# Brief Existential Psychotherapy for Life Stress

## A Pragmatic Approach

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# About the Author

**Massimo Biondi, MD** psychiatrist, Professor Emeritus of Psychiatry, Department of Human Neurosciences – Sapienza University of Rome, lives in Rome. Born in Milan, Italy, in 1952, was since 2022 Full Professor of Psychiatry, Director of the Psychiatry and Clinical Psychopharmacology Unit and Head of the Department of Neurosciences and Mental Health, Policlinico Umberto I°, Rome (one of the largest hospitals in Europe, with 1,100 beds), Sapienza University of Rome. In 2024 became Professor Emeritus of Psychiatry.

He is Author or Editor of 38 books in the field of psychiatry, psychosomatic medicine, and psychotherapy, (among them, with Springer Publisher: Dimensional Psychopathology, Biondi M, Pasquini P, Picardi A (Eds) Springer, New York, 2018; Empathy, Normalization and De-escalation. Management of the agitated patient in emergency and critical situations. Biondi M, Pasquini P, Tarsitani L (Eds), Springer, New York, 2021. The Clinician in the Psychiatric Diagnostic Process, Biondi M, Pallagrosi M, Picardi A, Fonzi L (Eds), Springer, New York, 2022) and of more of 500 papers, with invited chapters in international edited books. He is International Fellow of the American Psychiatric Association, Fellow of the International College of Psychosomatic Medicine, member of the Editorial Board of Psychotherapy and Psychosomatics (Karger, Basel), of the Italian Society of Psychopathology, President of the Italian Federation of Psychotherapy Associations, he also is Editor in Chief of Rivista di Psichiatria (Il Pensiero Scientifico, Rome), listed in several international data bases. Research and treatment studies are mainly in the clinical field: anxiety, mood and psychotic disorders; pharmacotherapy and psychotherapy; psychobiology of life stress; psychoneuroimmunology; psycho-oncology. He was scientific secretary of 8 different Consensus conferences on the treatment of psychiatric disorders and about informed consent. Natural photography, birdwatching, music and arts are his main non-academic interests.

# Abbreviations

| | |
|---|---|
| ACSE | Assessing Clinician's Subjective Experience |
| ACTH | Adrenocorticotropic Hormone |
| AI | Artificial Intelligence |
| ANS | Autonomic Nervous System |
| AVP | Arginin-Vapopresin Peptide |
| BDNF | Brain-Derived Neurotrophic Factor |
| BEP | Brief Existential Psychotherapy |
| Beta-EP | Beta-Endorphin |
| CCK | Cholecystokinin |
| CNS | Central Nervous System |
| cPTSD | Complex Post-traumatic Stress disorder |
| CREB | cAMP response element-binding protein |
| CRF | Corticotropin Releasing Factor (or CRH) |
| CRH | Corticotropin Releasing Hormone (or CRF) |
| DNA | Deoxyribo-Nucleic Acid |
| DSM III | Diagnostic and Statistical Manual of Mental Disorders 3th edition, |
| DSM IV | Diagnostic and Statistical Manual of Mental Disorders 4th edition |
| DM5 | Diagnostic and Statistical Manual of Mental Disorders 5th edition |
| DSM5-TR | Diagnostic and Statistical Manual of Mental Disorders 5th edition, Text Revision |
| EBM | Evidence-Based Medicine |
| ECG | Electrocardiogram |
| ECS | Central endocannabinoid system |
| EDA | Electrodermal Activity |
| EEG | ElectroEncephalogram |
| END | Empathy, Normalization, De-escalation |
| fMNR | Functional Magnetic Nuclear Resonance |
| GABA | Gaba-Amino-Butyrric Acid |
| GAD | Generalized Anxiety Disorder |
| GC | Glucocorticoid |
| GH | Growth Hormone |
| GH-RH | Growth Hormone Releasing Hormone |
| Gn-RH | Gonadotropin Releasing Hormone |
| GR | Glucocorticoid Receptor |

| | |
|---|---|
| GSR | Galvanic Skin Resistance |
| HPA | Hypothalamic-Pituitary-Adrenal Cortical Axis |
| HPGA | Hypothalamus-Pituitary-Gonadal Axis |
| HRV | Heart Rate Variability |
| 5HT | 5-idrossi-triptamine (serotonin) |
| 5-HTT | Serotonin transporter gene |
| IBD | Inflammatory Bowel Disease |
| ICD-10 | International Classification of Diseases, 10$^{th}$ revision |
| IG-A | Immuno-globulin Alpha IL Interleukin |
| LC | Locus Coeruleus |
| LCU | Life Change Units |
| LES | Life Experience Survey |
| LH | Luteinizing Hormone |
| MSH | Melanocyte Stimulating Hormone |
| NA | Noradrenaline |
| NPY | Neuropeptide Y |
| OCD | Obsessive-Compulsive Disorder |
| PAD | Panic attack disorder |
| PFC | Pre-frontal Cortex |
| POMC | Pro-opiomelanocortin |
| PTSD | Post-traumatic Stress Disorder |
| PVN | Paraventricular nucleus |
| RCT | Randomized Controlled Trial |
| REM | Rapid Eye Movement |
| SNS | Sympathetic nervous system |
| SRE | Schedule of Recent Experiences |
| SRRS | Social Readjustment Rating Scale |
| SVS | Stress-related Vulnerability Scale |
| SWOT | Strengths, weaknesses, opportunities and threats |
| TACSEH | Thought Analysis, Coping skills, and Emotional Handling |
| TH-RH | Thyrotropin Releasing Hormone |
| TNF | Tumor Necrosis Factor |

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# Brief Psychotherapies and Existential Psychotherapies: An Overview

1

This chapter summarizes two significant lines in the world of psychotherapy, the brief and crisis-oriented, and the existential.

Brief psychotherapies have spread since the 1960s, initially with the model of short-term psychodynamic psychotherapies, later diversifying and including behavioral, cognitive, strategic, crisis-oriented, or life events and trauma-focused ones. Short-term dynamic psychotherapies were born with limited treatment goals to promote adaptation rather than a reconstruction/revision of personality or work on deep, unconscious levels. Recent studies document good evidence of effectiveness in literature.

Existential psychotherapies are born on a deep and rich philosophical basis, developing some concepts in clinical practice. Most of them are distant from the method of natural sciences and they are not inclined to protocols, procedures, measures, or outcome data centered on phenomenological approaches. Some of them, therefore, have few clinical-experimental studies with evidence of effectiveness, also because it does not correspond to their vision and method; another, more recent part, however, has been studied with good evidence of effectiveness, especially in the field of serious physical illnesses like cancer and end-of-life.

The first two paragraphs of this chapter provide a summary of these orientations, brief and existential. Some principles of these two orientations, brief and existential, are revisited and merged in BEP. The last paragraph illustrates its theoretical lines and some activities.

## 1.1 Brief Psychotherapy: An Overview

Brief psychotherapies initially developed from the 1960s mainly in the psychodynamic field, to overcome the problem of the long time required for psychoanalytic treatments, the discrepancy between the growing demand and limited professional supply, reduced waiting lists, and the need for ready interventions for patients in

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crisis situations. In some countries, among those to my knowledge the United Kingdom, Canada, Germany, and Italy, time-limited psychotherapies have become appreciated resources for public psychiatry, and mental health interventions in general. In the recent globally aggravated situation of mental suffering post-Covid-19 pandemic, the need for brief interventions is becoming even more pressing.

Historically, one of the first psychoanalysts to introduce brevity in treatment was Sandor Ferenczi, who addressed the problem of the duration of psychoanalysis, introducing "active therapy" [41, 90], without, however, gaining widespread adoption. Harry Stack Sullivan, who was in the United States, also introduced some brief techniques [27]. Alexander and French also proposed to abbreviate analytic therapy [3], as did Lindemann in the United States, who opened the perspective of intervention on acute life crises with families of victims after the deaths at the Coconut Grove nightclub fire, where about 500 people died [60]. He was one of the first to initiate crisis interventions. It was conceived as a normal reaction to a life event of loss, with marked anguish and suffering. Normal grief reactions were, according to Lindemann, with a precise onset, lasting for a short period, with a sequence of specific stages, and he believed that early intervention could reduce the risk of psychopathological sequelae. His innovative approach was indeed defined as "preventive." Caplan, his collaborator and student at the Harvard School of Public Health, developed the crisis theory, clarifying how it was based on the concept of emotional homeostasis, continuously threatened by life events and situations. The intervention was conceived within the framework of preventive psychiatry [26]. The intervention, he further clarified, was not on the situation but on the emotional reaction when ordinary coping capacities failed, and the crisis thus began. The trigger factor was the imbalance between the perceived subjective difficulty, the meaning of threat, and the resources available for coping. Revisiting some themes of humanistic and existential directions, he saw a crisis as both a danger of psychopathological developments and an opportunity for growth.

Numerous directions flourished at the time, among which can be remembered: the Emergency psychotherapy and Brief psychotherapy by Bellack and Small [12]; the brief psychotherapy by Davanloo [52]; Malan [63]; the Brief psychotherapy for psychosomatic syndromes [49]; a brief-adaptation-oriented psychotherapy by Pollack and Horner; the Short-term dynamic psychotherapy [101]; the Brief interpretative psychotherapy by Ryle [83] Theoretical contributions and clinical case studies of individual cases or small groups in studies, some controlled and with follow-up, refined the selection of patients, the redefinition and delimitation of objectives, the differences compared to traditional dynamic therapies, as in the focal psychotherapy by Balint [7]; the Short-term psychotherapy and emotional crisis by Sifneos [87]; the Brief analytic psychotherapy by Gillieron [45, 46], which has recently had an interesting application in neurology in the treatment of the difficult condition of medication overuse headache [4]; the treatment focus of the Brief psychotherapy of stress syndromes by Horowitz and Kaltreider [54]; the Supportive-Expressive therapy [61]; applications for psychiatric disorders [93] and the Changing Lives through Redecision therapy by Goulding and Goulding [47]. Small offered a synopsis of brief psychotherapies with a review of techniques, and the details of over 70 specific interventions. It is

important to emphasize that crisis interventions and brief psychotherapies were not all suitable for all patients and all conditions [24]: the common characteristics were time-limited (usually within 25 sessions as an upper limit); communicating the time limit to the patient at the beginning (unlike many dynamic psychotherapies, unlimited); limited goals such as removal or amelioration of most disabling symptoms as soon as possible; rapid re-establishment of previous equilibrium, development of understanding of the present disorder and increase of coping ability; focused intervention and present centeredness, for which childhood memories, dream analysis, and transference are not usually included in the treatment as happens in analytic psychotherapy; the therapist has greater directiveness; therapeutic flexibility, rapid assessment; a greater ability of the psychotherapist to establish a working alliance quickly, with enthusiasm and involvement (unlike the traditional psychoanalytic setting); finally, a patient selection that includes acute onset of symptoms, good previous adjustment, patient with a good ability to relate, and high initial motivation. It is clear how these characteristics greatly differentiated brief and crisis psychotherapies from the theory and technique of the then-predominant psychodynamic approach but they were suitable only for a limited number of patients. As we will see, some of these characteristics coincide with those of BEP, others do not, as BEP is used not only for "normal" people with distress but also for severe psychiatric patients with previous disorders, concomitant use of psychotropic drugs if needed, and bodily interventions. Subsequently, other brief psychoanalytic approaches developed, including the supportive-expressive treatment by Luborsky [61]; the brief dynamic interpersonal therapy by Lemma et al. [59]; Abbass and Town [1] Abbass et al. [2] for intensive short-term dynamic psychotherapy [1]. Models with completely different theories and methods compared to the psychodynamic approach also entered the psychotherapeutic scene, such as the rational emotive therapy by Ellis [37]; the behavior therapy by Rachman and Wilson [79]; the behavior therapy by Wolpe [102]; the cognitive psychotherapy by Beck [9] for depression [11] and for anxiety and phobias [10]; the cognitive treatment of anxiety disorders by Wells [99]; Andrews et al. [5]; Mahoney [62]; the stress-inoculation training by Meichenbaum and Cameron [70]; the behavior therapy by Sanavio [84]; the acceptance and commitment therapy by Hayes [50]; the well-being therapy by Fava [40]; the positive psychotherapy by Rashid and Seligman [80]. Many of these psychotherapies did not define themselves as "brief" but were in fact also brief or time-limited by their own model and technique. In the 1980s, interpersonal psychotherapy by Klerman et al. [55] also established itself, close to Beck's cognitive psychotherapy for depression; they started a revolution in the field, documenting its effectiveness alongside pharmacotherapy and, for the first time, with randomized controlled studies. Both have been the subject of numerous controlled trials with evidence of effectiveness [65], volumes dedicated to the overview of specific brief psychotherapies for depression were published, including behavioral, interpersonal, cognitive, and psychodynamic approaches. Many of these works were based on controlled studies, and extensive systematic reviews various therapy types such as psychodynamically oriented therapies, brief behavioral, cognitive, and cognitive cognitive-behavioral therapies, eclectic psychotherapy, crisis-oriented therapies, and other miscellaneous brief therapies) They outlined common principles, technical

aspects, and findings derived from research. The common ingredients overlap those identified by Butcher and Koss years earlier: they have rapid and thorough assessments in the initial interviews, the therapist's ability to maintain focus, high levels of therapist activity and flexibility, prompt interventions, directiveness, and addressing the termination [56]. The multiplicity of interventions that have flourished is such that they cannot be fully detailed. However, there are some common elements across these diverse approaches. These include a direct relationship with the psychotherapist (in some cases as in behavior therapy with a teacher-student approach, in others, softer therapies with a humanistic approach). In addition, there is predominance learning techniques such as a structured setting with a defined agenda (sometimes including precise manuals for each session), intra-session homework, behavioral prescriptions, work on thoughts and behaviors, present-focused approach, intervention and modification of symptoms as a therapeutic goal; managed psychopathological severity, and a preference for not using psychotropic drugs. Contributions in this sector are numerous. Further approaches, such as supportive psychotherapy by Markowitz [64], have evolved. A fine-tuning of the latest developments can be found in Cameron [25], Abbass and Town [1] and Abbass et al. [2] for intensive short-term dynamic psychotherapy [1], Baée and Jeyasingam [6], Nieuwsma et al. for depression [74], Stein and Jacobo for inpatient treatment [91], and Winston et al. for personality disorders [100]. The work of Marks et al. for a general lexicon of psychotherapy procedures has been very useful. A large part of the psychotherapies considered involves brief interventions [66]; recently, Porcelan and Scribner proposed criteria to reduce therapy from months to weeks in selected patients [78]. COVID-19 pandemics and post-pandemics subsequently engendered entirely new and different conditions of psychological suffering in addition to traditional "neuroses" and psychiatric disorders [17, 76]. Demand for psychological and psychiatric treatments after COVID-19 grew rapidly but limited resources of care led to delivering therapies in a brief format, such as rapid-access focused treatment [58], for example.

In recent years, faced with strong demand, the psychiatric community has also proposed new brief interventions at the limit between brief psychotherapy and management of the clinical condition, such as a set of 10 sessions for borderline personality disorder [57], psychoeducation for bipolar disorder [29, 81] and other severe mental disorders [103], and lifestyle psychiatry for bipolar disorder, including stress management techniques [88]. As a final clinical note, communicating a time limitation before starting psychotherapy appears to have no negative effects. Rather, a review by De Geest and Meganck suggests that it can favor patient engagement [32], help structure intervention, and strengthen motivation [67]. Less favorable evidence exists for brief psychotherapies in schizophrenia [73].

## 1.2 Existential Psychotherapies: Main Perspectives

Existential psychotherapies have an ancient history, important philosophical foundations, and a decent following among professionals worldwide [96]. Apart from philosophers, the main reference authors in the clinical field include several key

figures, such as Ludwig Binswanger, Medard Boss, James Bugental, Mick Cooper, Emmy van Deurzen, Viktor Frankl, Ronald Laing, Alfried Längle, Rollo May, Simon du Plock, Carl Rogers, Kirk Schneider, Stefan Schulenberg, Ernesto Spinelli, Digby Tantam, Irvin Yalom, as also reported by a survey by Correia et al. [31]. He emphasizes that existential psychotherapies do not show a unified and shared theoretical framework. The existential approach follows the phenomenological approach, greatly valuing the encounter between therapist and patient as people (in this, it is close to the humanistic approach) [30, 38, 69, 72, 85, 86, 94, 95]. Given its theoretical premises, it chooses not to follow the method of naturalistic sciences, as mentioned at the beginning of this chapter. It is far from clinical-experimental trials, protocols and procedures, measurement tools, symptom reduction verifications, and follow-up evaluations; professionals adopt personal clinical approaches, also partially different from each other, since the founding principle concerns, among other theoretical issues, the uniqueness of each person's existence, freedom, and, for various authors, the choice of non-pathologization of individual sufferings. The phenomenological approach, rather than the epidemiological, categorical psychopathological one, therefore leaves the diagnostic issue, the issue of integration or not with psychopharmacological treatments (which, in treating difficult cases, can also be useful to allow psychotherapy itself) in the background. Attempts to systematize existential psychotherapies have on one hand recognized the broad and profound vision of this approach but, on the other hand, also reflect the variety of settings and vision, making systematization difficult [75, 98]. Some existential psychotherapies report deep and interesting single-case or multiple single-case studies, but without outcome and follow-up data, presenting the narrative application of working principles (such as Dasein-analysis). The psychotherapeutic activity described in existential literature appears oriented on three main directions: (a) counseling interventions mainly in private practice, with accurate descriptions of stimulating and in-depth single cases or multiple single cases. Diagnoses are reported but are in the second or third line, as psychopathological assessment scales are rarely used. Follow-up is rarely reported. As highlighted by some reviews in this field, existential psychotherapy has very little clinical evidence literature of efficacy, unlike other psychotherapies, and this can be penalizing in some contexts (issues of reimbursement; the choice of these treatments in public mental health settings) ([98]; 201). (b) A second group of existential psychotherapies reports case series or groups of patients with psychiatric diagnoses, but reviews note a "low-quality" methodology, which has often prevented the work from entering a meta-analysis. Although various authors have pointed out the need for research in this sector, as reported by Correia et al. [31], the difficulties still appear significant. Other psychotherapies have more available data with reviews and meta-analyses documenting efficacy according to the criteria of Evidence-Based Medicine (EBM), and this penalizes existential psychotherapies as a choice for public mental health services, reimbursement, health service planning. Many observations could be made in this regard. In my opinion, the first is that EBM psychotherapies are manualized and follow protocols (which is entirely contrary to the spirit of existential psychotherapies); the second is that EBM psychotherapies generally have therapeutic targets

that mostly identify with symptom reduction (anxiety, phobias, panic attacks, obsessions/rituals) easily measurable with dedicated standardized scales (which is not the therapeutic goal of existential psychotherapies); the third is that the population that turns to existential psychotherapies likely has motivations that are different—or deeper—than those of symptom reduction. Therefore, the outcomes are difficult to measure. The few scales on meaning in life and purpose in life are certainly useful, but minimal and perhaps fragile compared to the content of the psychotherapies themselves. (c) A third group of existential psychotherapies shows controlled, randomized clinical-experimental trials, protocols, manuals, and outcome measures, with results showing evidence of effectiveness; this mainly concerns patients with serious somatic illnesses such as cancer. One of these is meaning-centered psychotherapy, developed from the concepts of Viktor Frankl [43, 44] and Heidegger [51], in both individual and group formats [20, 23]. It is interesting to note that the high quality of this area of study is probably linked to the restricted sample types (oncological patients, patients in palliative care) and to the homogeneous and defined areas of suffering (death anxiety, end of life). This facilitates methodologies with protocols and evaluation scales, as well as outcome measures [21, 22, 28, 48, 53, 68, 82].

However, reviews of the methods and outcomes of existential psychotherapy studies are still few. Terao and Satoh [92] found that only nine of 19 models have produced randomized controlled trials (RCTs): meaning-centered group psychotherapy, individual meaning-centered psychotherapy, meaning-making intervention, meaning of life intervention, managing cancer and living meaningfully, hope intervention, cognitive and existential intervention, dignity therapy, and life-review interviews. They are concentrated areas of advanced cancer and on themes such as dying, realizing meaning in the life of an individual, and freedom, as also found by other reviews [8, 97]. This is a highly valuable aspect because they are the only psychotherapies available for these patients. Instead, the problem remains of the scarce documentation regarding the psychotherapeutic process, the heterogeneity of methods, the lack of outcome studies and follow-up evaluations, and the enrollment criteria and clinical indication—for whom these methods are appropriate—for almost all other orientations.

The recent approach of Sousa [89] is interesting: a genetic-phenomenological approach of existential psychotherapy, with principles supported by scientific evidence combined with clinical intervention. Of these, the three main aspects are: inner-time consciousness, the experiential self, and the passive synthesis theory.

In Italy, a significant contribution was made by Luigi De Marchi, who served as president of three Italian psychotherapy schools from the 1960s to the 1980s. These schools included the Wilhelm Reich Body-Psychotherapy School, Alexander Lowen's Bioenergetics, and Carl Rogers' Humanistic. In addition, he was instrumental in the founding of the Institute of Humanistic Existential Psychology in Rome [33]. The developments in this period led to the creation of a renewed and integrated manual of humanistic-existential psychotherapy [42].

A pragmatic, time-limited approach might also be of interest, connected on one side to the stress model and life events, and on the other, close to aspects of the

biology of psychotherapy, likely also valid for existential psychotherapy. For example, it has been discussed that many conditions that lead to the need for psychotherapy—often after relevant life stress events—also involve alterations in immune functions [77]. This approach certainly has both theoretical and practical limitations but seems to be beneficial even in challenging clinical settings, as well as among medical and surgical patients, as suggested by this text.

Creating trials for existential psychotherapy that can demonstrate effectiveness while incorporating certain principles of quantitative studies is certainly a very challenging endeavor. Some attempts—with issues addressed in this book—are underway. This requires a partial contamination with other models such as the stress/vulnerability model, to accept the elusive mind/brain relationship and the more concrete mind/body one, by including, for example, bodily interventions in the treatment. Various interventions of this type have begun at the Psychiatric Clinic of the University of Rome—Policlinico Umberto I°—a general hospital in downtown Rome with 1,200 beds and various articulations of psychiatry and consultation-liaison. The interventions have been partially reported in literature and concern acute psychiatric patients in the inpatient setting, stabilized in the day hospital, as well as outpatients in both public and private settings [13–16, 18, 19, 34–36, 39, 71]. Some experiences will be described in more detail in Chap. 8.

## 1.3 The Pragmatic Approach of Brief Existential Psychotherapy: An Overview

The approach of Brief Existential Psychotherapy (BEP) follows an articulated model, which integrates knowledge from existential psychotherapy, psychobiology of human stress, mind-body techniques, and principles of positive psychiatry and psychology. BEP is conducted according to a pragmatic method, centered on the view of an individual's own existence, analysis, and response to critical life stress events thereby designing a route of acceptance and searching for meaning in life.

BEP does not substitute other psychotherapies nor their indications. BEP is developed for the short-term treatment of crises after severe life stress events, such as deaths of loved ones, losses, divorce, retirement, personal or collective emotional traumas, and major violations of law and detention in jail, with a particular emphasis on severe somatic disease (cancer, myocardial infarction, stroke, degenerative diseases and other subacute or chronic conditions which changed the life perspective).

The methodology of BEP is based on traditional clinical psychopathology, beginning with a medical and psychopathological assessment to establish a categorical and dimensional diagnosis; subsequent steps are then provided in the course of brief psychotherapy, with a more common flexible format of 12–20 sessions, of one hour duration; the issues and aims of treatment are transversal across different psychiatric diagnoses, that is, the intervention follows similar activity lines, independently from the specific categorical diagnosis. The intervention is dedicated to people with existential suffering, without psychopathological diagnosis. In

addition, , medical therapy and psychopharmacological treatment are given according to patient needs; there is no barrier to integrating psychotherapy and psychopharmacotherapy, as well as other effective techniques moreover, in some cases, appropriate psychopharmacotherapy can complement psychotherapy, which could be very challenging otherwise.

To summarize, the basic issues are:

(a) The existential model emphasizes the importance of an *open attitude* of the psychotherapist towards the person/patient, welcoming and friendly professional during the first encounter, distant from the "one-up" or "one-down position." It is characterized by respect, active listening, understanding, and fostering *a personal collaborative relationship* where both the therapist and the patient focus on existential perspectives. (*existential mind*).

(b) Psychotherapy work relies on empathy, which is better conceived as *existential empathy*; the participation of the therapist towards the person/patient is oriented to the lived experience of the person/patient and returning to that comprehension and feeling of it.

(c) In clinical assessment, BEP follows classical criteria of psychiatry and clinical psychology; the BEP psychotherapist prioritizes a phenomenological approach and draws an *overview of the patient according to a matrix—graphically represented by a 3×3 grid,* simultaneously focusing on several levels, which explores the whole person, history, network (see Sect. 2.2). A clinical assessment of the patient is best done according to dimensional psychopathology, rather than referring exclusively to categorical diagnoses.

(d) The existential model aspires to *overcome the dichotomy and contest between the psychological and biological views about causes* of suffering, symptoms, and mental disorders, but gives value to the corpus of knowledge of psychobiology about life stress, according to a mind-body view and multiple levels of analysis and clinical work, engaging both the mind and the body in the current clinical work of psychotherapy; due to the specific clinical condition of intervention (i.e., patients with severe somatic diseases, patients after psychotic or bipolar breakdown, emotional losses, etc.) the BEF psychotherapist must adapt to the patient's setting and resources, that is the point, and not vice versa.

(e) The model distinguishes between the *internal* and the *external* world. On one side, it focuses on the personal lived experience from the subjective perspective, where the clinical work looks to understand and empathize with the individual's lived experience; on the other side, it examines the objective world, based on events and facts, confronting and coping with life stress. Clinical work in this context involves analysis, explanation, and planning behaviors and actions. The model of BEP differentiates between the *transversal* and the *longitudinal* view of existence, which are represented along a continuous trajectory (past, present, future). Severe life-stress events can produce a fracture or *discontinuity in one's existence*; this distinction is between the notion of *objective time* (time of clocks and calendars) and *subjective time* (the flow of the *time of one's own lived life, alongwith its cycle of phases*) (Fig. 1.1).

**Fig. 1.1** Brief Existential Psychotherapy works with a broad vision, like the sky of this sunset, spanning time and the perspective of existence. It is therefore suitable for crises triggered by life stress events

(f) The psychotherapist assists the patient in creating an *existential map*, using the metaphor of a ship during navigating the sea. Questions could include: Where are you along the longitude of your existence? As a ship, what is your route? Where are you coming from and where are you heading? Which perils are in your route? What opportunities and threats do you face?

(g) The work of BEP, as outlined above, involves facilitating the development of a specific style of thinking, techniques such as reframing and psychological decentering, which replace rigid, categorical thinking with probability thinking, leading to an *existential cognition.* This process attributes meaning to an event in the broader context of our existence and its life cycle, as well as various sub-cycles. This way of thinking and the process of existential cognition promotes one or more *existential insights,* the act of grasping the vision of one's existence along its longitudinal temporal arc, while being mindful of the present moment. This perspective fosters an appreciation of. We often recognize the value of the things we have—such as health, love, and serenity—only when we risk losing them. Why do we take our existence for granted?

(h) A typical workplan of BEP consists of 3 phases:

1. Acknowledging the Past: event, traumas, thoughts, emotions and reactions. The therapist gives explanations according to the stress/vulnerability model; validates the experience and helps the patient understand their history and roots in preparation for acceptance.
2. Focusing on the Present: The emphasis in this stage is on normalizing, elaborating on experience, preparing to overcome challenges, mobilizing hope, and engaging the body.
3. Negotiating with the Future: In this phase, the therapist helps the patient in finding meaning, taking action, thriving, and fostering post-traumatic growth. Goals—both minimal and major— are set for the individual case, alongside micro-goals that consist of small achievable goals.

(i) Communication with the person/patient throughout the steps of the clinical work of BEP is organized according to three principles: empathic communication; normalization; de-escalation and negotiation (the END method). During the dialogue, the therapist uses some principles from the Socratic method of communication, with its maieutics, sharing questions and actively engaging the patient in a discussion about moving backward and forward. The psychotherapist also suggests rather than declare, explores rather than affirm, makes hypotheses rather than giving solutions, prospects alternatives rather than discussing a singular choice, and—*mutatis mutandis*—is trying to harmonize thoughts in the mind of patient as a conductor does with their orchestra.

(j) The BEP model considers the strengths and weaknesses of the individual: the model represents the patient not only as a sum of symptoms, troubles, weaknesses, psychosocial and interpersonal dysfunctions, and psychic deficits (what this person suffered and what they were lacking in development?), but as a person with past successes, strengths (who was this person?), and legacies; the model encourages a focus not just on the negatives and its causes and their past roots but rather looks at positive attributes, and the potential for growth and construction aiming to build a better future. While it examines personal history, psychological traumas, and their presumed roles in present suffering, it emphasizes the question: but makes the point "and now, what can you do for your future, despite your past and your sufferings?".

(k) A central instrument of BEP is the SWOT analysis: Strengths, Weaknesses, Opportunities, and Threats. The method, drawn from business where it is useful in assessing a company under crisis or trying to improve performance, is similarly applied here to personal life situations, during and after life-stress events. Another concept in BEP recognizes that after a severe life stress event, we can be at a turning point in life. A further aim of BEP is to help the person accept it, adapt, and try to find a pathway for possible post-traumatic growth.

(l) Learning to develop *therapeutic thoughts*—learning to guide the mind influences what a person might think or not—is a central skill in BEP. It comes from the mental training of individuals in extreme or challenging situations (astronauts, military pilots, athletes in competitions, surgeons, and so on). They actively *choose what to think* in specific situations and they do not let the mind follow an uncontrolled flow of thoughts and emotions. This style is familiar to experts trained in meditation. We often allow our minds to be guided by automatic thoughts without questioning them. Too often they are negative, critical, pessimistic, or repetitive. BEP helps to recognize anxiogenic, depressant, or obsessive thoughts, and counters them with neutral thoughts and, especially, to counteract them with positive thoughts (anxiolytic thoughts, antidepressant thoughts, anti-obsessive and anti-psychotic thoughts, etc.). To some extent, mastering our thoughts is like managing steps while walking, such as when we decide where to go, which direction, to stop or proceed. The adoption of therapeutic thoughts requires choice: after expressing these thoughts several times

to a support therapist, we must decide whether to leave behind negative repetitive thinking, rumination over the past, passive complaining, and anger. It is essential to make a choice for change rather than remaining stuck in these patterns.

(m) This work and style of thinking prepares us to *overcome and accept the past*, with its burden of pain, trauma, losses, and grief; you can't repair them, or make them not have happened: your only option is to accept them and prepare to build what you can of your future, valuing what you *have* and who you *are*. Like a town after an earthquake, the citizens mourn the destruction and devastations and ruins of their houses and life; then, they react. In response to community disasters, research suggests beneficial solutions. Individuals can find value by looking back at their own roots—country and community, homeland, family, and values—and their personal resources, best significant memories, and strengths. They can recognize gratitude, practice solidarity, and experience compassion to others and self-compassion; people accept and react, they respond by getting on with life. A significant concept in this phase of therapy is the one of *legacy*. According to Viktor Frankl, our legacy consists of what we have received, what we give in our lives, and what we want to leave behind. Furthermore, a true legacy requires openness to others, because there is no legacy if the person is isolated in their own world.

(n) Existential psychotherapy can be significantly enhanced through bodily interventions. Existence, in fact, is inherently physical. A life stress event affects both the mind and the body. The psychobiology of stress has offered many examples of the relationship between life events and various bodily systems—including musculoskeletal, autonomic, neuroendocrine, and immune-inflammatory systems, which may increase the risk of disease. Incorporating bodily interventions into existential psychotherapy can effectively address life stressors. Numerous interventions have shown evidence of the effectiveness of maintaining wellness during adversity and can be integrated into care for various mental and somatic health conditions. These interventions include physical exercise, relaxation techniques, biofeedback, slow guided breathing, heart rate

**Fig. 1.2** To experience compassion to others, to practice solidarity, and sense of gratitude are some of the basic skills needed in the approach of Brief Existential Psychotherapy (help during a Summer storm, walking with a very strong wind, at Achill Island, Ireland)

variability training, nutrition (especially brain-healthy foods), light therapy, and the regulation of activity/rest and sleep/wake cycles as well as sensory focusing techniques.

(o) The final step of BEP involves getting on with life by finding meaning and purpose for the future. This process embodies the spirit of resilience: building, thriving, trying to be valid even in the face of a changed or shortened life perspective caused by illness.

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