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Developing an emotion-focused therapy model for fear of cancer recurrence: A case-level task analysis

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Abstract

Fear of cancer recurrence (FCR) involves anxiety about the possible return or progression of the disease. It is common among people surviving cancer, covering a range of adaptive and maladaptive responses including clinical presentations of FCR, for which different psychological interventions have been developed, most within the cognitive-behavioural paradigm. Recently, emotion-focused therapy (EFT) has been proposed as an alternative and has been the subject of research focusing on the cancer population and cancer-related issues, including FCR. In this study, we looked closely at a successful case from a larger exploratory study, carrying out a discovery-phase task analysis aimed at identifying the main components of EFT–FCR. We found that this approach generally followed the usual structure of an EFT intervention, with four distinct phases. However, we identified some specific secondary processes (e.g., hypervigilance and catastrophising) and clarified the nature of the core pain in this presentation as existential (e.g., fear of dying).

KEYWORDS
emotion-focused therapy, existential pain, fear of cancer recurrence, health anxiety, task analysis

1 | INTRODUCTION

Fear of cancer recurrence (FCR), that is, the fear, worry or concern of cancer coming back or progressing (Lebel et al., 2016), is a major issue for people surviving a cancer diagnosis (Simard et al., 2013). Recognised as a multidimensional construct since the first theoretical formulations (Lee-Jones et al., 1997), FCR is a highly diverse experience, described by survivors as affecting their perceptions, emotions, body, cognitions and behaviour (Almeida et al., 2019).

Understandably present after a serious and potentially life-threatening disease, FCR is a form of health anxiety (Lebel et al., 2020) with similarities to other anxiety problems (e.g., social anxiety and generalised anxiety). Like cancer-related distress more generally (Riba et al., 2019), FCR ranges on a continuum from adaptive to maladaptive (Lebel et al., 2016). Thus, FCR can support patient self-care and health-oriented behaviours or, conversely, it can impact negatively on a person's quality of life and well-being. Maladaptive FCR can manifest, for example, in persistently high levels of preoccupation or worry about cancer and death, or hypervigilance to bodily symptoms; furthermore, these difficulties can interfere with daily functioning and planning for the future (Mutsaers et al., 2016, 2019).

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Different psychological interventions are available for people presenting with significant FCR-related distress, the most common being cognitive behavioural approaches, either in traditional or contemporary versions (see Hall et al., 2018; Tauber et al., 2019 for systematic reviews and meta-analyses). Examples of these interventions range from psychoeducation and preventative interventions (Dieng et al., 2016; Pradhan et al., 2021) to mindfulness-based interventions (Lengacher et al., 2009), cognitive-existential (Lebel et al., 2014) or acceptance and commitment therapy (Arch & Mitchell, 2016). In general, these interventions have been shown to be effective, with small but robust effects at postintervention, largely maintained at follow-up (Tauber et al., 2019).

Emotion-focused therapy (EFT) is a humanistic-experiential approach to psychotherapy (Elliott et al., 2004), empirically validated for different psychological difficulties, such as depression, complex trauma or anxiety (Elliott, 2013; Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Timulak & McElvaney, 2015). Individual EFT has also been used effectively with cancer populations, albeit in only a few studies. Six women with breast cancer showing comorbid anxiety and depression improved significantly after an EFT treatment (Connolly, 2016). A hospital-based exploratory outcome study with 17 patients with different cancer diagnoses and presenting with FCR, among other cancer-related concerns, also found significant pre- and postoutcome differences, both for client-generated and standardised measures (Almeida et al., 2022).

Although EFT can be considered a transdiagnostic approach (Timulak & Keogh, 2020), there is still a need for understanding how EFT works with different difficulties or populations, refining its practice. Specifically regarding EFT–FCR, there is not enough information about the change process or the helpful factors in therapy, which can be researched by methods such as task analysis of significant therapy events or microanalytic research of sequences of client–therapist in-session interactions (Elliott, 2010).

The goals of this study were, first, to identify the EFT components used with a good-outcome client who presented with high levels of FCR, and second, to develop a rational-empirical model of how successful EFT–FCR can unfold over therapy.

We addressed these questions via case-level task analysis.

Implications for Practice

- Typical EFT principles and tasks can be used with patients/survivors of cancer who present with clinical levels of FCR.
- Emotional/experiential avoidance and existential pain are critical issues when working psychotherapeutically with FCR.
- FCR may involve different layers of anxiety, linked with past cancer-related and life traumas.

Implication for Policy

- The development of a model of EFT for FCR can contribute to the diversity of therapeutic approaches for FCR, serving different client preferences and needs.

2 | METHOD

Although task analysis has been used for more than a century (for an history of cognitive task analysis, see Militello & Hoffman, 2008), its application to psychotherapy originated in the 1970s with Laura Rice and Leslie Greenberg (Greenberg, 1983, 2007; Rice & Greenberg, 1984) and provided the basis for the development of EFT, which was based on task analyses of the different therapeutic tasks (e.g., empty-chair work for unresolved relational issues). In psychotherapy research, task analysis aimed at discovering and validating the specific/detailed steps by which clients address and resolve particular emotional processing difficulties, that is, successfully complete relevant therapeutic tasks (Pascual-Leone et al., 2009). Usually, a complete task analysis consists of two phases: (a) a discovery phase, in which both rational and empirical methods are used to build a model of how a given therapeutic task is effectively performed; and (b) a validation phase that will test and validate the discovered model (Greenberg, 2007). In this study, we conducted an adaptation of the task analysis methodology, in its discovery phase, using a good-outcome single-case study. In general, task analysis involves examples of a particular task being collected and studied. Here, however, we decided to broaden our scope by examining an entire EFT treatment to discover how a particular client used it to achieve change in her FCR, creating a case-level form of task analysis of a successful therapy. Specifically, we aimed at identifying the most relevant elements of EFT for FCR with this client, along with the sequence by which these elements unfolded, leading to the creation of a rational-empirical model of the change process in EFT–FCR.

2.1 | Participants

2.1.1 | Client

The client, whom we will call "Louise," was part of an exploratory outcome study involving 17 persons with a cancer diagnosis who presented with FCR, among other cancer-related difficulties, and who received an adaptation of EFT (Almeida et al., 2022). This research observed all relevant ethics requirements, including approval by the hospital ethics committee and informed consent from the patient for participation in the study and research purposes.

Louise was a 55-year-old White European woman who had had breast cancer 6 years before, for which she received a mastectomy, radiation treatment and chemotherapy, along with psychotherapy from the first author. At the time of the study, 5 years after her initial

treatment, she was still on hormone therapy when she sought further psychotherapy.

The major difficulty that brought Louise to therapy was an overwhelming fear of her cancer coming back, expressed by intense levels of anxiety, frequently related to bodily signs and symptoms (e.g., whenever she felt something in her body or was physically sick, she was terrified thinking it was cancer again) and to what she saw as her inappropriate health behaviours, which she believed could lead her to a cancer recurrence (mostly "bad" eating and sleeping). Her high levels of anxiety resulted in some panic episodes in the previous months, as well as a general difficulty regulating her own emotions (besides the panic attacks, she was also feeling she was talking and eating too much).

Since she had been free of disease for some years already and had thought that she had coped well with her cancer process, she was also quite puzzled by her own feelings and behaviours; as a result, one of her major goals in therapy was to understand her own reactions and present distress.

Her therapy extended over 15 sessions, mostly every 2 weeks, with sessions occurring in the cancer hospital in which she had previously been treated. In accordance with the research protocol, the client completed a client-generated weekly outcome measure (*PQ—Personal Questionnaire*; Elliott et al., 1999; Portuguese version: Sales et al., 2007; Louise's items are shown in Table 1) and a standardised general clinical distress measure (CORE-OM; Evans et al., 2002; Portuguese version: Sales et al., 2012), every five sessions, as well as a postsession questionnaire (HAT-*Helpful Aspects of Therapy Form*; Llewelyn, 1988; Portuguese version: Sales et al., 2007).

Based on her outcome results, Louise showed clinically significant change on the PQ (Elliott et al., 2016; ≥1.5 pre- and postpoints): at pretest, her score was 5.4, slightly above the average for clients beginning therapy in outpatient settings; at posttest, her score was 3.2, in the nonclinical range; her pre- and postchange therefore substantially exceeded the reliable change value of 1.5. Similarly, she showed reliable change on the CORE-OM (pretest—24; postscore—13; reliable change value: 5; see Barkham et al., 2006). By the end of therapy, Louise described feeling less anxious, having better emotional regulation and understanding her own process and fully attaining her goals for therapy. Therefore, Louise was considered a good-outcome case.

2.1.2 | Therapist

Louise's therapist was the first author, a clinical psychologist in her mid 30s; she had worked in a Portuguese cancer hospital for around 10 years when she saw this client. During this period, the therapist was completing her formal training in EFT and was supervised by the second author, one of the developers of EFT, who also assessed treatment integrity and audited research processes.

2.2 | Analysis

2.2.1 | Rational model construction

Following our adaptation of standard therapeutic task analysis (Greenberg, 2007; Rice & Greenberg, 1984), we began by constructing a rational model for the expected course of EFT for FCR, based first on the general model of the phases of EFT, as presented by Elliott and Greenberg (2021); for further details, we also drew on the EFT Model for Social Anxiety (Elliott & Shahar, 2017). In addition, the first and third authors worked from their extensive clinical experience of working with people with cancer. This model specified four phases of work:

1. making contact and beginning to explore FCR experiences;
2. initial work with presenting secondary FCR processes (e.g., anxiety episodes);
3. deepening: working on and resolving primary existential processes (e.g., fear of death);
4. consolidation: maintenance (e.g., continuing intermittent support) or ending.

TABLE 1 Louise's *Personal Questionnaire* items

1.	Fear that the disease comes back
2.	Eating voraciously
3.	Guilty—I should not do this, I have not the right to have these risky behaviours
4.	Difficulty in going to sleep
5.	Talk too much (I get tired)
6.	Irritability and lack of patience
7.	I do not work well (I am a fraud)
8.	Remorse (burning my stomach)
9.	Tightness in my stomach (imprecise anguish)
10.	Sadness for having had the disease (added at third session)
11.	Conscious of mortality (added at fourth session)
12.	Fear of starting things (added at seventh session)

2.2.2 | Data preparation

For the case study, transcriptions of all of Louise's therapy sessions were prepared; each session was divided into *session episodes* (defined as segments of the session organised around a common task or topic; Elliott, 1993), which also included identifying EFT markers and therapeutic tasks. This stage of the research was developed by the first author and audited by the second author, a specialist in qualitative methods in psychotherapy.

To construct the rational-empirical model, a mapping exercise iteratively worked between the initial rational model and the data generated from Louise's sessions. Whenever necessary, adjustments or alterations to the original model were made, so that the final model mirrored Louise's therapeutic process as closely as possible.

3 | RESULTS

As noted, the rational-empirical model of EFT for FCR we started from followed the adaptation of the current EFT treatment phase model (Elliott & Greenberg, 2021) to work with social anxiety processes, requiring us to make adjustments and refinements to the initial model to make it better fit FCR. The proposed Model of EFT for FCR, described below, is also presented in Table 2.

3.1 | Phase 1: Making contact and beginning to explore fear of cancer recurrence

a. *Alliance Formation*. In Phase 1, the main goals were creating a safe environment and an emotional bond to work productively and effectively with the client, as well as clarifying and exploring the client's main difficulties. Louise stated clearly that her different complaints converged with or related to FCR, as she concluded at the end of Session 1 (minute 43): *It all started to be channeled, everything always in the same direction…the illness doesn't spare me, the illness is there again*.
b. *Narrative work*. The narrative work, which occurred in different forms across her therapy, began at this stage with Louise recalling traumatic events, such as the cancer diagnosis and several episodic memories from her cancer trajectory, as well as identifying some cherished beliefs that were violated by the cancer experience (an EFT marker for the creation of meaning task). The rupture she felt before versus after her cancer clearly involved grief and trauma, as can be seen in this account from Session 1: *And I've never had again that feeling of being a winner*, "I'm going to make it", *thinking, I was already ill and didn't know, and I've never had that again after the illness, of* "I'll now be able to"…*never again*.
c. *Empathic exploration/focusing*. Using mainly empathic exploration (Elliott et al., 2004) and experiential focusing (Gendlin, 1981) allowed the client to access, deepen and symbolise her experiences of FCR, which, in turn, led the client to begin to approach what seemed to be her core pain (i.e., the thing that hurts the most), the fear of dying. Here is an example of this from Session 2 (minute 16):

T: What does that side [of you] tell you, because there's a side of you that frightens you in some way, or…what does that side tell you? That it might be…
C: That the second time I don't make it.
T: The second time you don't make it.
C: That's it! Or very difficultly (T: very difficultly) because I don't rule it out: [that] I'll still get away with it, if there's another time, I'll still get away with it!

3.2 | Phase 2: Initial work with presenting secondary anxiety processes

a. *Narrative retelling/systematic unfolding of fear/FCR episodes*. In Phase 2, the experiences of FCR were progressively explored in more depth through narrative work and systematic unfolding, in which the therapist guides the client through specific difficult or puzzling experiences. While doing this, Louise evidenced strong experiential avoidance, which she realised had been an important coping mechanism until recently. In Session 3 (around minute 20), Louise revealed how difficult it was to access her painful emotions:

C: Some time ago I was sent an e-mail, one of these colleagues, an email that there's a movement now where people must, what was it like? Talk about the thing, let themselves be sad and I shook it off, I said, "I don't want that!"
T: I don't want to let these difficult things come.
C: Because I focused backwards [crying voice].
T: What's it like to be letting it come for a bit?
C: It's horrible [mixture of laughter and crying], it's horrible!!!

b. *Emotion regulation*. Also fundamental at this stage was helping the client deal with emotion dysregulation or potentially dysregulating experiences in therapy. Louise tended to oscillate between over-regulating her emotions, such as overly describing experiences in a nonemotional or externally focussed mode, or using laughter (as can be noticed in most of the excerpts presented) for distancing from the painful emotions, and becoming under-regulated, as when experiencing panic attacks. The main strategies used with Louise in therapy were helping her take a breath, grounding, using therapist presence/pacing and experiential teaching, which helped her approach her most difficult emotions using two-chair work.
c. *Two-chair work for conflict splits*. Throughout this phase, presenting secondary processes were worked with mainly through two-chair work (which started in Session 6). These included different conflict split markers regarding FCR, revealing the critic/coach/guard aspects of self, related, for instance, to body checking or hypervigilance (i.e., anxiety splits, which involve one part of the person scaring another part); the attribution to others of own

TABLE 2 Rational-empirical model of emotion-focused therapy for fear of cancer recurrence

Phase I: Making contact and beginning to explore FCR

a. Alliance formation: Bonding and clarification of therapy goals

b. Narrative work for developing a coherent cancer narrative:
   - Cancer trajectory and impact on life projects; possible identification of cancer-related traumatic events.
   - Account of FCR experience(s).

c. Empathic exploration/focusing for accessing, deepening and symbolising experience of FCR; differentiation of specific fears and validation of fear

Phase II: Initial work with presenting secondary anxiety processes

a. Narrative retelling/systematic unfolding of specific fear/FCR episodes

b. Emotion regulation work: dealing with dysregulation; helping the client to approach potential dysregulating experiences (Leads into:)

c. Two-chair work for conflict splits: anxiety; attributional; self-criticism; and self-interruption

Phase III: Deepening: Working with and resolving primary existential processes (fear and sadness)

a. Two-chair work (with focusing) on deeper primary maladaptive stuck emotions (e.g., depression, abandonment, vulnerable and resentment/protest) and/or sense of defective/weak/bad self (e.g., for having had cancer) moves to core existential pain (e.g., dying/death; isolation; meaninglessness; and responsibility)

b. Reprocessing work: trauma; meaning protest (regarding cancer and death); from fighting to grieving; connecting sadness/shared human experience; meaning construction

c. Compassionate self-soothing chair work for repairing core pain/old injuries

d. Cyclic/complicated processes related to anxious and traumatic processes: cyclic movements between Phase II and Phase III

Phase IV: Consolidation: Maintenance or ending

a. Providing ongoing support for cancer process (e.g., periodic tests/medical appointments) as needed (*or*)

b. Ending: Tapering off frequency of therapy; helping client consolidate change and carry this forward in their life; preparing for and processing the end of therapy

feelings/perceptions, such as feeling blamed for not being sufficiently involved in professional activities (i.e., attributional splits, in which feelings about self are projected on to others); as well as self-interrupting deeper emotions (i.e., self-interruption splits, which involve part blocking or silencing another part), frequently through self-critic processes (e.g., Louise found herself "stupid" or "ungrateful" for having certain feelings "after so much time" and "since having survived").

Progressively reducing the avoidance or interruption of her emotional experiences, Louise started to express herself more freely, as can be seen in Session 4: "I'm no longer a woman with cancer who refuses to say, 'This is very bad'; [now] I'm saying it." In Session 6, in two-chair work for self-criticism, Louise criticised herself for being more active in her job recently and experienced being "a poor thing" after the illness, revealing a kind of self-pity (a secondary reactive emotion), eventually leading to a vulnerable sense of a fragile or diminished self (a maladaptive primary emotion). The dialogue between the critic and the experiencer evolves to a point where the experiencer comes to a better understanding of the negative impact the cancer diagnosis had in her life/self and assertively expresses her needs, at this point appearing as a partial resolution (minute 39):

T: What about that part that says, "You're always going to be an underdog and you're not going to get out of it?"

C: I don't know, I don't believe it, I don't want to be an underdog.

T: Tell them that.

C: I don't want to always be an underdog.

T: "I'm not that, I don't want to be."

C: I'm not, I wasn't before, I wasn't an underdog, I wasn't, I became [that] after the illness.

T: "I became like that, I was weakened."

C: I became like this, I'm not the one that's like this, I became like this.

T: "I became like that," that's not an intrinsic thing or…

C: No, it's not (T: It's not) I want to believe that it's momentary, that's what I want it to be, transient, not momentary because it's been a long time, but transient

T: Okay, "Transient, this is not what I am, it doesn't define me, therefore…"

C: It's not what I am, I didn't have these fears before, I didn't have the disease either, I wasn't afraid that any day I'd go there and that's it, I wasn't afraid of that.

T: "I wasn't, now it's as if I…"

C: I wasn't afraid to talk about death, I wasn't afraid to talk about [it], I wasn't, and now I am. But I wasn't afraid to talk about these things, it was a natural thing (T: Most natural thing); of course, I didn't want to die, I never wanted to, I always thought that, as I say, I was going to be very old and grumpy like my grandmothers and, but I was calm about it, I could talk about it, and I never could anymore (…)

In a subsequent dialogue, in Session 7 (minute 26), the coach/critic/guard part expresses its fear that it is afraid of Louise returning to her *old life* before diagnosis, in which she now recognises that she neglected herself:

C: And this side is very distressed because I have the feeling that this voracious eating or whatever is like before, it's dangerous for my health, it's dangerous.

T: Okay, so it's this side that says, "just stop it or don't get into this stuff because it can…"

C: It makes you very tired (T: very tired), it also doesn't do you any good and it gives you (T: gives you) uncontrolled (T: gives you uncontrolled) sleep.

T: Of sleep, of food.

C: And that's dangerous. (T: That's very dangerous) That's my old life.

T: Okay, and it connects to what's happened before and you don't want that, we don't want that, nobody wants that.

C: Nobody wants that.

T: Okay, it's clearer what that side, it leads to…

C: Is the old fears.

T: And it brings the old fears, "I'm very afraid."

C: Or rather, it brings the fear of going back to the beginning.
T: You can say, [pointing to the other chair] before you then move on here, can you say, "I'm afraid that when you do this…"
C: The lack of control (T: the impact that that…), the lack of control, the panic - so the lack of control, the overeating, the not sleeping, not resting, because that was, that's what led to the illness.
T: "That's what led to the illness, and I don't want you to get sick again."
C: Exactly.

3.3 | Phase 3: Deepening: Working with and resolving primary existential processes (fear and sadness)

In Phase 3, more consistently present from Session 8 onwards, we found that chair work for conflict splits deepened to meet and transform primary maladaptive processes, making way for adaptive (useful) needs and emotions.

a. *Two-chair work (with focusing) on deeper primary maladaptive emotions*. Using two-chair work and focusing, Louise progressively identified the multiple physical and psychological losses derived from her cancer experience, including what she called the "loss of the illusion of eternity." Louise grasped how this had left her with a sense of a defective, weak and vulnerable self. Existential issues (i.e., dying/death, isolation, meaninglessness and responsibility; cf. Yalom, 1981) were found to make up Louise's core pain. Finding more distant sources of existential pain in her childhood and young adulthood (when dealing with the loss of her mother), Louise realised these had been there essentially since her cancer diagnosis, but most of the time covered, suppressed or distanced, as this statement in Session 9 (minute 24) shows:

C: It bothered me a lot since I got sick, it bothered me a lot, the idea of nothing, the nothingness, the disappearing; very very bad, very difficult, and I, for many years, didn't think and now I think [about it] [laughs].

Fully recognising the fact of her own mortality and how her current difficulties related to that, Louise felt the need to face her existential fear and sadness, which carried some clarity and underlying relief (Session 10, minute 36):

C: At least I can see better what's going on (T: a little better, ah, a little clearer), basic, I didn't think it was so basic and so primary; I like being alive and I really like living and I'm afraid of walking through nothingness.

Nonetheless, she was still finding it challenging (same session, minute 37):

C: This doesn't have a solution, but it doesn't have a solution. (T: It doesn't have a solution, ah, defi-) How does one live, how does one, how does one learn to live with this, without having all those manifestations around?

b. *Reprocessing work re: trauma and cancer*. Reprocessing work also continued mainly through the trauma retelling and meaning recreation therapeutic tasks. Louise reviewed several difficult cancer-related episodic memories, accessing, expressing and reprocessing aspects of those experiences she had not before, such as sadness and anger for having had the disease. This allowed her to build some meaning bridges, significant connections involving her different cancer-related experiences, helping her to better understand her present situation, but also to link her present experiences to previous traumatic experiences, as she clearly stated in Session 11 (minute 4):

C: Basically, what I already had, was the first time when I was a little girl with the history of the universe and then when my mother died, that was a direct confrontation without much of a chance, there was no remedy. Then I had it again and I gained about 20 kg at that time. This week I've been thinking about (T: mm-hm, mm-hm, there was that too) the manifestations, the manifestations were the same [as in my cancer experience].

c. *Compassionate self-soothing chair work*. At this stage, as Louise started unveiling her existential anguish, the therapist proposed some compassionate self-soothing chair work. At the end of Session 9, in work with her deep emotional suffering, Louise provided soothing to an imagined vulnerable friend, as seen in this excerpt, which, in the end, brought her some hope and comfort:

C: It'll pass, these things will pass (T: This will pass), just hang in there and it will pass.
T: Ah hang in there, is that it? That's it, hang in there, it's not easy, but just hang in there, it will pass (C: It will pass), you will come out of this?
C: Because I too in my life can't do that easily.
T: But tell her that, tell her!
C: It will pass, people have it too, I have it too, everyone has it, problems, bad phases (T: problems, more difficult phases), I just must learn to get out of the phase.
T: "You must learn to get out of it" – How can she learn to get out of it?
C: To get out of the phase by analyzing (T: That and what's happening), eat the elephant one bite at a time (T: one bite at a time, ok, so instead of trying to solve the whole problem) all at once, one at a time.

In the following session (Session 10), in another chair work for compassionate self-soothing, Louise found it harder to get to a place of self-comfort when she moved to the soother chair (around minute 20): "I'm feeling that thing, that voice of fears and that thing in my chest

growing, that red, purple thing." Using the focusing task, which helped her to clearly point to her deepest pain, Louise was progressively more able to find comfort inside herself, coming to this declaration at the end of the session (minute 41):

C: There's the fears deep inside and there's a certain peace of "This is no big deal after all," this is what it is.
T: Okay, it is what it is, okay?
C: And you're going to have to deal with it.

Approaching the transformation of her maladaptive emotion scheme, Louise was able to access primary adaptive emotions, such as sadness for having had the disease and existential fear and sadness, which she was able to express and be with.

d. *Cyclic/complicated processes for anxiety/traumatic processes*. One of the differences/adjustments we found from the initial rational model is that Louise oscillated between the tasks of Phase 2 and Phase 3 in most of the middle sessions of her therapy. We realised it was difficult for the client to get past her experiential avoidance/self-interrupting processes, even in the late phases of therapy, while she was, at the same time, progressively more capable of identifying and dealing with her core pain. It was also reflected, for example, in the progress and setbacks in two-chair work (from secondary to primary processes and back again). As such, we found the model needed to better reflect the fluidity and complementary work between these two phases.

3.4 | Phase 4: Consolidation: Maintenance or ending

In Phase 4, Louise found herself ready to end therapy, "because it disappeared that thing that made me come here" (Session 14, minute 26). She felt she had solved her initial puzzlement and showed actual changes in her previously dysfunctional behaviours, such as not having panic attacks and feeling what she considered to be a normal and proportional fear of certain situations. Overcoming experiential avoidance and dealing with deeper painful emotions were also considered important accomplishments, as referred to in Session 13 (minute 22):

C: So, it comes the sadness but it also comes more of a, more normal, more normality (T: ok), it's both things (T: ok); it comes the sadness because I actually face it, it was a big bummer.
T: Sure, because you look more at it, to what happened and to what it brought you.
C: Yeah and because I really look at it, I really do.

This ending of therapy excluded the other element of the rational model (*Maintenance*), although we think this might be a real possibility in other cases, considering the practical experience in the field on the part of the research team.

4 | DISCUSSION

This client's therapy involved common aspects of EFT for other anxiety presentations, generally following the expected phases of intervention in the initial rational model: (1) Louise's therapy started with the development/strengthening of the therapeutic alliance and empathic exploration of her cancer-related experiences, including FCR; (2) it progressed with work around secondary emotional processes, such as emotional avoidance and secondary anxiety splits, until it reached; (3) the primary maladaptive processes, which allowed the identification, deepening and transformation of her core pain; and (4) the consolidation of the changes achieved led the therapy process to its completion. However, our analysis provided considerable detail about how these broad stages unfolded.

The centrality of the relational and empathic aspects of EFT, documented here, points to the importance of a unique and safe relationship of the client with someone who genuinely cares and sees, understands and accepts their experience. This is emphasised by different psychological interventions with cancer patients (Boulton et al., 2001; Carlson, 2015; Krenz et al., 2014; MacCormack et al., 2001).

Secondary processes in Louise's case involved strong experiential avoidance and self-interrupted emotions, found in previous research (Connolly, 2016) and generally understood as typical perpetuating emotional difficulties in women with breast cancer (Aguirre-Camacho et al., 2017). Emotional and behavioural avoidance have been conceptualised in EFT as ways for the person not to feel core, chronic painful feelings and may involve avoiding all feelings (Timulak & Keogh, 2020). For Louise, this was also related to what has been termed the *guilt of the (cancer) survivor* (Glaser et al., 2019), as she felt she had no right to feel sad/angry/fearful, given that she had survived cancer, unlike other patients. During other periods of the cancer trajectory, such as through treatment, connecting with "negative feelings" was also viewed by the patient as contradicting the widely held push to think positively, which, for patients with cancer, has long been considered an *unfair burden* (Rittenberg, 1995) and even a kind of *tyranny* (Holland & Lewis, 2000).

Given that FCR was identified as the main problem for Louise, our data nicely illustrate the complexity of the lived cancer experience (Iskandar et al., 2021), impacting different areas of life (personal, professional, family), for a long period of time, and connecting to past experiences and to the prospect of future life. Cancer experience thus often includes a succession of multiple stressful and potentially traumatic events, namely diagnosis, treatment and post-treatment/survivorship stages (Cordova et al., 2017), which may be exacerbated by precancer psychological vulnerabilities (Connolly, 2016). In Louise's therapy, this indicated the importance of her reprocessing her cancer-related traumatic experiences, with events extending from her strong emotional response after hearing the cancer diagnosis to the impact of an interaction with a nurse during a chemotherapy session. This latter situation implicitly triggered a fear related to a possible recurrence in the future, but also

led to the need of reprocessing other noncancer previous traumatic events related to her existential condition (e.g., first childhood experience with the immensity of the universe). Fully emotionally processing all these different major and minor events may be somehow more difficult during periods of intensive treatment, making the phase of post-treatment more suitable for revisiting and completing this internal work.

Although we found aspects similar to other anxiety presentations, the identified core pain in EFT for FCR was related to existential pain (fear and sadness), which was in line with what was found in participants of Connolly's study (Connolly, 2016), but differed from what has been considered central in social anxiety (shame/fear; Elliott, 2013) or in generalised anxiety (loneliness, shame and fear/terror; Timulak & McElvaney, 2015). Death anxiety has been argued to be a transdiagnostic construct relevant for various psychological conditions (Iverach et al., 2014), and it might also be a central factor in the FCR experience (Berlin & von Blanckenburg, 2022), although there is still a need to further investigate this theory, taking into account the possible multiple manifestations of FCR and death anxiety (Sharpe et al., 2018).

Another difference from the initial rational model was the cyclic movements between secondary and primary processes we found in Louise's therapy, confirming the idea of a non-linear "saw-toothed" pattern of emotional progress in psychotherapy (Pascual-Leone, 2009, 2018). It is also possible to relate it to the demands of facing the existential givens (Yalom, 1981), which can be hard for patients and health professionals, including psychotherapists (see Sharpe et al., 2018, for a reflection on some barriers to the study of death anxiety and FCR).

Using a single case for a task analysis limits the generalisation of the conclusions we arrived at, bearing in mind that FCR may be very different for different people (Almeida et al., 2019). At the same time, considering that this is a new field of research for EFT, in spite of its overlap with other anxiety difficulties, this study provides a basis for future research, for example via further exploratory case studies and the validation step of task analysis (Greenberg, 2007). Another limitation is the allegiance of most of the research team to EFT, which is also important to consider when generalising from these results.

Although the PQ has shown clinical utility and robust psychometric qualities, namely strong correlations with standardised outcome measures (Elliott et al., 2016), we also acknowledge the absence of a specific measure for assessing FCR in this study. This also relates to the fact that, in the original larger study, the authors did not define the cancer-related issues to be treated in therapy; instead, FCR emerged as a salient issue for around 60% of the patients (Almeida et al., 2022).

In clinical terms, this study can inform psychotherapists using EFT with clients presenting with problematic FCR. For example, it illustrates how standard EFT humanistic and experiential elements can be combined with attention to particular issues, such as emotional/experiential avoidance and existential concerns.

5 | CONCLUSION

EFT for helping people dealing with dysfunctional FCR seems to generally follow the common steps of EFT intervention. More specifically, however, this task analysis has highlighted the difficulties a person who has had cancer may have in addressing painful core emotions and moving out of experiential avoidance, which might relate to complex experiences of anxiety and trauma. Dealing with existential issues was also found to be possibly central in this cancer-related issue.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare that are relevant to the content of this article.

ETHICAL APPROVAL

Approval was obtained from the Ethics Committee of the Portuguese Institute of Oncology of Porto Francisco Gentil, E.P.E. The procedures used in this study adhere to the tenets of the Declaration of Helsinki. Informed consent was obtained from all individual participants included in the study. The names of the participants have been changed to protect their identification.

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