component of clinical assessment and treatment planning for depression and suicidality. Life meaning may also be an important target in psychological treatment of depression and suicidality. Indeed, the inclusion of meaning-focused components in traditional cognitive behavioural therapy techniques for depression has been proposed (Ameli, 2016a, b; Ameli & Dattilio, 2013); and psychological interventions, such as acceptance and commitment therapy, that ostensibly enhance the purpose component of life meaning (by encouraging action on personally important life values) have been shown to have utility for reducing depressive symptoms (A-Tjak et al., 2015; Bai et al., 2020; Hacker et al., 2016). Further, efforts to enhance life meaning pre-emptively may help protect against the onset and/or advancement of depressive symptoms and suicidality in response to life stressors. Indeed, the utility of building resilience to counter depressive relapse after recovery has been noted (Waugh & Koster, 2015). Enhancing life meaning may be a promising candidate in this regard. Further longitudinal and experimental research would be helpful to elucidate this. Notwithstanding, approaches to enhance life meaning hold promise to ease the personal and societal impact posed by these aspects of mental ill health.

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# Letting Go, Creating Meaning: The Role of Acceptance and Commitment Therapy in Helping People Confront Existential Concerns and Lead a Vital Life


**Joseph Ciarrochi, Louise Hayes, Gareth Quinlen, Baljinder Sahdra, Madeleine Ferrari, and Keong Yap**

**Abstract** We all must confront existential crises such as sickness, death of loved ones, loss of job, mistreatment from others, and relationship breakdown. These crises can shatter our sense of meaning. How can we face that moment with honesty and courage, embrace the distress, and create new meaning? This chapter provides a theory of how language and self-awareness can lead us into existential crisis and loss of meaning. It then provides an evidence-based account of how the DNA-V model of Acceptance and Commitment Therapy (ACT) can help people to answer "Yes" to Camus' most important philosophical question, "Is life worth living?". ACT can help people recreate coherence after a coherence-shattering event, overcome alienation from the body, overcome inertia, overcome a sense of self that is self-destroying or feels "empty," and bridge the gulf between self and others and create genuine connection.

**Keywords** Existentialism · Acceptance and commitment therapy · Mindfulness · Acceptance · DNA-V

Each of us will experience dramatic change in our lifetime: relationship breakdowns, loss of job or career, life-threatening illness, adverse transitions (e.g., moving to a nursing home), and the finality of death. Because we are hardwired to anticipate danger and avoid pain, we can torture ourselves not just by the experiences of actual crises as they occur but by the very *thoughts* of having future crises.

> the resourceful creatures see clearly
> that we are not really at home

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in the interpreted world – Rilke

How can we prepare ourselves for that life defining moment, when we can no longer pretend that everything will always be ok? This is even more difficult as we know deep down that we ourselves and all those we love will die. What will we do in *that* moment? How will we engage with this existential crisis? We could push our fear of powerlessness away by making it external, e.g., some blame others, such as those with different skin color or culture or different political views. Others blame the people closest to them: partners, family, and friends. Still others try to escape existential fear through overconsumption, work, drugs, or opting out of everything risky in life. We can also choose to live courageously in the present moment. The awareness that all things pass, that we suffer and die, need not lead to avoidance, paralysis, and blame, but instead can lead to a renewed focus and vitality for the things that matter in life.

This chapter will explore how Acceptance and Commitment Therapy (ACT) helps people to meet existential crises. ACT does not offer the promise of a stress-free life where we eliminate existential crises or interpret them positively; rather, ACT helps people to acknowledge and accept the distress inherent in life. It shows us how our ability to use language along with self-awareness can trap us in existential crises and the how we can take concrete steps to escape the trap.

## 1 Language, Self-Awareness, and Crisis

ACT is a behavioral approach, which means it is grounded in precise behavioral principles such as operant and classical conditioning (Hayes et al., 2012). However, it went beyond traditional behavioral approaches, because it has successfully tested a behavioral theory of language and symbolic activity, Relational Frame Theory (RFT) (Hayes et al., 2001). Therefore, it is useful to begin by explaining RFT.

RFT's potential value for practitioners lies in its focus on the manipulable context and, in particular, in how practitioners can alter context to influence complex symbolic processes (Ciarrochi & Bailey, 2008), such as those involved in the nausea of alienation (Sartre, 2013) and the terror of death (Yalom, 2008). Here we review the implications of RFT for practice. If the reader is interested in exploring the substantial evidence base behind RFT, we encourage them to explore the citations that follow (Barnes-Holmes & Barnes-Holmes, 2020; Dymond et al., 2010; Kissi et al., 2017; Montoya-Rodríguez et al., 2017).

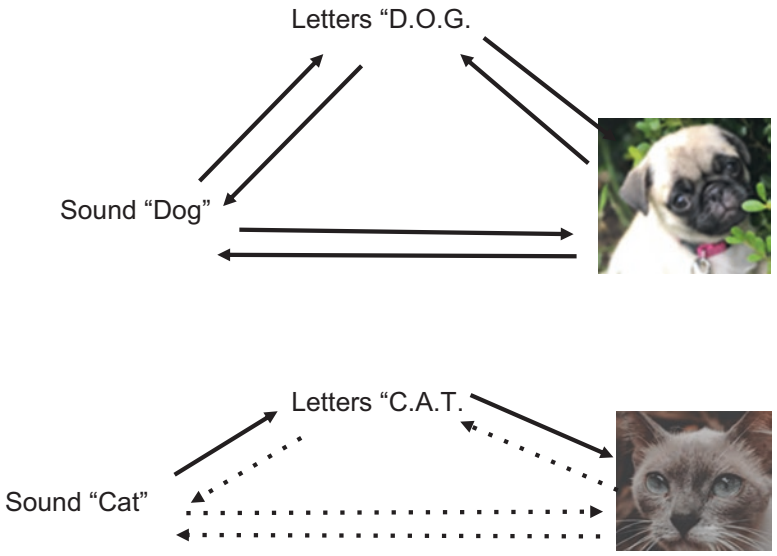
We explain RFT by starting with the simplest symbolic process and working our way up to complex existential processes. In RFT, symbols (like words and thoughts) are not "things" in the head, but "behavior" that are controlled by learning context (Barnes-Holmes & Barnes-Holmes, 2020). People teach us to engage in symbolic activity in our childhood. For example, a caregiver might point at a dog and say, "dog." If the child says "dog," the parent reinforces with "good." The caregiver teaches the child to name thousands of things and to explicitly look for the thing

when the name is said out loud. Thus, the caregiver will say "dog," and if the child points at a dog, the caregiver will reinforce the association. In this way, the relations between a dog, the letters "D.O.G.," and the sound "Dog" are explicitly taught to a child. We illustrate this in the figure below by the solid lines.

After some time of reinforcing young people to name things, something interesting happens. Young people start to engage in the naming process, and the deriving, as a matter of habit (Dermot Barnes-Holmes & Barnes-Holmes, 2000). Thus, you can teach a young person to relate the sound, "cat" with the letters "C.A.T." and the letters "C.A.T." with the visual image of a cat (bottom image, Fig. 1). The young person will then derive all other relations. If you point at the animal, the child will know to spontaneously say "cat," even though the child was never explicitly taught to say cat.

We have used a very simple example here, but the reader might imagine a child beginning to derive or verbally relate everything to everything else. A child can even eventually derive, "I am like a cat" or "Cats are magical" or "Cats have a secret life underground." Note that all this verbal behavior is based on deriving rather than on direct experience. In this way, our symbolic life can run far from reality. Existential crises come when we make ultra-complex derivations such as "life is meaningless" and "God has abandoned me."

One of the key principles of RFT is "transformation of stimulus function (Barnes-Holmes et al., 2004)." People teach children to respond to symbols, whether sound or visual, as they would to the object to which the symbol points (Fig. 2).




**Note:** Solid lines are trained; dotted lines are derived

**Fig. 1** The development of relational framing
**Note: Solid lines are trained; dotted lines are derived**

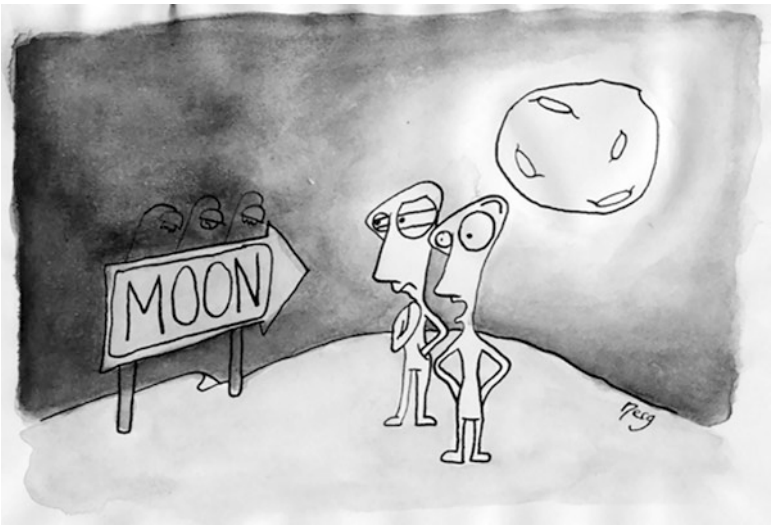



**Fig. 2** "The moon is black tonight." People respond to symbols as if they are the "real" thing

For example, if you say "doggy" to children who love dogs, those children may respond with excitement, even before they see the dog. They are responding to the symbol in the same behavioral and physiological way that they would respond to an actual dog. In the same way, adults can display emotional reactions to words like "death." We don't have to experience death to experience the fear of death and dying or the terror at having "wasted our life." The research suggests that this process only occurs in verbal humans, with other animals lacking the capacity to engage in transformation of stimulus function. Without this ability, nonhumans will never fear the word "death" – unless we pair the word with some painful stimulus like a shock (Joseph Ciarrochi & Bailey, 2008).

We have focused on simple verbal relating, because simple relating is the building block for the most complex verbal behavior, including that behavior involved in existential angst. Rule-governed behavior is one example of complex verbal behavior and involves relations nested within relations (Törneke et al., 2008). For example, some people believe, "If God is not real, then life has no meaning." Consider the complexity of the symbolic activity here. First the sound "God" has acquired many stimulus functions due to a person's particular history of relating ideas to it. Perhaps, a person has been taught that God is equivalent to an all-loving father who protects and cares for you and tells you what is right or wrong. Imagine a person believes this. When this person thinks of their god, they feel life is meaningful. Now imagine they have some experience that seems to negate the belief, e.g., the death of their young child. In an instant the verbal relation "god is not real" powerfully transforms their world. It is as if the person has lost an all-loving protector. If the verbal conclusion is believed, then their life can be rapidly transformed from purposeful to dead and meaningless.

Research suggests that verbal beliefs and rules can lead to rigidity and insensitivity to context (Törneke et al., 2008). Consider the rule, "if I lose my job, I will no longer be a real man. I will have no use or purpose." This is a rather complex relation where all meaning is caught up in a symbolic attachment to a job role. Thus, the loss of their job can rapidly transform the person's view of their life from meaningful ("I am a provider") to meaningless ("I am useless"). If the person believes this verbal rule (real men provide), they will become insensitive to times when the rule is wrong. For example, when he loses his job, he may have an increased opportunity to participate in family functioning and child-rearing. His partner may reassure him and describe the lost job as an opportunity. Still, he might hold on to his self-rule, "men are providers," and this leads to significant angst. Just like this example, research suggests rules can make us insensitive to new contingencies of reinforcement (Törneke et al., 2008).

To summarize this section: RFT is the theoretical foundation of Acceptance and Commitment Therapy (ACT) and has shown us three basic things: (1) We relate words to everything we touch, smell, hear, feel, and think. (2) Verbal relating transforms how we experience and respond to events. Words take on the power of the thing they point to. (3) Verbal relating, and especially self-rules, can make us insensitive to context.

Verbal relating has given humans great power, but it also has a downside. Language lies at the heart of our existential crises. There is no such thing as an existential one-year-old. Without verbal behavior, the child cannot feel the terror of death, the anguish of responsibility, or the alienation of an indifferent world. Each of the phrases in this sentence, so simple for us to construct and understand, has been made possible only by years of deriving and transforming symbols. A 1-year-old girl inhabits the same physical world as you and I, eats the same chocolate cake, but she experiences that cake far more purely than we will ever be able to again. Our spontaneous verbal evaluation of the cake will transform how we experience it (e.g., "will I put on weight?"). Such is the downside of language.

## 2 The ACT Approach to Existential Crises

Let's consider ACT, the practical application of RFT, and see how it helps people confront and grow from existential crises. There are now over 300 clinical trials that have examined the efficacy of ACT (ContextualScience, n.d.; Walder et al., 2019). There is strong evidence that ACT is beneficial for chronic pain and moderate evidence that ACT is beneficial for depression, mixed anxiety, obsessive-compulsive disorder, and psychosis. There is also evidence that ACT does better than wait-list control and treatment as usual (Bai et al., 2020; Hughes et al., 2017) and is effective in real-world clinical settings (Pinto et al., 2017). It is, at present, uncertain whether ACT is better than CBT or an active control (A-Tjak et al., 2015; Atkins et al., 2017;

Bluett et al., 2014; Hacker et al., 2016; Jiménez, 2012; Lee et al., 2015; Walder et al., 2019).

ACT focuses on therapeutic processes to create change rather than following standard protocols. There are many different frameworks and names for ACT processes, such as those found in the popular "hexaflex" (Hayes et al., 1999), DNA-V (Hayes & Ciarrochi, 2015), and "the matrix" (Polk & Schoendorff, 2014). What is important here is the function of processes, not the particular label. Different named processes may have similar functions (e.g., "noticing" and "mindfulness"), and similarly named processes may have different functions (e.g., two different variants of "mindfulness"). The use of labels for processes has become extremely complex and confusing. To simplify things, Hayes et al. (2012) have proposed an Extended Evolutionary Meta-model that provides a "periodic table" of processes that all researchers, regardless of therapeutic orientation, might use.

We use the DNA-V framework here but define each process and show how we map the processes to the hexaflex framework and the Extended Evolutionary Meta-model. Table 1 provides this mapping.

**Table 1** Mapping ACT process labels to function

| DNA-V process label | Hexaflex process label | Extended evolutionary meta-model | Purpose of intervention |
|---|---|---|---|
| Discoverer | Committed action | Overt behavior | Use trial-and-error learning. Help people to willingly engage in new or nontypical behavior, to develop their skills and resources, and expand their context |
| Noticer | Present moment awareness; acceptance | Attention<br>Affect<br>Physiological states and responses | Help people notice inner and outer experience and have the capacity to accept rather than avoid or cling to it. Help people attend to the present context |
| Advisor | Defusion | Cognition | Help people to navigate their context with language and disengage from unhelpful language processes |
| Values | Values | Motivation | Create contexts that empower people to clarify what they value, choose value-consistent action, and sustain action across time and hardship |
| Self-view | Self-as-process. Self-as-context | Self | Help people take perspective on themselves, overcome self-limiting rules or beliefs, view self with compassion, and take actions towards self that are self-enhancing rather than self-destroying |
| Social view | All six processes at the social level | All six dimensions above | Help people take perspective on others, to recognize social interdependence and the value of others, and to behave effectively in social situations |

## 3 A Quick DNA-V Overview

Before we link the DNA-V framework of ACT to existential concerns, we provide a quick overview of how one might use DNA-V to understand the core goal of ACT, which is to promote psychological flexibility, or the ability to mindfully experience thoughts, feelings, and sensations, in the service of persisting in behavior that builds value and changing behavior that is inconsistent with value. DNA-V seeks to build this flexibility by helping people to shift between different psychological spaces. The DNA-V exercise below will allow you to experience this "space shifting" rapidly (and perhaps you will notice that space is merely a relational frame, there is no physical space). If you are interested in completing the exercise, we recommend starting with A and working your way around the disk clockwise – A, N, D, and then V (Fig. 3).

We have placed value in the center of the disk, to highlight how value is central to all ACT processes. The core goal of ACT is to develop the ability to flexibly shift or "pivot" (Hayes, 2019) between different spaces, always in the service of meaning and value. "Inflexibility" occurs when a person does not pivot, for example, by

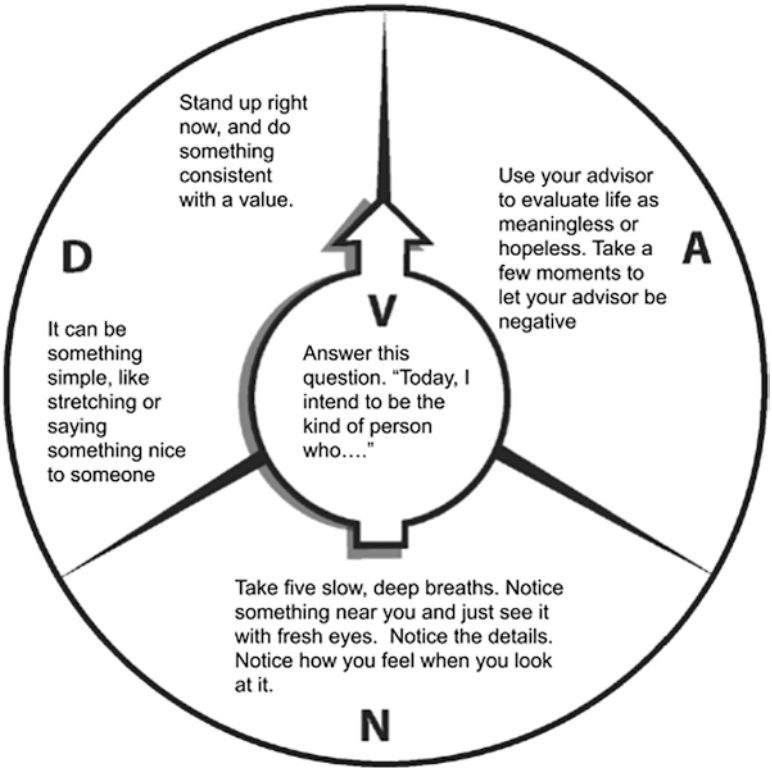



**Fig. 3** An example of modelling ACT psychological flexibility

staying stuck inside the advisor (e.g., ruminating, dysfunctional beliefs), noticer (e.g., excessive focus on escaping feelings), or discoverer (e.g., impulsive acting). The components of the DNA-V model can be viewed as varying on a continuum, from low skill to high skill. The goal of the practitioner is to help identify skill weakness, or presenting problems, and help people develop those weaknesses into strengths (Hayes & Ciarrochi, 2015; Hayes et al., 2012).

## 4 Valuer: Crisis of Meaning

Camus argues that the most important question in philosophy is, "Is life worth living?" or the corollary, "Should I commit suicide?" (Camus, 2013). Although ACT doesn't aim to answer this existential question directly, it assumes that engagement in valued action creates meaning and makes life "worth living." A key intervention in ACT is helping people to choose valuing or meaningful actions. Valuing guides us like a compass, helping us to choose what to do at any given moment. Examples of valuing include "being a loving parent," "being active," "supporting disadvantaged youth," "challenging myself," and "connecting with my friends."

Values are choices we can make without having to justify them with language. For example, we can declare, "I love to care for animals," and there is no need to justify this preference. As we will see in the advisor section, the "need" to justify with language is a verbal trap that can accelerate the existential crisis. Living things choose without verbal justification. We might say even flowers "choose" to grow towards the sun rather than the shadows.

That values are a choice leads to an existential dilemma: if we can choose anything, why not choose evil action? This issue is illustrated in Dostoyevsky's classic book, *Crime and Punishment* (Dostoyevsky, 2017). The chief character, Raskolnikov, murders an elderly pawnbroker, a "free choice." What follows is Raskolnikov's relentless internal struggle, guilt, and anxiety about being caught. He made a "free choice" but discovered via his verbal behavior, his own deriving, that the choice did not bring meaning and vitality. Eventually he confesses to the crime, accepts the punishment, and only then ends his alienation from society. Values are not abstract or lofty ideas, but guiding principles which inform and direct ways of acting that have consequences in the world.

The general assumption in ACT is that when we encourage people to freely choose, they will choose prosocial actions or at least actions that won't harm others. We humans are, by nature, social and interdependent (see social view section). If we were to choose to enact antisocial values, we would fail to satisfy our fundamental need for social connection. There is now good evidence that antisocial behavior is linked to worse mental health and lower self-esteem (Ciarrochi et al., 2019).

Generally, research suggests that helping people to choose valued action will lead to them experiencing a higher satisfaction of their basic needs for competence, connection, and autonomy (Chen et al., 2015; Ryan & Deci, 2017). There is also evidence that having people affirm their values can help them overcome stereotype

or ego threat and perform at a higher academic standard (Bancroft et al., 2017; Cohen & Sherman, 2014).

## 5 Advisor: Crises Involving Incoherence and a Shattering of "Reality"

Humans spend much of their lives inside an "interpreted" reality which can shatter when it no longer matches physical reality. We can think we are immortal and important, until the moment the world confronts us with death and indifference.

Our "advisor" is a label to describe our inner voice, our learned verbal behavior that allows us to predict and plan. It is constantly shaping our symbolic and physical reality. It is relentless and never turns off. We offer ourselves advice like "You've got to try harder" and, more unhelpfully, "You are so broken that no one can ever love you." When the advisor is working well, it helps us to navigate our physical environment efficiently and to avoid trial-and-error learning. An adaptive advisor allows us to benefit from advice communicated from others' experiences, without us needing to suffer the consequences of a poor decision. If I say, "Avoid that tree. There is a poisonous snake living under it," you know what advice to give yourself when you approach the tree: "Stay away!"

Our advisors are so useful that we use self-talk not only to interpret reality but also to "build" preferable realities in our head. We use it to try to make all future threats disappear (worry), to make the past seem more palatable (rumination), to symbolically dominate another or to win their approval (resentment, reassurance seeking), and to fix the parts of our self that the advisor has evaluated as broken (self-criticism). We often fail to notice when our advisor strategies are failing, and our interpreted reality is becoming more and more disconnected from physical reality.

As the figure below illustrates, there are two pathways we can take in response to our own unhelpful advice. We can take the top pathway and respond to our advisor's conclusions by staying with our self-talk and engaging in problem-solving and reasoning. When this becomes excessive, it is termed "fusion" in the hexaflex model, as in a fusion between words, the person, and action – they become one. Fusion increases the impact of the unhelpful conclusions on our behavior. When fused, we believe that "Life is meaningless" is a literal truth, and we must act accordingly.

The top pathway involves seeking "coherence" between our thinking and our external world. We experience a shattering of coherence when the physical world contradicts our understanding. For example, we might want to believe, perhaps unconsciously, that "people must always have my best interests in mind." And then, when a lover betrays us, we may be shocked, and our world seems destroyed. "If this person can betray me, anybody can betray me." Then we create new self-advice, "I must never trust anybody again." These verbal statements cohere with each other, to some extent, and perhaps help the person feel a sense of control, even though they often have long-term costs.

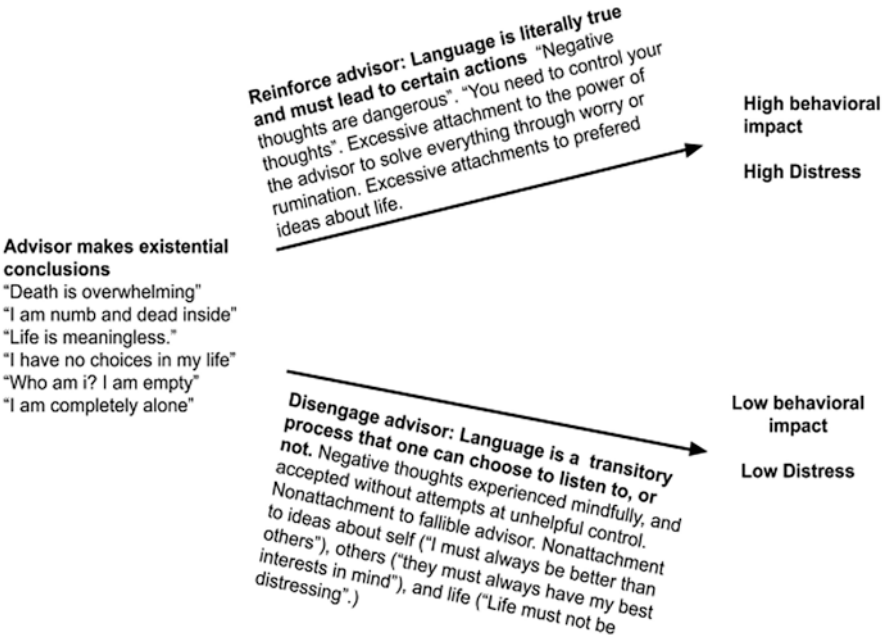



**Fig. 4** The two ways of relating to the advisor

When our advisor is not being helpful, the remedy for this is to lessen such advisor activity and to shape and reinforce the second path (Fig. 4). We help a person disengage from their advisor and move into their noticer, valuer, or discoverer space. That is, we encourage people to experience their thoughts mindfully (noticer) or to think about what brings vitality and meaning (valuer), and/or to engage in new, value-consistent action (discoverer). We invite people to make space for advisor incoherence, for the possibility that our advisor has spun a story that is useless. This opens the way for a new kind of coherence, one that is not based exclusively within an interpreted world. Rather, it is based on functional coherence, which is a clear link between advisor content and effective, real-world action. The question shifts from, "Is my reasoning right?" to "Is my reasoning useful?"

Disengaging from our advisor is not always easy. Our advisor is such a constant companion that we fail to notice it in the background restructuring our world. In fact, the advisor is so ubiquitous that we are often completely unaware of it, and then we believe that the contents of our thoughts are the unquestionable truth. ACT helps to increase awareness through structured mindfulness, curious observing of thoughts, and homework that involves noticing unhelpful thoughts as they occur in daily life (Hayes & Ciarrochi, 2015; Hayes et al., 2012).

People are sometimes reluctant to disengage from their advisor because they are attached to its seeming power. We worry, ruminate, judge others, and judge ourselves because we think it helps. For example, we often value worry, because we believe it will help us avoid problems and disastrous situations (Cartwright-Hatton

& Wells, 1997). Worry can also feed into the illusion of control and can encourage a mistaken belief that the act of worrying is adaptive; for example, "if I worry about every possible worst case scenario, I will be better prepared when one does occur" (Wells, 2006). Unfortunately, our advisor is rarely helpful for existential questions like, "What is the meaning of life?" because if we depend on reason for an answer, we will become despondent and give up, for words are unable to solve this problem. The advisor is not in charge of meaning, it is the servant.

Advisor attachment also occurs when we cling to an idealized version of life, where we convince ourselves that we should always be treated fairly, be better than others, have pleasant lasting experiences, or have a life without regrets. When reality inevitably violates these false ideas, we suffer unnecessarily (Ciarrochi et al., 2020; Ellis & Harper, 1961; Sahdra et al., 2010) and become less effective at achieving our goals (Sahdra et al., 2015). For example, imagine someone is given an unfair job promotion and you are overlooked. You will not only experience distress at the lost opportunity ("clean discomfort"). You might be attached to the idea that things should have never been this way and should not be unfair. You might ruminate about the problem, resent the coworker, and become increasingly distressed and distracted at work ("dirty discomfort"; Hayes et al., 1999).

When we are attached to an idea about how the world "should" be, we may use our advisor in an attempt to magically transform the world (Sartre, 2000). In the above example, we may seek to deal with the unfair promotion by engaging in rumination: "The coworker will fall on his face eventually. The promotion was not that good anyway." Unfortunately, both rumination and worry only add to our distress and rob us of the opportunity to face realities and cope with or manage them. Magical thinking is the beginning of what Sartre calls "bad faith" or the tendency to deceive ourselves and deny we have choices and freedom (Sartre, 1967). The ACT solution to this problem is typically not to argue with people, or reinforce advisor behavior, but rather help people to experience life from less verbal "spaces."

## 6 Noticer: Crisis Involving Emotions and Alienation from the Physical Body

Language allows us to create verbal labels for our emotions, like "anxiety," "sadness," and "guilt." Then we learn to evaluate these states as good or bad. We can magnify the aversiveness of anxious sensations, with thinking like, "I can't stand feeling anxious," "If I feel sad, something is wrong with me," or "guilt is horrible" (Ciarrochi & West, 2004). Once emotions are "horrible," we use our advisor to solve the "emotion problem" through a vast array of experiential avoidance strategies, such as drinking, avoiding situations, and thought suppression. Most experiential avoidance strategies are ineffective and lie at the heart of clinical disorders (Hayes et al., 1996).

Experiential avoidance alienates us from our own bodies and leads us to avoid contact with how we are feeling from moment to moment (Lindsay & Ciarrochi, 2009). When we derive sensations as an enemy, we must, by necessity, see our bodies as the enemy, because it holds and generates the sensations. We seek escape from this "enemy" by fighting, fleeing, or freezing in the presence of the bodily signals, just as we would in the presence of a dangerous foe. We become strangers in our own bodies. Not only can this body alienation be a source of fear and angst (Ciarrochi et al., 2008); it can interfere with our ability to form supportive relationships (Rowsell et al., 2016), which typically require identifying and sharing emotions.

Noticer interventions typically involve three components: normalizing, awareness, and accepting (Hayes & Ciarrochi, 2015). Concerning normalizing, ACT practitioners help people to see that all feelings are merely signals and are not inherently good nor bad. Attacking one's body because it sometimes holds unpleasant experiences is as misguided as attacking one's phone because it sometimes receives unpleasant text messages. Once people begin to view emotions as normal, they are more willing to accept that some of their experiential control strategies have not been working and are more willing to allow and accept bodily sensations. They learn to notice emotion-related sensations with curiosity, without reacting to them.

Noticer interventions have much in common with those found in mindfulness interventions and emotion-focused interventions, especially those that emphasize observing, identifying, describing, and non-reactivity to feelings (Greenberg & Pascual-Leone, 2006; Gu et al., 2015; Wiebe & Johnson, 2016) and have been shown to improve our connection with our emotions (Cooper et al., 2018). By helping people to end their war with their body, we believe noticer interventions reduce the feeling of emotional alienation and promote visceral, emotional connection to meaning. Meaningful lives are not based merely on thought but also on feeling, on visceral connection to gravity and other people.

## 7 Discoverer: Crises of Action

Low skill in recognizing and engaging with advisor, noticer, or valuer can lead to a crisis in action. For example, low skill valuers may refuse to act because they can find no external justification for their action, cannot make sense of their life, or cannot generate the "right" feelings for action, such as enthusiasm or hope.

We overcome these barriers by first agreeing with Sartre (1967): existence precedes essence. We are not defined by what we think (advisor) or feel (noticer), but rather by what we overtly do (discoverer). Indeed, it is in the doing and discovering of life that we improve our thinking and feeling skills.

We can understand the discoverer by contrasting it with the advisor. When we are in advisor space, we are seeking to avoid trial-and-error mistakes; when in discoverer space, we are seeking trial and error, monitoring consequences, and embracing mistakes as a way of learning. Discoverer is the ultimate get-out-of-jail card. Even

when we feel completely stuck and don't know what we feel or care about, we can still act and see what happens next.

Many interventions, including the hexaflex versions of ACT, promote discoverer skills, even if they don't use this label. Positive psychology interventions also encourage people to explore to "broaden and build" their skills, social connections, and resources (Cohn & Fredrickson, 2010). CBT promotes behavioral activation, even in the presence of sad feelings (Dimidjian et al., 2006), and behavioral experiments to explore and experience new behaviors and evaluate beliefs (Bennett-Levy et al., 2004). Many clinical interventions engage in functional analysis to help people see and track the consequences of their behavior (Hurl et al., 2016). Exposure is perhaps the most validated clinical intervention (Feske & Chambless, 1995), and can be seen as a broadening and building, or discovery process. Through exposure, people discover new ways to relate to their feared object and new ways of viewing the object.

## 8 Self-View: Crisis of Identity

Let's return to Sartre's quote: "Existence precedes essence" (Sartre, 1967). This is such a profound idea because many people believe the exact opposite: "Essence precedes existence." They believe that some aspect of their genes, personality, or character dictate how they must act. This way of thinking is a trap. If we believe that our essence dictates what we do, then we cannot develop beyond our self-beliefs.

We cling to our self-evaluations and stories, even when that story is negative. People will defend the idea that they are really "not good enough." We attach to self-stories for two reasons. First, the story seems to protect us. For example, If we believe, "I am useless at math," then we will not try to learn math and avoid the disappointment of failing. If we believe "I am unlovable," we will avoid seeking love and risking rejection. Second, the self-story becomes equated with our essence. We don't think, "I'm having the **evaluation** that I am unlovable"; we think "I **am** unlovable." We think unlovable is our essence, in the way that ceramic is the essence of a cup. Then, we cannot challenge "unlovable" without seeming to destroy ourselves.

The ACT/DNA-V way of handling this issue is to encourage perspective taking directed at the self (Foody et al., 2013) and to see that our self-evaluations are just one aspect of us that we hold or carry. The verbal "I" which is experienced as *here* learns to "look" at selfing behavior, which is experienced *there*. For example, "I see that I am evaluating myself as broken." Once "I" is experienced as an observer that is separate from the evaluation, we are then free to listen to the evaluation or disengage from it.

We help people to develop a sense of self-as context (Dermot Barnes-Holmes et al., 2001), to see themselves as the holder of the DNA-V processes. We are noticers, advisors, discoverers, and valuers at different times. We are also the ones who shift between these spaces. Therefore, we are more than our ineffective behavior,

unhelpful thoughts, or unpleasant feelings. We hold them all. To use a metaphor, we are the sky, and our experience is the weather (Kabat-Zinn, 2013). The core idea behind this kind of intervention is that if people can identify with their observer self or self-as-context, they will more easily let go of unhelpful self-concepts. Self-concepts are not real things that define our essence.

Research supports the value of self-as-context interventions. The tendency to experience self-as-context is linked to well-being and mindfulness (Zettle et al., 2018). Further, ACT creates self-as-context, and this predicts improvements in functioning (Yu et al., 2017). Though not explicitly discussed in ACT, we might also classify growth mindset interventions as promoting a flexible self-view (Dweck, 2008). These interventions teach people to view themselves as changing and growing and not fixed. There is reliable evidence that growth mindset interventions have at least a small effect on well-being and performance (Burnette et al., 2020; Miller, 2019; Yeager et al., 2019). Similarly, we classify self-compassion interventions as promoting self-view. These interventions ask people to see themselves as someone who sometimes suffers and deserves kindness. Self-compassion interventions have been showing promising effects (Ferrari et al., 2019; Wilson et al., 2019).

## 9 Social View: Crisis of Isolation and Loneliness

Humans need others as much as they need clean air. Chronic loneliness can make us as sick as smoking ten cigarettes a day or being chronically obese (Hawkley & Cacioppo, 2010; Heinrich & Gullone, 2006). In contrast, social connections give us physical and emotional support, help in reaching goals, greater access to ideas and knowledge, and the ability to accomplish things that we could not accomplish by ourselves (Adler & Kwon, 2002; Ciarrochi et al., 2017). If relationships are so important to us, why is it so hard for us humans to get along? 15–30% of people experience chronic loneliness (Hawkley & Cacioppo, 2010).

There is an existential tension between our individual needs and group needs, between selfishness and cooperation. For example, if we give our time to helping others, we may give them the advantage over us, or we may allow them to take advantage of us. However, if we fail to support others, we may develop a bad reputation and lose people's trust. Research suggests that the best social strategy often depends on context. For example, people are less likely to cooperate in contexts where cooperation payoff is low, where it is unclear who is cooperating and who is cheating, or where the environment comprises a high percentage of people using noncooperative strategies (Dal Bó & Fréchette, 2019; Grant, 2013). The solution to this problem, if we want to increase cooperation, is to create environments in which we reward cooperation (Biglan, 2015).

ACT undermines strategies that destroy social relationships, such as refusing to take another's perspective and avoidance of social situations. But why would we avoid social situations unnecessarily?

We have argued that the advisor's job is to keep us safe. If we look to our evolutionary past, we discover that the greatest danger to humans was often not tigers or snakes: it was other humans. War and murder were one of the most common causes of death in prehistoric times, and our advisor adapted to this (Pinker, 2012). Thus, our advisor has evolved to keep us safe *from others*. We are constantly seeking to infer people's intentions and assess their trustworthiness. When we are chronically lonely, we become stressed, hypervigilant to social threat, and more likely to see people's behavior as negative (Hawkley & Cacioppo, 2010). Our language skills give us the ability to verbally transform any human into an uncaring person or a monster. If we are not careful, we will end up inside a verbally interpreted world with nothing but monsters.

Making matters worse, we can become addicted to self-enhancing consequences (ego; see self-view above). We see life as a zero-sum game, where the only way I can enhance myself is by bringing you down or not letting you shine. Research suggests that people who are able to let go of self-enhancing feelings and thoughts, that is, those who are non-attached, are more likely to engage in prosocial behavior (Sahdra et al., 2015).

All the ACT interventions described previously can be used to target ineffective social behavior. If people are addicted to self-enhancement, we can help them to let go of the ego (self-view), in the service of building relationships (valuer). If people have an overactive advisor who distrusts everybody, we can help them to be aware of this bias and to disengage from the advisor sometimes and use discovery to find out what a certain person is like. We can also help them notice the feelings of distrust without automatically reacting to them. If experience teaches us that a person can't be trusted, we can use discovery processes to find the best social strategy for managing this person. Finally, we teach people to take perspective, which often has the effect of transforming someone from an inhuman monster to a merely human one, or perhaps no monster at all.

## 10 Conclusion

Humans make the same life journey. We all start in the physical world of sun, wind, and rain and rely on safe and reliable physical contact with our caregivers. We travel along this path for about one or two years, touching the earth with our senses and connecting and depending on others for our needs without using words. Then, gradually, we develop language. We start verbally "touching" and transforming the earth and our relationship with others. Soon, we don't just see sun and rain; we see "good," "bad," "terrible," "lovely," "meaningless," "right," "wonderful," "intolerable," "mine," "theirs," and "can't." We use words to gain power, to learn complex skills from books, to build social alliances, and to persuade others. Our words are so useful that soon we think they can solve everything. We think we can use words to make death disappear ("I will live through my work"), to make everybody respect us ("She knows I am better than her"), to make all those who don't love us into

villains ("They have no heart"), and to make life fair ("People deserve what they get"). But the physical world does not care about our words. The physical world breaks through the walls of our interpreted world when we experience loss, unfair treatment, social exclusion, sickness, and death. If we react to these existential crises with denial, we can become lost in our verbal mazes, searching for a way out.

> O waste of loss, in the hot mazes, lost, among bright stars on this most weary unbright cinder, lost! Remembering speechlessly we seek the great forgotten language, the lost lane-end into heaven, a stone, a leaf, an unfound door. Where? When? – Wolfe, Thomas

Words don't lead to the unfound door. They lead away. How far have we strayed from that preverbal world of sun, wind, and rain and from a connection with another person that is beyond words? Not far. This world is still here, now. Meaning is here, now, if we awaken.

ACT seeks to promote this awakening in six ways. First, ACT helps people to become aware of values and choose to organize their lives around them (valuer). Second, ACT seeks to increase awareness of verbal processes (advisor) and teaches people to use these processes when useful and disengage when not useful. Third, it promotes present moment awareness and acceptance of all experiences, both internal and external, good and bad, so that people are no longer at war with unpleasant sensations and their own bodies. Rather, through their body, people learn to let the nonverbal back into their lives. Fourth, ACT helps people engage in exploratory action. Through trial-and-error experience, people discover meaning (discoverer). Fifth, ACT helps people to recognize self-limiting thoughts as they occur, to see that they are the observer of these thoughts and not the same as the thoughts, and to take a kind, compassionate view of themselves (self-view). Finally, ACT teaches us to take perspective of others and to recognize our fundamental interdependence (social view). Together, these processes help people to confront existential crises with courage and acceptance, break through the delusion of wishful thinking, and create a life that is meaningful and deeply connected to others.

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