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Existential therapies and the extended evolutionary meta-model: Turning existential philosophy into process-based therapy

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ABSTRACT

This article reviews the central theoretical claims found in the various psychotherapeutic approaches broadly referred to as the existential therapies. Despite substantial differences across existential packages, these therapies broadly arise from the theoretical position that the pain and suffering common to our species arises, not from illnesses hypothesized in traditional medical and psychiatric accounts, but rather from a set of existential concerns that all humans must face. These 'givens' of existence include death, identity, isolation, meaning, and freedom. From this theoretical perspective, all branches and brands of psychotherapy need to include some procedures to address these issues. Evidence for the importance of these constructs in human experience is presented, followed by evidence for existential therapies themselves. A dearth of quality research trials establishing a strong evidence base for this branch of therapy was noted. Further, process-based research in this area was shown to be weak. That is, few researchers have sought to show that the hypothesized processes are responsible for the changes observed in existential therapy. We describe how viewing existential therapy through a Process-Based Therapy (PBT) framework and the Extended Evolutionary Meta-Model (EEMM) will encourage: (1) a greater examination of the processes of change occurring; (2) an expansion in the way in which existential therapies operate, enabling the inclusion of procedures drawn from other therapeutic modalities; and (3) more nuanced targeting of existential processes in any given case.

The family of therapies that may be regarded as existential are a somewhat diverse group of approaches, although they share common aims. In the broadest sense, existential therapies aim to explore the way in which each individual "comes to choose, create and perpetuate his or her own way of being in the world" p. 2 (Cooper et al., 2019). In both its theoretical orientation and practical approach, existential therapy explores what it means to be human. It considers the unique 'problems of being' that all humans must face as they attempt to find their way in the world. The boundaries of what might be considered an existential therapy are vague, but textbooks in the field would typically include, at a minimum: (1) Daseinsanalysis based on the philosophy of Heidegger; (2) Existential-phenomenological therapy, derived heavily from various schools of philosophy of Ancient Greece; (3) Existential-humanistic therapies emerging from the works of Rollo May, James Bugental and Irvin Yalom; (4) Logotherapy, a meaning-centred approach to counselling, and; (5) Existential Group Therapy, which highlights a fundamental difficulty in the human condition - being an autonomous individual that must exist in a social context (see van Deurzen et al., 2019 for a comprehensive review of the full range of existential therapies).

At their core, existential therapies share the notion that human suffering is the result of a series of existential 'givens'; aspects of life that are inherent to the human condition (Cooper et al., 2019). The different types or brands of existential therapy focus on different 'problems of being' that may include, but are not limited too: (1) death awareness (i.e., the fact that by the end of the first decade of life all humans are aware that one day they will cease to be sensate and will die); (2) isolation (i.e., that we must live out our days with only one consciousness, never knowing the inner experiences of another person); (3) meaninglessness (i.e., the realization that one is little more than an evolved ape and that our daily activities have no inherent meaning); (4) identity (i.e., the endless search for an authentic sense of self or, put differently, a genuine answer to the question "Who am I?"), and; (5) freedom (i.e., the burden that one must make choices between the various options at school, college, in relationships and so forth, and that these choices will determine our future). In sum, existential therapies propose that the burden

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of these and other 'givens', in all of their complex interactions and combinations, inherently cause psychological pain and maladaptive behaviour.

Notably, existential therapies (ETs) inherently reject medical models of psychopathology that emphasize the idea of malfunction in the form of neurotransmitter imbalances, genetic weaknesses and the like. In contrast, existential therapies view psychological pain as part of the normal human condition – in fact, it is a necessary part of human experience that cannot be avoided (Cooper et al., 2019). ETs also reject psychiatric diagnosis as the linchpin of clinical work, (although it may be useful for the purposes of communication), because diagnosis does nothing for describing an individual's existential issues. For example, someone with Major Depressive Disorder could be suffering from an inability to accept their inevitable death, the pains of isolation from all others, a lack of meaning in the repetitive nature of their mundane daily life, an inability to understand the self, feeling impossibly stuck and defeated in choosing a direction in life, or any combination of these factors. Finally, inherent in the existentialist position is a partial rejection of the notion that patterns of behaviour acquired through punishment and reinforcement (e.g., avoidance in phobias) are the fundamental cause of mental health problems. This is because the *deeper* cause is viewed as centering on an existential given (e.g., death awareness). Having said this, the notion that the individual may engage in self-defeating behavioural, psychological, and emotional patterns that help maintain mental health problems is completely consistent with an existentialist position (see further van Deurzen et al., 2019).

This paper shall firstly explore the evidence for the role of the various existential dimensions in mental health, before examining research supporting the therapy programs that have emerged in this domain. It is beyond the scope of the present paper to explore all of the evidence for all of the proposed processes for all of the divergent existential therapies that exist. Accordingly, the focus is on the existential themes discussed above. Strong support for the influential role of these existential factors in mental health conditions will be shown, particularly for death awareness. In contrast, the research base for existential brands or packages is insufficient to support them as first-line therapies. It will be argued that Process-Based Therapy (PBT) and the Extended Evolutionary Meta-Model (EEMM) offer a way forward for working in this domain, rather than simply conducting more randomized controlled trials in favour of one program over another. A case illustration will demonstrate how PBT and EEMM allow for an expansion of existential therapies to include a range of findings on critical existential processes that have arisen in other fields (e.g. social, developmental and cognitive psychology).

1. Evidence for the mediating role of existential concepts

1.1. Death

Of the five existential concerns, the strongest evidence exists for death awareness as a significant mediator of adaptive and maladaptive behaviours. Terror Management Theory (TMT) (see further Pyszczynski et al., 1999) proposes that the desire to live, combined with our awareness that death can arrive at any moment, leaves all humans with an existential tension that must be managed. In the main, these theorists argue that we use various forms of denial in claiming a *literal* immortality (i.e. through religious belief systems and/or an afterlife) or a *virtual* immortality (i.e. through adhering to cultural worldviews that make us seem larger than the self; part of a community that existed before we were born and will continue after we die). As Solomon et al. (1991) put it, humans "could not function with equanimity if they believed that they were not more significant and enduring than apes, lizards, or lima beans" (p. 96). TMT is supported by hundreds of mortality-salience (MS) studies demonstrating that subtle reminders of death drive a wide range of behaviours including the urge to spend money and consume, have children, create permanent products and achieve a legacy, consult a doctor for a checkup, aggress against people of other ethnicities, punish transgressors, and adhere to religious and sociocultural values (see Menzies & Menzies, 2021 for a review).

Iverach et al. (2014) argued that the evidence for death anxiety as a driver of mental health problems is so strong that it should be regarded as a pivotal transdiagnostic contrast that must be addressed in mental health treatment across a wide range of conditions. They argued that cognitive-behavioural treatments typically target surface-level manifestations of death anxiety (e.g., handwashing in OCD), reducing symptoms but failing to address the existential core of the disorder. Death priming in the laboratory has been shown to increase maladaptive behaviours in outpatients with OCD (Menzies & Dar-Nimrod, 2017), panic disorder, illness anxiety disorder, and somatic symptom disorder (Menzies et al., 2021). Experimental research supporting the role of death anxiety as a driver of phobic disorders (Strachan et al., 2007), eating disorders (Forrester et al., 2024), and body dysmorphia (Menzieset al., 2022) is also strong. Further, severity of death anxiety has even been found to predict number of life-time diagnoses, number of hospitalizations, number of psychotropic medications prescribed, and symptom severity in heterogenous clinical samples (Menzies & Dar-Nimrod, 2017; Menzies et al., 2019).

Finally, large and significant, positive relationships have been found between death anxiety and severity of specific mental health disorders including OCD, phobias, illness anxiety disorder, panic disorder, separation anxiety disorder, alcohol use disorders, depression, social anxiety disorder, and somatic symptom disorders (see further Menzies et al., 2022). Given these findings, it has been speculated that the failure to treat the existential core of mental health disorders is contributing to the 'revolving door' so often seen in clinical practice, in which a client is treated 'successfully' for a specific condition (e.g. separation anxiety disorder) only to return with another disorder (e.g. panic disorder) at a later date (Menzies et al., 2019). This clinical observation is supported by recent meta-analytic findings (see further Menzieset al., 2024a), suggesting the need to target existential issues which may be contributing to this 'revolving door'.

1.2. Isolation

Existential isolation refers to the unbridgeable gap that exists between the self and all others (Yalom, 1980). Since we only experience the consciousness of one individual (i.e., the self), we are never privy to the private longings, desires, memories or pains of another. No matter how close we may get to another individual, these aspects of their inner world remain distal from us. That is, "an uncrossable bridge will lie between us and all others", a bridge that will remain in place from birth to death, destabilizing the individual (Menzies & Menzies, 2021, p. 2).

Research on the relationship between existential isolation and mental health is in its infancy but early findings are encouraging. Several studies have found positive relationships between existential isolation and measures of depression and anxiety (Constantino et al., 2019; Kretschmer & Storm, 2017; Mayers et al., 2002). Helm et al. (2020) reported that existential isolation, even when loneliness was held constant, accounted for unique variance in depression and suicidal ideation in young adults. In addition, positive and significant correlations have been reported between measures of existential isolation and overall OCD severity (Chawla et al., 2022). In particular, existential isolation has been found to be strongly associated with certain presentations of this disorder, such as relationship OCD (Menzies, 2024). Existential isolation has also been found to be elevated amongst people with borderline personality disorder, and to predict depression, anxiety, and stress among this group (Menzies, Sharpe, et al., 2024).

In contrast to existential isolation, the relationship between interpersonal isolation (i.e. loneliness associated with social distance) and impaired mental health is very well established. Dozens of studies have found positive, significant and large relationships between these constructs (e.g. Akelind & Hornquist, 1992; McClelland et al., 2020;

Richardson et al., 2017; Russell et al., 1984; Stravynski & Boyer, 2001; Theeke et al., 2014; Tremeau et al., 2016). In addition, treatment packages targeting interpersonal isolation, often referred to as 'social prescribing' programs, have been found to reduce social anxiety, depression, loneliness, general practitioner visits, and increase life satisfaction and social functioning (for a review, see Dingle & Sharman, 2022).

1.3. Identity

Perhaps never before in human history has identity been the subject of such scrutiny in the general community. The possible ways in which one can identify seem almost infinite and are challenging our notions of what it is to be human (Rhodes, 2022). Higgins (1987) proposed that the notion of self is complicated by three versions that are constantly in interplay: (1) the actual self (i.e. including the component parts that the individual believes they possess); (2) the ideal self (i.e. including the qualities that the individual aspires to possess); (3) the 'ought' self (i.e. including the qualities expected of the individual from a sociocultural point of view).

Recent findings suggest that a fractured, uncertain or labile sense of self increases vulnerability to obsessive-compulsive symptoms and other mental health difficulties (see further Bouguettayu et al., 2022). Instability in one's sense of self is also a key symptom in borderline personality disorder (Liu et al., 2023), with identity concerns being shown to predict poorer mental health amongst this population (Menzies et al., 2024b). Similarly, fear of self (i.e. "who am I really, and what am I capable of") has been found to be a unique predictor of unacceptable thoughts, negative mood states and obsessive beliefs in clinical samples (Aardema et al., 2018; Melli et al., 2016). Similarly, identity concerns have been shown to be significantly related to sexual (but not aggressive) obsessions in OCD (Chawla et al., 2022), as well as symptoms of relationship OCD (Menzies, 2024).

Despite these encouraging results, it must be acknowledged that all findings on the self to date are correlational. At present, there exists no demonstration that laboratory manipulations of the self reliably impact mental health symptoms in predictable ways. Thus, despite decades of interest in the self, experimental research is sorely needed to establish the importance of this existential given in mediating maladaptive behaviours.

1.4. Freedom

Sartre (1999) argues that we are "condemned to be free" since we must constantly choose from a seemingly unlimited, and ever-changing, list of life directions open to us. According to the existentialists, freedom involves a heavy burden since, in choosing one action over another, we are implicitly signaling the merits of the choice. For example, in choosing not to get a COVID-19 vaccination one might ultimately influence another to do the same. Endless possibilities or options for action give rise to regret and ontological guilt (i.e. the guilt that may arise from not living up to one's potential), common themes in clinical presentations (see further, Menzies, 2022a). Rumination about decisions that have been made in the past is a feature of many disorders, most obviously OCD and Major Depressive Disorder. Menzies and Menzies (2019) describe cases of 'real-event' OCD in which an individual continual replays actual happenings from their life, often occurring decades earlier, searching for fault or personal blame. Existential guilt has been found to be associated with symptom severity in people with OCD aggressive obsessions, (Chawla et al., 2022), borderline personality disorder (Menzies et al., 2024a,b; Menzies, Sharpe, et al., 2024) and even poorer mental health in people with physical illnesses, such as rheumatoid arthritis (Sharpe et al., 2023).

Treatment recommendations for regret include elements of applied stoicism, acceptance-based strategies, self-compassion, mindfulness exercises, and eliminating the desire to maximise all outcomes (Schwartz & Ward, 2004; Zeelenberg & Pieters, 2007). While research support for these procedures exists, they have typically been included in larger programs as part of a broader treatment target. Research designs to date do not allow any meaningful conclusions to be drawn on the mediators of change in treating the pains of existential freedom (see Menzies, 2022b for a review).

1.5. Meaninglessness

Consistent with the arguments of Camus and Sartre, Frankl, 1962/2004 placed life meaning at the centre of logotherapy, arguing that the desire to find personal meaning is central to human well-being. Similarly, Seligman et al. (2006), Wong (2010) and Steger (2012) have all suggested that 'found meaning' is critical to well-being or flourishing. Further, establishing meaning in life is inherent in several other branches of therapy, although not explicitly being the target of the intervention. For example, Ciarrochi et al. (2022) argues that Acceptance and Commitment Therapy (ACT) inherently promotes a meaningful life through its emphasis on values-based living, present-moment awareness, self-compassion and exploratory action. Consistent with this position, Sharp et al. (2004) have suggested possible integration of ACT and logotherapy.

Considerable support for the importance of life meaning has been found in longitudinal studies with community and clinical samples. In a large study involving nearly 800 adults from multiple countries, high scores on the Meaning in Life Questionnaire (MLQ) predicted low depression scores at three- and six-month follow-up (Disabato et al., 2017). Life meaning has also been shown to buffer the negative effects of life trauma and loss (e.g. Krause, 2007), and low scores on life meaning have been shown to increase vulnerability to depression (Volkert et al., 2014). Finally, an absence of found meaning has been associated with suicidal ideation and action in many studies involving adolescents and adults (e.g. Chan, 2018; Harlow et al., 1986; Lester & Badrow, 1992; Schnell et al., 2018).

2. Evidence for the existential therapies

Although evidence for the role of the individual existential constructs is growing, there is surprisingly little evidence for the efficacy and effectiveness of specific existential treatment programs. Vos et al. (2014) reviewed the evidence on the efficacy of different types of existential therapies. Twenty-one randomized controlled trials were found, however only 15 reported on unique data sets. These studies, comprising 1792 participants, were included in the analysis of weighted pooled mean effects. In an unsurprising finding, given the target of these treatments, meaning-oriented therapies (n = 6 studies) showed large effects on positive meaning in life immediately post-intervention (d = 0.65) and at follow-up (d = 0.57). They also had moderate effects on measures of psychopathology (d = 0.47) and self-efficacy (d = 0.48) at post-treatment, although long-term effects were not reported. Supportive-expressive therapy (n = 5 studies), a manualized approach to gaining self-control over substances, had small effects at posttreatment on measures of depression and anxiety (d = 0.20). However, effects on self-efficacy (n = 1 study) and self-reported physical well-being (n = 4 studies) were not significant. Several studies did not report significant reductions in psychopathology, although all studies were underpowered, making conclusions difficult to assess. Finally, it should be noted that the participants in these trials were generally drawn from populations of physically ill people, making the generalization of findings to the general community difficult. Meaning-making strategies and existential therapy more broadly have been a focus of therapy in terminal illness cohorts.

Research in this area is growing and a recent review by Vos (2023) describes a significantly larger pool of studies revealing similar effect sizes for treatment to his previous review. If we include studies targeting existential constructs, rather than using published existential

approaches to treatment, a greater pool of studies can be found. For example, Menzies, Zuccala, Sharpe & Dar Nimrod (2018) identified fifteen randomized controlled trials targeting death anxiety in their meta-analysis and review. Across these trials small to medium effects on death fears were reported (Hedge's $g = 0.45$). Cognitive behaviour therapy (CBT) produced significant reductions in death anxiety relative to control, whereas other therapies did not. Unfortunately, Menzies et al. (2018) noted the low quality of the included studies which were generally underpowered, did not include clinical samples, and displayed bias toward finding effects.

Clearly, more work is needed to establish the processes and procedures of existential therapy. However, in our view, more group-based, head to head trials of existential brands is unlikely to advance clinical care because such trials fail to address the idiosyncratic existential needs of the individual at any given point in their history. In a similar vein, Vos et al. (2014) notes that no studies have attempted to assess which existential intervention works best for which individual client.

3. Process-based therapy (PBT) and the extended evolutionary meta-model (EEMM)

Hofmann and Hayes (2019) trace the history of manualized packages for disorders to assumptions based on medical models of mental health problems in the past. If one assumes that mental health disorders are homogeneous conditions that are the result of specific malfunction or malformation in the organism (e.g. neurotransmitter imbalances, genetic errors), then identical treatment protocols should be effective across individuals. However, as Hofmann and Hayes (2019) persuasively argue, diagnostic labels have failed to deliver us homogeneity, just as biomedical research has failed to find specific lesions, genetic or brain sites for disorders (see also Hayes et al., 2019; Hayes et al., 2020). For a variety of reasons, it is clear that the psychological pains of being human are too complex for the assumptions of a medical model. Most obviously, mental health problems reside in individuals who have lived completely unique lives, experiencing a unique set of triumphs and tribulations. The processes at play in their adaptive and maladaptive responses to the world will also, unsurprisingly, be unique, as will be their therapy goals. It is for these reasons that Hofmann and Hayes (2019) urge us to consider "What core biopsychosocial processes should be targeted with this client given this goal in this situation, and how can they most efficiently and effectively be changed?" This is the key question in Process-Based Therapy (PBT) (see further Hofmann et al., 2021).

In PBT, Hofmann and Hayes (2019) reintroduce the notion of a functional analysis, a prominent feature of early behavioural work that appears to have been sidelined in favour of randomized controlled trials of completely replicable treatment packages. Psychotherapy, particularly within the dominant school of cognitive-behaviour therapy, appears to have moved away from the individual in favour of establishing large group effects with tightly controlled protocols (see further Hofmann & Hayes, 2019; Hofmann et al., 2021). In response, Process-Based Therapy focusses on the network of processes at play in the individuals presentation, a network that may change across time within the treatment. In this way PBT frees the therapist from the limitations of their particular therapeutic orientation by encouraging an exploration of any evidence-based processes that may be active in the individual.

In order to allow communication across various therapeutic modalities Hofmann and Hayes (2019) introduced an Extended Evolutionary Meta-Model (EEMM) to describe the various layers of process that may be present. The meta-model includes six dimensions (i.e. affect, cognition, attention, self, motivation, and overt behaviour), multiple levels (i.e. individual, physiological and sociocultural), and allows for both adaptive and maladaptive processes to be included. Emphasis is placed on both the strengths and weaknesses in the client's presentation. Finally, consistent with evolutionary models more generally, problems are analysed in terms of variation (e.g. is the client too rigid in their behavioural responses, never experiencing sufficient variation to enable learning and adaption?); selection (e.g. what functions do particular thoughts or behaviours serve?), and; retention (e.g. what are the maintaining behaviours that work in one's repertoire?).

4. Existential therapies (ET) as a form of PBT

Existential approaches to psychotherapy fit neatly into the PBT framework right from their basic assumptions. First, as stated above, existential therapies inherently reject the biomedical model and obsession with diagnostic labels, aligning them closely with core ideas of PBT. As we have seen, the existentialists normalize psychological distress, arguing that it is in the nature of being human to experience emotional pain. In addition, their work is already predominantly individualized. Few existentialists argue for identical, replicable treatment packages (although in the interests of RCTs, some protocols have emerged). Yalom (1980), for example, does not seek a manualized approach, but suggests that growth comes from a thoughtful and fulsome exploration of one's pain: "At this moment, at the deepest levels of my being, what are the most fundamental sources of dread?" (p. 11). In addition, existential therapies and PBT both aim to enhance adaptive features (e.g. well-being, self-actualization) rather than simply remove maladaptive features (e.g. symptoms).

Yalom's (1980) form of psychotherapy is perhaps the most widely known of the existential approaches, and shall be used to illustrate the ways in which ETs can be seen through a PBT lens. Yalom's (1980) model includes four of the five existential domains discussed above, namely death, freedom, isolation and meaninglessness. In his model, anxiety is said to arise from becoming aware, or 'awakening' to the existential concern. To deal with the anxiety arising, the individual appeals to various defense mechanisms to offset their fear (e.g. responsibility avoidance or letting others make your choices to offset existential freedom; immortality projects to offset death). These defense mechanisms may be adaptive (e.g. dedication to a worthy cause to offset meaninglessness; deepening love attachments to offset isolation), or maladaptive (e.g. repetitive handwashing to offset contamination and therefore death). It is the maladaptive defense mechanisms that give rise to clinical syndromes, although Yalom (1980) goes to great lengths to argue that all humans must suffer because of the existential givens: "only the universality of human suffering can account for the common observation that patient-hood is ubiquitous" (p.13). While all four existential concerns are given importance in his model, special status is given to death: "psychopathology is the result of ineffective modes of death transcendence" (p. 27). It should also be noted that Yalom (1980) argues that the therapeutic relationship is critical to healing, in that the authentic coming together of client and clinician treats isolation and enhances the self. This provides another similarity to PBT which recommends a collaborative approach to treatment, and recognizes the role of the therapeutic relationship in the social level of the EEMM. PBT encourages an exploration of the function of the therapeutic relationship (e.g. to not feel alone in the universe, to help clients feel accepted and loved) (see further Hofmann & Hayes, 2019).

Interestingly, Yalom (1980) borrows heavily from other traditions and advocates behavioural and cognitive strategies that one might associate with traditional CBT. For example, he explicitly (and repeatedly) describes exposure to death-related stimuli for the purpose of desensitization. He also encourages rational analysis (i.e. cognitive restructuring) to master elements or aspects of our fears (e.g. challenging the belief that dying will inevitably be horrifically painful). He recommends Maslow's self-actualization as a potential solution to felt meaninglessness and the importance of relationships and social networks (pre-empting the social prescribing movement) to deal with isolation and meaning. In this way, Yalom's (1980) thinking aligns with PBT – it is not wedded to any particular set of procedures and is open to identifying processes from other fields of psychotherapy.

Yalom's hypothesized processes and targets for treatment are many

and varied, but Table 1 presents many of his key ideas in an EEEM form. The ease with which existential therapy can be viewed within the extended network analysis of PBT shall be illustrated with a case example.

5. Case illustration–Peter

Peter was referred by his only sibling, his brother whom he rarely saw, who was increasingly concerned about his well-being. Peter's father (a Professor of History), and mother (a published Australian poet). had both died in a car accident 10 years earlier, and his brother was his only remaining family member.

Peter was a 32-year single, heterosexual man who lived alone and worked from home as a copy-editor for a major publishing house. He described himself as an anxious man, with his first fears arising in childhood at around age 8. He had suffered with terrible separation anxiety, insisting on being near his mother at all times. He slept on a mattress on the floor at the foot of his parents bed and, despite this proximity, regularly had nightmares of his mother being killed by rabid dogs, accidents, or random shootings.

He had seen a therapist for these difficulties who used gradual exposure to separation experiences from his mother. By 10 years of age he was sleeping on his own. He was able to travel to school without his mother beside him by 12 years of age. However, these gains had regressed when he turned 16 after a series of panic attacks in which he experienced hyperventilation, dizziness and a terrifying sensation that he simply wasn't getting enough air. He had rung an ambulance on several occasions, and had routinely consulted cardiologists for the next 16 years. He said he still believed there was "something fundamentally physically wrong with me". Working in front of a screen all day, and engaging in no formal exercise, had seen him gain weight over recent years, something that had increased his health-related fears.

Now, at 32, his current presenting problems included contamination-related fears and constant anxiety and rumination about illnesses. He leaves his home as little as possible, having his groceries, books, and clothes delivered, primarily out of concern about touching public surfaces and coming into contact with contagious humans. These features of his presentation, and fears of contamination in general, had worsened during the COVID years. Physical contact with any human left him in terror, and sexual contact of any kind was too difficult for him to face. The threat of coming into contact with bodily products was simply too great. Even at home he would wash repeatedly throughout the day because of concerns that he had inadvertently brought germs into the house. Peter also worried about illnesses, particularly life-threatening conditions (e.g. terminal cancers, motor neuron disease, mesothelioma) and was constantly palpating for lumps and scanning his body for unusual pains or discomfort.

Unsurprisingly, Peter reported a strong sense of loneliness and isolation, low mood, and ambivalent self-esteem. "I've lost myself" he declared. On the one hand Peter saw himself as talented – someone who could really leave a mark. He had completed a liberal arts degree at a major university after leaving school and took pride in his ability to write. For several years he had been working on writing "the great Australian novel", but early drafts had been rejected by agents and publishing houses. He continued to aspire to greatness, but multiple rejections had led him to see his goals as futile and had contributed to his sense of "being a loser". He oscillated between believing that his novel was brilliant and that publishers were incapable of seeing it (e.g. "I give pearls before swine"), and believing that he was hopeless (e.g. "I'm a talentless hack that can't construct an English sentence"). The only area in his life that he spoke positively of was chess. In years on his own he had relentlessly studied opening theory and middlegame strategy and he was now rated in the top 1% of all players on the world's biggest chess servers. But he rarely played humans, preferring, he would claim, to play automated bots for their consistency of play.

Peter's personal goals in therapy amounted to wanting life back: "I feel I stumbled somewhere, like a runner who falls on the track, not knowing how to catch up with the others. I had so much potential when I was young. I could have done anything".

5.1. Case conceptualization

From an existential point of view, Peter's case centres on his awareness and dread of death. His first fear arose at 8 years of age, consistent with the emergence of a mature understanding of death that has been shown to become complete before the end of the first decade of life (see Menzies & Menzies, 2018 for a review). At this point, death of loved ones dominated his dreams and he sought safety by forever being near his mother, a common correlate of death anxiety (Menzies et al., 2019). His fears progressed to terror of his personal death, which variously involved fear of sudden collapse from an undiagnosed heart condition as a teenager, to fear of contagious illnesses through contamination, and fear of terminal medical conditions in adulthood. He reports body scanning and palpating for lumps. All of these fears, beliefs and behaviours have been linked to death anxiety (see further Menzies et al., 2019). As stated above, death anxiety has been shown to be involved in the "revolving door" we often see in mental health services (see further Iverach et al., 2014; Menzies et al., 2024a,b).

Peter's avoidance of humans, based of his fear of contagion, has presented him with a second existential crisis, namely isolation. Peter feels deeply alone, distant from his former self and distant from all others. His self-esteem is ambivalent, moving between grandiosity ("I could have been anybody", "I'll write the great Australian novel") and a profound sense of ineptitude ("no one is a bigger loser than me"). The weight gain associated with his inactivity has had a significant impact on his impoverished self-esteem and seemed, by his direct report, to have further raised his health fears.

From an existential point of view, Peter's ambivalent and insecure self-concept merits comment. Yalom (1980), in a similar vein to Becker (1973), argues that humans rely on a narcissistic edge, a belief in their specialness, to transcend death. Our desire to be more talented and

Table 1
EEMM analysis of key elements of Yalom's (1980) existential psychotherapy.

Target for change	Aff	Cog	Self	Mot	Att	Beh	Lev
Death acceptance for the self and all living things	x	x	x				I,S
Acceptance of ageing, decrepitude and the dying process	x	x	x		x		I,S, P
Exposure to fear stimuli for desensitization	x	x		x		x	I,P
Elimination of the 'specialness' of the self		x	x				I,S
Challenging maladaptive thoughts	x	x					I,S
Deepening of attachments	x			x		x	I
Caring for others, rather than focusing on the self		x	x	x	x	x	S
Social prescribing and building networks				x		x	I,S
Self-actualization for meaning			x	x		x	I
Meaning making through engagement in social movements and causes	x	x	x	x		x	I,S
Taking responsibility for personal action and choice	x	x	x	x		x	I
Moving toward an internal locus of control		x	x	x	x	x	I
Valuing a 'life well lived' over safety achieved through avoidance and withdrawal	x	x	x	x		x	I

Note: Aff = Affect; Cog = Cognition; Mot = motivation; Att = Attention; Beh = Behaviour; Level = level at which process is targeted, and includes physiological (P), individual (I), and social (S).

successful than those around us lets us face death as a supreme example of our species, becoming someone who will be remembered long after we die. Peter's aspiration to be the greatest is also fed by sociocultural issues. His father and mother were both published authors, one an academic and one a poet. Accordingly, Peter was raised in a family that achieved legacy through permanent products – published works that continue to exist after death. In this way, Peter's desire to write can be seen as his "immortality project" (see further Menzies & Menzies, 2021).

5.2. Treatment

In exploring the EEMM dimensions and levels and how relevant variables might be interacting with each other, we developed an extended network model to illustrate Peter's presentation (see Fig. 1). The direction and strength of hypothesized relationships is displayed by the relative size of the arrow heads on each connector. The utility of the network approach of PBT is readily apparent in that it highlights feedback loops, identifies which processes are mediating which relationships, and where the initial targets in treatment might lie. Our network analysis favours Peter's dread of death as a target for treatment as it lies at the origin of so many of his problems. We have hypothesized direct links between his dread of death and his anxiety, low mood, body scanning, worries about terminal illness and contamination, and even his narcissistic edge and need for legacy (a pursuit that is constantly lowering his self-esteem). In addition, indirectly (through other relationships between processes) his dread of death is linked to all aspects of his presentation. The use of the EEMM assisted in case conceptualization and treatment planning by forcing a comprehensive evaluation of Peter's presentation, in particular his death-related fears. Peter's dread of death maps neatly onto all six dimensions of the EEMM: (1) cognition (e.g. worry about contamination); (2) motivation (e.g. to stay well); (3) behaviour (e.g. washing, working from home); (4) self (e.g. narcissistic 'specialness' defence); (5) affect (anxiety), and; (6) attention (e.g. body scanning).

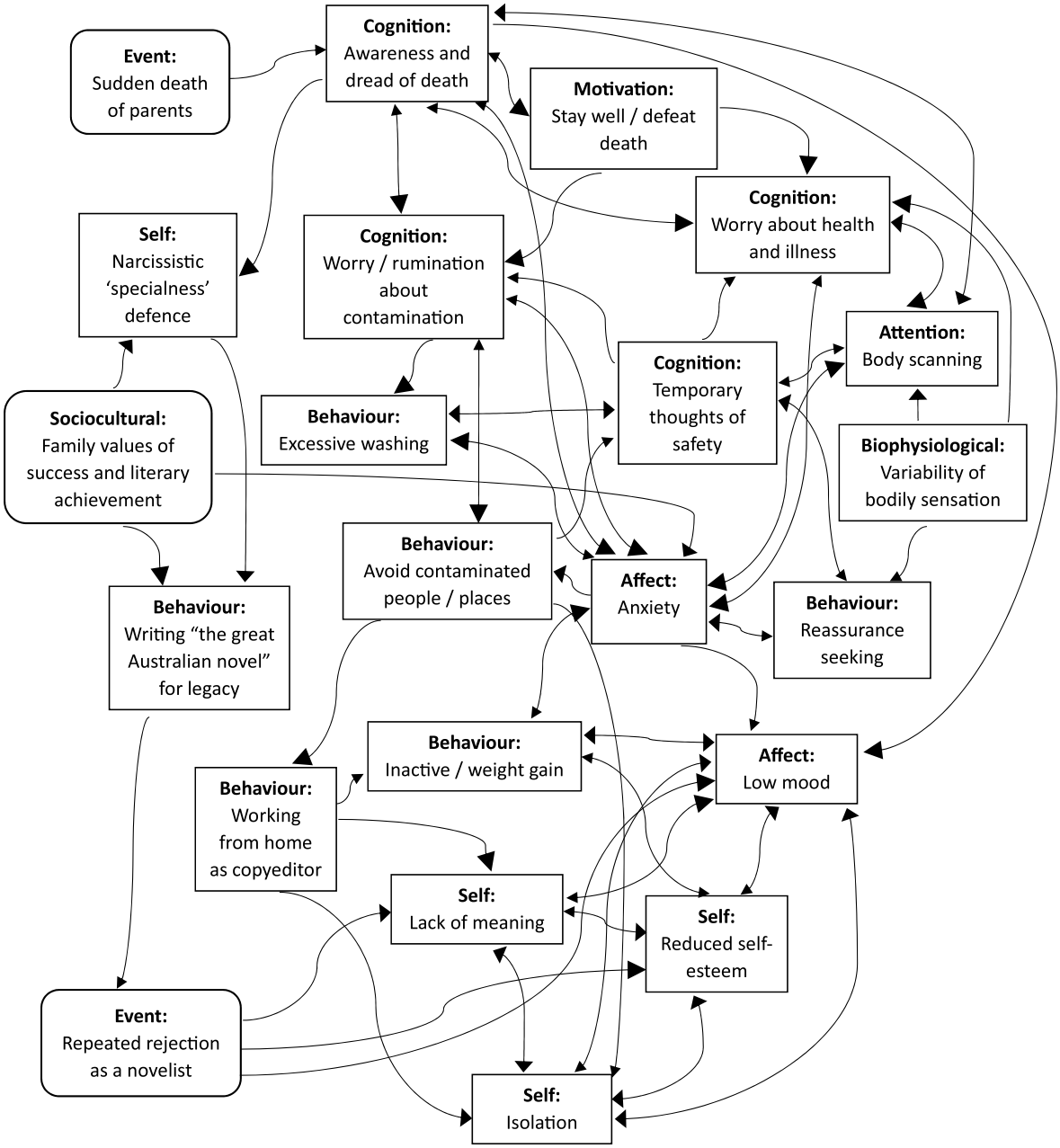

Fig. 1. Peter's expanded network model.

As described above, within the EEMM problems must be analysed in terms of variation, selection, retention and context, allowing far richer treatment planning. Peter's avoidance of public places, for example, can be seen as a problem of variation in attempting to stay well. He has become extremely rigid in his approach to contamination, never experimenting with even limited exposure to public places. This rigidity has not allowed him to learn that short walks to purchase bread or milk would not be followed by sickness. This could become a focus of treatment. Similarly, Peter's washing behaviours can be viewed as a problem of selection. His handwashing has been selected because it has been associated with temporary reductions in anxiety, but this has left him with chronic compulsive behaviour. Getting Peter to record the pattern of his thoughts, feelings and overt actions would show him that washing only leads to temporary relief, soon followed by depressed mood, negative self-concept and more loathing. Retention strategies would also be essential in planning treatment with Peter. For example, creating a lasting commitment to exercise might require hiring a personal trainer to design him a plan, public posting of progress in habit change or similar strategies. Context would be particularly important in planning strategies with Peter. He lives alone and fears close contact with other people, limiting some of the retention strategies one might normally consider.

Yalom's (1980) existential therapy focuses of death awareness and acceptance, and is ideally suited to Peter's complex presentation. Yalom (1980) encourages the individual to personally experience his own death through various exercises. He asks the client to imagine their death – where will it occur, when, under what circumstances – and to imagine their funeral. Individuals are encouraged to write their obituaries (in real and idealized form), and to write their emotional responses to deaths they read in the news. Much of Yalom's thinking on death is drawn from Buddhist and stoic traditions of radical death acceptance and meditating on death. These suggestions are echoed in aspects of Acceptance and Commitment Therapy (e.g. the eulogy and headstone tasks in various values-based activities; see Hayes, 2005), and contemporary cognitive-behavioural programs on death anxiety (see Menzies, 2018). Yalom (1980) promotes surrounding oneself with symbols of death (e.g. in art, poetry and song). Further, in group therapy, he recommends introducing terminally ill individuals into the lives of the death anxious for more direct exposure.

From an existential point of view, Peter's relentless search for immortality through the great Australian novel would be identified and explored as part of his death crisis. The need to transcend all others – to live in words beyond the self that will remain when Peter is dead – needs to be faced. The concepts of achievement striving, narcissism, and searching for virtual immortality would be used to explain Peter's writing, a choice that has consistently created frustration and lowered his self-esteem for some time. In existential work, all of these constructs are explored with the central idea of diminishing the self in order to accept death. Peter, like the reader of this manuscript, is just another of the 107 billion humans that have lived on this planet, soon to join his predecessors in the grave. It is acceptance of this existential given that allows freedom to find an authentic life. As Menzies and Menzies (2021) put it: "It is time for you to face the facts. You are a mortal ape and, soon enough, you will be dead. You will not be remembered" (p. 374).

5.3. Extensions to treatment enabled by PBT and the EEMM

As we have shown, the utility of PBT in Peter's analysis comes from its comprehensiveness. By ensuring that all aspects of his presentation are included, along with considerations of retention and context, new avenues for exploration are possible. For example, the sociocultural aspects of Peter's background (i.e. he is the son of a poet and academic), might be raised as a driver of his desire to write, rather than it simply being seen as existential narcissism arising from fear of mortality. PBT allows us to extend the existentialist perspective, recognizing that Peter's choices have been somewhat tied to his parents aspirations, thoughts and beliefs. Shedding the shackles of these beliefs and sociocultural influences would allow Peter a greater chance of finding the authenticity that Nietzsche, Sartre and the other existentialists implore us to find.

PBT emphasizes evidence-based processes that might be active in an individual's presentation. This frees the therapist from the strictures of any particular therapeutic orientation. For example, one might introduce mindfulness meditation to teach Peter to experience the minor perturbations of his body in a non-judgmental way. The introduction of defusion as a concept, along with exercises borrowed from ACT, might assist Peter to stop responding to threat-thoughts as if they are right, wise, and concern matters that must be examined. Ritual prevention coud be added to his treatment as a direct procedure to target his washing behaviours and his body checking. Exposure to his threat thoughts could also assist to reduce their potency. All of these possibilities emerge from a simple viewing of Peter's network of processes, but would never be apparent from a strict adherence to published existential therapy programs.

In this way, PBT and EEMM allow those working from an existential perspective to easily accommodate processes and procedures from other fields of psychotherapy, while still maintaining their roots in dealing with the painful 'givens' of being human. None of these innovations question the core claims of the existential therapist (i.e. that psychological difficulties arrive from the nature of being) and should not present any cultural challenge to the existential worker.

6. Future directions

In many ways, the existential therapies provide an exemplar of the gains to be made through the integration of PBT principles and the EEMM framework. Existential therapy brands or packages have been poorly researched with little attention, to date, as to whether they are acting through hypothesized existential processes. In fact, most of the evidence for existential processes has been found outside of existential therapy trials, in other domains of psychology and in other types of therapy (e.g. attachment and developmental psychology, social psychology, values work in ACT, social prescribing in CBT). In our view, we do not need a new brand or package of existential therapy, or more rigorous trialing of packages in group designs. On the contrary, this would lead to further division with futile experiments comparing one existential 'brand' with another. As others have pointed out, 50 years of this type of trialing has not improved clinical outcomes and reduced suffering at the level of the individual (Hofmann et al., 2021). This road, well-travelled in other forms of psychotherapy research (e.g. CBT), has not led to improvements in outcomes at the level of the individual precisely because it is inflexible to the needs of the individual, often failing to address the specific needs and goals raised by the sufferer at intake (see further Hofmann et al., 2021). PBT and the EEMM framework will allow the inclusion of existential work to be better integrated with processes established across other fields of therapy, along with nuanced and individualized treatment responding to the raw data given by the client in the assessment process.

The existentialists argued that psychological difficulties must inevitably arise in all humans. Put simply, the givens of existence cause our problems. If they are right, then all branches or brands of psychotherapy must, in order to assist individuals, assess for these difficulties and, through one process or another, address these issues. It is our view that PBT and the EEMM framework allow the psychotherapist of any persuasion to readily integrate this work to better meet the current needs of their clients.

Author note

We have no conflicts of interest to disclose.

CRediT authorship contribution statement

Ross G. Menzies: Writing – review & editing, Writing – original draft, Conceptualization. **Rachel E. Menzies:** Writing – review & editing, Writing – original draft, Conceptualization.

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