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Emotion-Focused Therapy for Fear of Cancer Recurrence: A Hospital-Based Exploratory Outcome Study

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Fear of cancer recurrence (FCR) is a main concern for most cancer survivors and can bring significant distress impacting well-being and quality of life. Although other psychological approaches have been developed for dysfunctional FCR, based on previous research, emotion-focused therapy (EFT) might also be a relevant intervention for treating this concern. A total of 17 adults with a cancer diagnosis and presenting FCR among other cancer-related concerns were offered EFT, delivered in a regular practice in a cancer hospital (mean number of sessions = 13, range: 4–25). Outcome and process instruments were used to assess general psychological distress, client-generated outcome items, and helpful and hindering aspects of therapy. Significant pre–post outcome differences were found, both for client-generated (d = 1.53) and standard (d = .88) measures, with no cases of reliable deterioration, although most patients did not show clinically significant change by the end of therapy. The most frequent helpful in-session processes were client verbal expression of experience and work on parts of self; the most common immediate session impacts were positive feelings and self-realizations. EFT may be a useful alternative treatment for FCR.

Clinical Impact Statement

Question: Is emotion-focused therapy (EFT) a potentially effective treatment for fear of cancer recurrence (FCR)? ***Findings:*** EFT was found to be an effective intervention for helping a Portuguese sample of people seen in routine practice to deal with their cancer-related distress, including FCR. ***Meaning:*** Based on this exploratory study, EFT might be a useful alternative treatment for FCR. ***Next Steps:*** Replication studies and randomized controlled trials will be necessary to confirm and expand these results.

Keywords: emotion-focused therapy, psycho-oncology, psychotherapy, cancer, fear of cancer recurrence

Fear of cancer recurrence (FCR), the "fear, worry, or concern relating to the possibility that cancer will come back or progress" (Lebel et al., 2016, p. 3266), is a major concern for over 70% of cancer patients and is frequently cited by survivors as their most important concern (Simard et al., 2013). FCR has been described by survivors of cancer as a complex, intense, and difficult experience, affecting multiple dimensions of their lives (perceptions, emotions, body, cognitions, and behavior; Almeida et al., 2019)

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and taking the form of existential distress (Vehling & Kissane, 2018). Also, there is strong evidence that higher FCR is associated with poorer quality of life and higher psychological distress, anxiety, depression, and avoidance/intrusion (Sarkar et al., 2014; Simard et al., 2013). Patients experiencing clinical FCR have high levels of preoccupation or worry and recurrent and long-lasting thoughts or images related to cancer or death, which increase over time, are difficult to control, cause excessive distress, and impact their daily lives, making it difficult to plan for the future (Lebel et al., 2016; Mutsaers et al., 2016).

Psychological interventions for helping people dealing with FCR have been developed mainly in the past decade, and a recent systematic review concluded that there is a small but robust effect on decreasing FCR (Tauber et al., 2019). Most of these interventions rely on cognitive–behavioral approaches, either traditional or contemporary. For example, a randomized controlled trial using a blended (face-to-face plus online) cognitive–behavioral intervention with a sample of people with different cancer diagnoses showed significant clinical improvements with a moderate-to-large effect size (Van De Wal et al., 2017). Another intervention for FCR combining metacognitive and acceptance/commitment elements was also successfully tested in a randomized controlled trial, with significant results not only by the end of therapy but also after 3 and 6 months (Butow et al., 2017).

Although less frequently, other therapeutic approaches have been used successfully, such as supportive-experiential group therapy (Herschbach et al., 2010) or a gratitude intervention, which showed a significant decrease in death-related fear of recurrence (Otto et al., 2016). In addition, a psychoeducational booklet plus three individual telephone-based psychodynamic sessions have also proved to be effective in reducing FCR in a sample of melanoma patients at high risk for developing another melanoma (Dieng et al., 2016). In any event, considering the importance of combined or tailored interventions (Leichsenring et al., 2018) as well as the need for taking into account client preferences (Swift et al., 2018), it is important to further explore different therapeutic options.

Emotion-focused therapy (EFT), an individual humanistic-experiential psychotherapy stemming from person-centered, gestalt, and existential traditions (Elliott & Greenberg, 2007), is an evidence-based approach shown to be efficacious for several psychological problems, including depression, interpersonal problems, anxiety, and trauma (Elliott, 2013; Elliott et al., 2004, 2013). As an individual therapy, EFT combines contemporary emotion theory (Goldman & Greenberg, 2015) with active therapeutic tasks such as two-chair work and empty chair work for helping clients deepen and transform stuck or reactive emotions into adaptive (useful) emotions (Elliott et al., 2004). In cancer populations, Connolly (2016) reported significant pre–post results in six women with cancer and comorbid anxiety and depression involved in individual EFT therapy. A randomized controlled trial using an EFT couple intervention with patients in advanced stages of cancer and their caregivers also proved to be effective (McLean et al., 2013). Other studies with cancer population have successfully used particular emotional deepening or regulating interventions commonly used in EFT, such as *focusing* or *clearing a space* (Katonah & Flaxman, 1991; Klagsbrun et al., 2010). At this point, however, it is not clear from these studies what elements of EFT are likely to contribute to client change.

The present study was carried out mainly to explore the effectiveness of EFT for helping people dealing with FCR and also to identify the specific aspects of therapy that clients find helpful.

Method

Clients

Participants for this study were selected from a wider sample of patients ($N = 29$) who agreed to participate in an exploratory study on the applicability of EFT to people with cancer (Elliott et al., 2014). These were adults (≥18 years old) with a cancer diagnosis treated in a Portuguese cancer hospital and referred to the psychology consultation of a psycho-oncology service; exclusion criteria were having a limiting physical condition for psychotherapy or major cognitive deficits. All participants were of Portuguese nationality, were of European origin/White, and spoke Portuguese. Because it was the most common presenting problem, a subsample of 17 patients who presented with FCR was selected for the current study.

The selection process of participants was done by Susana N. Almeida and Eunice R. Silva (they were also the therapists of these patients) by analyzing each participant's Personal Questionnaire (PQ) items for the presence of FCR (see measures section for more on the PQ): Each PQ was classified as Main FCR when FCR was explicitly referred to (i.e., "fear that the disease comes back") and a main concern was identified for the patient (among their three most highly ranked PQ items), or as Minor FCR when there was no FCR either in the first three items of the PQ or FCR was implied but not referred to explicitly (e.g., "uncertainty about the future"). Each rater independently categorized each participant into one of three subgroups (Main FCR, Minor FCR, not FCR); disagreements or doubts were later discussed by the two raters until consensus was reached. Before the discussion of ratings and reaching consensus, the initial interrater reliability between the two raters on the inclusion and assessment of participants was good (Cohen's $\kappa = .74$; McHugh, 2012). Nine people were included in the subgroup Main FCR; eight people were in the Minor FCR group (53% vs. 47% of the sample). The two raters also extracted from the PQ all the items they considered related to FCR (PQ-FCR; item examples: *fear of the disease coming back*; *fear of not having cure, of suffering, of the worsening of the disease*) for later analysis (all the participants included had at least one of these items). From the 22 participants who presented FCR, five were excluded: three dropped out of therapy (two patients had three and four sessions, respectively, not attending the following one; the other had 11 sessions and stopped attending due to deterioration of her medical condition, which eventually led to her death); one had no assessment measures (although the therapist confirmed the patient had FCR as a main issue); and another was still in treatment when the data analysis began.

The demographic and clinical characteristics of the final sample for the present study are presented in Table 1. The research was approved by the hospital ethics committee, and participants gave their informed consent for participation in the study and research purposes.

Table 1
Demographic and Clinical Characteristics of the Sample

Participants	$N = 17$
Female	14 (82%)
Mean age at study entry (range)	45 (range: 24–69)
Married/civil partnership	11 (65%)
Single	4 (23%)
Divorced	2 (12%)
With children	13 (76%)
Level of education	
0–4 years	2 (12%)
4–9 years	4 (24%)
9–12 years	6 (35%)
12+ years	5 (29%)
Cancer site	
Hematological	6 (35%)
Colorectal	5 (29%)
Gynecological	3 (18%)
Urologic	2 (12%)
Breast	1 (6%)
Stage of disease	
0/I	5 (29%)
II	8 (47%)
III/IV	4 (24%)
Medical treatment status	
Off-treatment	13 (76%)
On treatment	4 (24%)
Psychiatric medication	
Yes	6 (35%)

Therapists

The two therapists of the study (Susana N. Almeida and Eunice R. Silva) were clinical psychologists who had been working in the cancer hospital site of the research for more than 10 years at the time the study began. In the previous years, each had formal training in EFT, following the standards for accreditation of EFT therapists set by the International Society for Emotion Focused Therapy. Their main supervisor was Robert Elliott, one of the developers of EFT, who assessed treatment integrity. These three authors were engaged in a wider project of exploring the applicability of EFT to people with cancer. In the present study, one of the therapists delivered therapy to 10 patients, the other to seven patients.

Measures

The PQ (Elliott et al., 1999; Portuguese version: Sales et al., 2007) is an individualized client-generated outcome measure designed to measure changes in psychological difficulties during therapy. It consists of a list of problems identified by the client, described in their own words and which they want to work on in therapy; each item is rated by the client according to how much it had bothered them in the past week (for procedure manual and blank forms, see Elliott et al., 1999). The PQ has been shown to be a robust measure with good psychometric properties as well as clinical utility, with an established cutoff of 3.25 (on 1–7 scale) and a reliable change index value of ≥1.5 points for pre–post reliable change (Elliott et al., 2016). In this study, a PQ was created for each client during their first session and was subsequently filled out at the beginning of each session, constituting a session-by-session outcome measure (although only the scores from the first and last sessions were used for analysis). As no specific measure of FCR was available in Portuguese, we retrieved from each participant's PQ all the items related to FCR, which we called PQ-FCR.

The Clinical Outcome in Routine Evaluation–Outcome Measure (CORE-OM; Evans et al., 2002; Portuguese version: Sales et al., 2012) is a measure of general psychological distress. It includes 34 items on four different dimensions: subjective well-being, problems/symptoms, life functioning, and risk (to self and to others), and each item is rated on a 5-point scale ranging from *not at all* to *most or all the time*. CORE-OM is a well-established measure, with extensive data supporting its psychometric properties as well as a clinical utility with patients presenting with a broad range of psychological problems (Evans et al., 2002). The recommended cutoff is 10 (Connell et al., 2007), with a reliable change index value of 5 points (Barkham et al., 2006). In this study, the CORE-OM was administered at the first session and completed every five sessions (although only the scores from first and last sessions were used for analysis).

The Helpful Aspects of the Therapy (HAT) form (Llewelyn, 1988; Portuguese version: Sales et al., 2007) is a postsession questionnaire in which the client describes in their own words the most helpful and hindering event in the session and rates its helpfulness on a 5-point scale corresponding to the degree of the positive or negative impact of the event. The HAT form helps clients reflect on their therapy sessions and describe significant events (Stone & Elliott, 2011). In this study, the HAT form was to be given at every session; generally, clients took it home between sessions, bringing it to the next session or in some cases sending it by e-mail to the therapist.

Psychological Treatment

The treatment was the version of EFT developed by Greenberg et al. (1993), which uses a range of different kinds of emotion work ("tasks") as appropriate. Patients were offered individual EFT, presented to them as "EFT for people with cancer" and adapted for common characteristics of this population, such as having a potentially life-threatening illness, frequently difficult and prolonged treatments, and various cancer-related sequelae. Existential issues are particularly relevant, including cancer as a "boundary" situation, touching people's ultimate concerns including death, freedom, isolation, and meaninglessness (Yalom, 1981). Considering all the possible losses that the cancer experience may involve (e.g., infertility due to cancer treatments, loss of an organ or limb, changes or impairments in communication and feeding), grieving processes are other typical aspects therapists must work with. Also, it is common for patients to present strong self-interruption processes, such as holding back awareness or expression of their difficult emotions to "be strong," to not interfere with their treatment, or to avoid burdening their loved ones. Nevertheless, sessions were generally carried out in a manner typical for EFT, valuing emotion as a main source of meaning, direction, and growth (Elliott & Greenberg, 2007) and working through the relational and task principles described by the developers of the approach (Greenberg et al., 1993). The distinctive feature of this form of EFT is its combination of deep empathic work with specific experiential tasks, which provides different ways to help

clients deepen and transform their emotions (Elliott et al., 2004). The therapists therefore identified markers for working with particular therapeutic issues (e.g., self-criticism) and offered to engage with the client in a particular emotion process to work toward resolution (e.g., therapist proposes two-chair work between the critic and the criticized aspects of the self). To work specifically on the FCR issue, the therapists most frequently used two-chair work for anxiety splits (in which the person makes their self anxious; Elliott, 2013), trauma retelling, as well as meaning creation (Clarke, 1989). Vulnerability markers were also frequently present in these patients, related to either deep existential suffering and/or cancer-related traumatic experiences. Some of these cancer-related traumatic experiences were linked to other previous traumatic experiences.

Sessions generally lasted 50 to 60 min. The scheduling of the sessions was adjusted to patients' ability to attend, including distance from the hospital, financial situation, and physical status, with the result sessions not always being weekly (ranging from one to four per month). The general conditions for the treatment of these patients reflected what was available in the regular clinical practice of psychology in the hospital, considering that there were not any extra resources for the research. Although we expected high variability of the number of sessions (based on our hospital experience), we were aware that 16 to 20 sessions were common in previous studies (Elliott, 2013; Timulak et al., 2018). Data for this study were collected between 2013 and 2017.

Data Analysis

Statistical analyses for quantitative data were performed using SPSS. Paired samples *t* tests were conducted to compare scores before and after therapy on both PQ and CORE-OM; this was also explored for PQ-FCR items. Additional exploratory analyses were done to test whether the subsamples Main FCR and Minor FCR were significantly different from each other regarding the pre–post scores of the outcome measures through independent samples *t* tests and covariance analysis. Effect sizes for pre–post therapy differences were determined using Cohen's *d*. Rates of clinical improvement and deterioration (Jacobson & Truax, 1991) were determined according to the established criteria for each measure (Barkham et al., 2006; Elliott et al., 2016).

For analyzing qualitative data from HAT, we used descriptive–interpretive qualitative analysis (Elliott & Timulak, 2005, 2021). As the HAT form generally provides information on within-session processes (things client or therapist did in sessions) and client reactions to these processes (Elliott et al., 2001), Susana N. Almeida and Robert Elliott first divided the HAT content in meaning units, then allocated them to either *process* or *effects* domains, and then clustered them into categories and subcategories within each of these domains based on similarity of meaning units. Susana N. Almeida identified a set of categories, which Robert Elliott audited and revised and sent back to Susana N. Almeida and so on until consensus was arrived at. The representativeness of each category/subcategory was determined by recording the number of participants referring to it. The categories/subcategories were classified as "general" when occurring in at least 75% of the sample, "typical" when present for at least half of the sample, "variant" when reported for at least two participants (but less than 50%), and "unique" when only one participant indicated it (Elliott & Timulak, 2021). All but one meaning unit referred to helpful aspects of therapy sessions.

A case study retrieved from the sample was briefly analyzed to help illustrate EFT for FCR, including elements of EFT case formulation (Elliott, 2015; Goldman & Greenberg, 2015).

Results

Outcome Data for EFT for FCR

On average, therapy lasted 13 sessions (*SD* = 6.26; range: 4–25). In the beginning of the therapy, all patients presented clinical levels of psychological distress on the PQ (*M* = 5.78; *SD* = .52) and all-but-one on the CORE-OM (*M* = 18.38; *SD* = 5.15). In all, 26% of the PQ items (40/154) were considered to be related to FCR, with a mean of two of these items per person (*SD* = 1.46; range: 1–7). All PQ-FCR items were also in the clinical range (>3.25) at the beginning of therapy (*M* = 6.15; *SD* = .95).

By the end of therapy, PQ and CORE-OM scores were significantly lower than at pretherapy (PQ: $t_{17} = 5.67$, $p < .001$; CORE-OM: $t_{16} = 5.96$, $p < .001$); the same was true for PQ-FCR post-therapy scores ($t_{17} = 4.28$, $p = .001$; Table 2). Eleven patients (65% of the sample) showed a reliable change in PQ by the end of therapy, and four patients (24%) moved from the clinical to the nonclinical range; four patients (24%) achieved clinically significant change. For PQ-FCR items, seven patients (41%) showed a reliable change, although only two patients (12%) moved to a nonclinical score; two patients (12%) achieved clinically significant change. On the CORE-OM, seven patients (41%) presented a reliable change after therapy, and four (24%) moved from a clinical to a nonclinical range; only one patient (6%) achieved clinically significant change. There were no cases of reliable deterioration, based both on PQ (including PQ-FCR items) and CORE-OM measures. Pre–post effect sizes for PQ (*d* = 1.53), PQ-FCR (*d* =.98), and CORE-OM (*d* = .88) exceeded Cohen's (1988) convention for a large effect (*d* = .80). No significant differences were found between therapists.

Dividing the total sample into two subsamples, Main FCR and Minor FCR, we also found pre–post significant differences in all measures for both subsamples (Table 2), but no significant difference between subsamples, using both independent samples *t* tests and one-way analysis of covariance.

Complementing the outcome data, and providing a kind of credibility check, there are some spontaneous reports from participants on HAT forms in which specific improvements relating to FCR were declared: "I was able to overcome the fears I had and live naturally" (Sophie, 30 years-old); "I felt the fear of recurrence was more controlled" (Isabel, 56 years old); "I realize that I was able to enter the [oncology] hospital without fear and without fear of having a serious disease" (Tom, 26 years old).

Helpful Aspects of EFT for FCR

Thirteen patients (76% of the sample) fulfilled at least one HAT form during the psychotherapy process (*M* = 4, range: 1–13), providing 55 completed forms in total. Quotes from participants exemplifying each category and subcategories as well as the proportion of participants presenting them are presented in Table 3.

Table 2
PQ and CORE-OM Pre–Post Scores

Measure	Cutoff	*N*	*M* (*SD*) Pretherapy	*M* (*SD*) Posttherapy	*t*	*p*	Cohen's *d*
			Total sample				
PQ	3.25	17	5.78 (0.52)	4.22 (1.34)	5.67	<.001	1.53
PQ-FCR	3.25	17	6.15 (0.95)	4.89 (1.56)	4.28	.001	0.98
CORE-OM	10	16	18.38 (5.15)	13.56 (5.76)	5.96	<.001	0.88
			Main FCR subsample				
PQ	3.25	9	5.68 (0.31)	4.10 (1.17)	4.89	.001	1.85
PQ-FCR	3.25	9	5.92 (0.94)	4.61 (1.52)	2.76	.024	1.04
CORE-OM	10	9	18.11 (4.31)	13.89 (4.81)	3.52	.008	0.92
			Minor FCR subsample				
PQ	3.25	8	5.89 (0.70)	4.36 (1.58)	3.18	.016	1.25
PQ-FCR	3.25	8	6.42 (0.96)	5.21 (1.64)	3.32	.013	0.90
CORE-OM	10	7	18.71 (6.42)	13.14 (7.20)	5.34	.002	0.82

Note. PQ = Personal Questionnaire; CORE-OM = Clinical Outcome in Routine Evaluation–Outcome Measure; PQ-FCR = fear of cancer recurrence items of PQ; Main/Minor FCR = subsamples of patients in which FCR was a main/minor concern.

Within the *helpful process* domain, we were able to identify therapist and client helpful processes. Although therapist helpful processes were quite variable (variant themes present for at least two participants and less than 50% of participants), patients most commonly referred to the importance of therapist expert interventions (e.g., differentiating fears), therapist encouragement of awareness and exploration, and therapist empathy.

The helpful client processes most frequently referred to included verbal expression of experiences, found to be typical themes, such as disclosing particular experiences, discussing difficult or important topics and unburdening, venting, or catharting. Aspects related to chair work during sessions, a typical category, were inferred when clients referred to the importance of separating out different parts of self, facing/talking with/from fear/worry/negative parts, and finding new or different parts of self. Reflecting on, analyzing, interpreting, and clarifying experiences were also valued by patients, although all were variant categories. Other in-session helpful processes included research procedures (e.g., "the questionnaire"), asking for help from the therapist, and general unspecified aspects of sessions.

Within the *effects* domain, we found four categories: positive feelings/states, self-realizations, emerging action tendencies, and relational impact. Regarding their representativeness, positive feelings/states and self-realizations were found to be general categories, emerging action tendencies a typical category, and relational impact a variant one. Most frequent were patient descriptions of positive feelings/states resulting from therapy sessions, from general positive feelings to feeling more relieved, calmer/more relaxed/less anxious, and secure/safer; some patients expressed feeling empowered/legitimated, more capable/self-confident, and hopeful. Others reported personal improvements or progress. Feeling better by putting things into perspective, such as relativizing/distancing/organizing, was also appreciated. In the self-realizations subcategory, we identified general realizations about self, awareness (realizing something specific about self, i.e., getting more in touch with it without connecting it to something else), and insight (new realization of some kind of connection involving self, including parallels, causes, sources). The emerging action tendencies category involved subcategories for self-coercion/coaching orientations, action determination, internal suggestions/possibilities, and desiring/idealizing. A much smaller but relevant set of comments were related to relational impact, reflecting the importance of shifts in the therapeutic relationship.

Only one meaning unit involved a hindering process, dysregulated distress ("I start to cry when I want to talk about the theme"), leading to self-interruption ("I start trying to 'swallow' the crying"). Based on these qualitative data and the near-absence of reports of hindering aspects, we can conclude this therapeutic approach (and its central therapeutic tasks) was acceptable and valuable for this sample of patients.

Illustrative Case Study

Having presented the results from the outcome and qualitative data, we now present a case study that illustrates how EFT might look in a person with a clinical presentation of FCR. The patient has been de-identified by changing his name and age; no further personal information was used.

Tom was a 26-year-old man in medical follow-up since he was 18 after having a surgery for a colorectal cancer, found to be related to a genetic condition that strongly increases the likelihood of getting cancer at a young age. He had no further treatments for his cancer besides this surgery, and he had been free from the disease since then. He was referred to therapy for high levels of anxiety related to the possibility of cancer recurrence as well as for severe depressive symptoms including despondency, lack of motivation, hopelessness, isolation, and suicidal thoughts. Emotional regulation was also troubled, with Tom presenting with frequent panic attacks, which led to several emergency room visits. Coming to the hospital for follow-up was another very difficult situation for him. He also presented with sleep difficulties, headaches, abdominal pain, and body tension; he generally interpreted his somatic symptoms as a cancer recurrence and was constantly monitoring his body for signs of possible cancer. These difficulties had started about 6 months before psychological treatment and were interfering with his life goals and ability to work.

Tom's EFT process lasted 17 sessions and included a range of different kinds of emotion work (cf. Elliott et al., 2014). Developing a solid therapeutic alliance was challenging due to Tom's hospital avoidance and general helplessness, leading him to frequently

Table 3
Examples of Participants' Quotes Regarding Helpful and Hindering Aspects of Therapy

1. Helpful processes
1.1. Therapist processes (5/13; 38%*)
1.1.1. Therapist expert interventions (4/13; 31%)
• [Therapist] tried to separate my fears in order to be easier to solve the various situations
1.1.2. Therapist encouragement of awareness/exploration (2/13; 15%)
• The therapist encouraged the awareness of the "problem"
1.1.3. Therapist empathy (2/13; 15%)
• After that it was the psychologist understanding me
1.2. Client processes (12/13; 92%)
1.2.1. Verbal expression of experience (7/13; 54%)
1.2.1.1. Disclosing particular experiences (4/13; 31%)
• In this session, it was important to talk about the time of the diagnostic. The moment I knew I was at a risk of life. The way it affected me, and stills affects emotionally.
1.2.1.2. Discussing difficult or important topics (2/13; 15%)
• Talk about my short-term plans, how to take better care of myself and practice more physical activity to lose weight, continue with dietary education.
1.2.1.3. Unburdening, venting, or catharting (4/13; 31%)
• Doing a catharsis of the events that bring me anguish.
1.2.2. Reflecting on/stepping back from experiences (3/13; 23%)
1.2.2.1 Reflecting on/thinking aloud (2/13; 15%)
• It helped me to reflect in a more organized way about my conjuncture.
1.2.2.2 Analyzing/interpreting/clarifying (3/13; 23%)
• We analyzed the situations during the session.
1.2.3. Parts of self-work (client view of chair-work; 7/13; 54%)
1.2.3.1. Separating out different parts of self (3/13; 23%)
• To represent, by separating, two of the "entities" that I'm composed of.
1.2.3.2 Facing/talking with/from my fear/worry/negative parts (3/13; 23%)
• During this session it helped me a lot being face-to-face with my fear, confront him, and find solutions and positivism in what I fear.
1.2.3.3 Finding new/different parts of me (1/13; 8%)
• It was important to find a possible way out, first imagining how it could be and secondly finding a solution to another I could find some way out for me.
2.0. Helpful effects
2.1. Self-realizations (10/13; 77%)
2.1.1. General realizations about self (2/13; 15%)
• I'm getting to know myself again.
• Seeing these things, I feel I understand myself better.
2.1.2. Awareness (8/13; 62%)
• I was able to understand the origin of the problems, and in that sense, I think it can help solving them.
• It helped me to realize that the fear isn't my enemy at all. I can live with him as he is part of me, and he will be for all my life.
2.1.3. Insight (6/13; 46%)
• In this session, I was able to identify the fear as the great booster of the majority of the problems.
• Although still not very clear, it's recognizable a link between the difficulty of facing the "inevitability of death" and the situations of panic (. . .)
2.2. Emerging action tendencies (7/13; 54%)
2.2.1. Self-coercion/coaching orientations (4/13; 31%)
• I also realized that I must be less demanding of myself, act with less pressure.
• It made me understand that I have to open more to the people who love me.
2.2.2. Action determination (5/13; 38%)
• Set priorities. Minimize my pain by avoiding blaming myself. See the world as it is, accept the facts, the reality.
2.2.3. Internal suggestions/possibilities (4/13; 31%)
• However, may be to alert me to start acting instead of always postponing what I should do to improve self-esteem.
2.2.4. Desiring/idealizing (1/13; 8%)
• I managed to idealize what I want to solve in relation to myself.
2.3. Positive feelings/state (11/13; 85%)
2.3.1. General positive feeling (3/13; 23%)
• And the less positive thoughts weren't so present.
2.3.2. Relieved; calmer/more relaxed/less anxious; secure/safer (8/13; 62%)
• It was useful mainly for calming me down.
2.3.3. Empowered/legitimated; more capable/self-confident; hopeful (7/13; 54%)
• I felt human and that my opinion counts.
• I stay with more hope about my problem being totally solved.
2.3.4. Realize/identify own improvements/progress (7/13; 54%)
• I noticed that from the previous session to this I wasn't thinking so frequently about my disease.
2.3.5. Putting things into perspective (2/13; 15%)
• It was important as it helps me to position myself in a more distance and to reflect in a more objective way.
2.4. Relational impact (2/13; 15%)
• I feel confidence in the psychologist and with the patience with which she listens to me.
3.0. Hindering process (1/13; 8%)
• I start to cry when I want to talk about the theme. And I start trying to "swallow" the crying.

* Proportion of clients and corresponding sample percentage for each domain and category/subcategory.

postpone therapy sessions. Experiencing tasks, such as allowing and expressing emotions and experiential focusing, helped the patient to progressively access, express, and symbolize his avoided difficult emotions. It was also necessary to help Tom reprocess specific traumatic cancer experiences and memories, namely, the terror of dying he experienced while he was waiting for his surgery (trauma-related fear). Recovering and reconnecting aspects of his memories helped Tom in making new meaning associations. Trauma retelling work was intertwined with the meaning creation work, with identification and reexamination of violated cherished beliefs—such as "I'm too young for having cancer." Two-chair work was proposed for working with anxiety, self-criticism, and self-interruption splits as well as with compassionate self-soothing. An example of a chair work for an anxiety split is illustrated by this excerpt at the sixth session:

Client (C; speaking as the experiencer):	*Don't bug me anymore, I can't stand hearing you anymore.*
Therapist (T):	*Right. . .don't bug me anymore. . .right, mm-hm. Can you move over here?* (Client changes chairs). *What does this side- What does he say to this, "Don't bug me," always pessimistic, always saying, "I'll never make it, I'll never make it, I'm fed up of this"?*
C (as critic):	*But I'm warning you of worse things.*
(T: Mm-hm):	*I'm making you alert.*
T:	*Right, what I want to do. . .*
C:	*. . .Is to prevent you from suffering*
T:	*It's as if somehow what this side wants is . . .*
C:	*Deep inside me I want to*
T:	*Tell him* (gesturing to the other chair)
C:	*Deep inside I want you to be alert, active, to avoid greater suffering*
T:	*Right, as if in some way, I want to protect you*
C:	*I want you to always be alert, thinking about it so that the symptoms you have don't evolve.* (T: Mm-hm) *or get worse.*
T:	*Right, I want you to be always alert. What is it like when you see him like this, because deep inside he is suffering with this, he is suffering from being always reminded, this whole burden, so . . . is this what this side wants, to bring this suffering to him? Do you want him to suffer?*
C:	*No. . .*
T:	*No, no, ok, so it's not exactly . . . I don't want you to suffer,*
C:	*What I don't want is for you get into something worse.*
T:	*Mm-hm. . . I don't want you to suffer more.*
C:	*That you don't stay alert and then the consequences become more serious.*

As this segment illustrates, we often found that FCR was a secondary process (e.g., fear of feelings in general) and resulted in further secondary processes such as depression/hopelessness, all stemming from primary maladaptive trauma-related fear, often left over from cancer- or treatment-related medical trauma. Working through Tom's emotional difficulties allowed him to touch and connect his deep vulnerabilities and core pain, unfolding existential anguish, a sense of "loss of meaning and of dignity" and the sadness of being lonely in the face of death and of losing self and others. It allowed Tom to activate primary adaptive emotions, such as protective anger, along with connecting sadness and finally self-compassion. He was also able to reconnect to previously unmet needs for hope, as well as meaning, connection, security, and grieving ("And I feel that I can slowly accept things as they really are in a more natural way," HAT form, 10th session). Tom's perceived changes were likewise expressed in the different assessment measures, with a clinically significant change on the PQ (prescore = 5.4; postscore = 3.2; Elliott et al., 2016, $\geq$1.5 pre–post points) and a reliable change on the CORE-OM (prescore = 21; postscore = 13; Barkham et al., 2006, +5 points below).

Discussion

To our knowledge, this is the first study examining the applicability of EFT to FCR in Portuguese people dealing with cancer. EFT was found to be an effective intervention for helping this sample of people dealing with their cancer-related distress including FCR, which was a main concern for more than half of the larger sample.

According to our PQ data, participants in this study presented significantly higher pretherapy distress than broader clinical samples (Elliott et al., 2016; M = 5.78 vs. M = 5.04; t = 3.26; $p < .01$; d = .81). On the CORE-OM, we found similar values to other clinical populations (M = 18.4, SD = 5.15 vs. M = 18.3, SD = 7.1; Connell et al., 2007). In the previous research, clinical distress has been estimated in 30% to 50% of cancer patients (Mehnert et al., 2018; Mitchell et al., 2011), reflecting the cancer experience as a highly demanding situation. Considering that the patients in this study had been referred to a mental health service within a cancer hospital, they might represent an exceptionally distressed subpopulation, which however seems better captured by an idiographic measure (PQ) than by a nomothetic one (CORE-OM). These high initial scores in our sample might help explain the significant pre–post effects. We also note that most of the participants were women with children, which has been found to be associated with higher FCR (Mehnert et al., 2009; Simard et al., 2013; van de Wal et al., 2016). Having a very heterogeneous sample, namely, regarding the level of education and diagnosis, it was not possible to determine whether these variables had also influenced the results. Dinkel et al. (2012) found that level of education was the only predictor of a long-term reliable change in a group psychotherapy for dysfunctional fear of progression, with patients with an

educational level above elementary school more likely to improve (Dinkel et al., 2012).

Clients were doing significantly better by the end of therapy, with no cases of reliable deterioration, but most were still presenting clinical levels of emotional suffering, remaining in the clinical range on PQ, PQ-FCR, and CORE-OM. The PQ showed to be the most sensitive measure to change, reinforcing previous psychometric analysis (Elliott et al., 2016). These results might point to some degree of relief from distress with presenting problems rather than specifically to a dissolution of the anxiety related to the real threat of a cancer recurrence. It would be relevant in future research to assess other variables that could also help explain this result, such as the presence and severity of physical symptoms, a factor related to higher levels of FCR (Simard et al., 2013).

Because EFT is a new approach to address this specific cancer-related concern, exploring aspects of the therapeutic process through the HAT form data helped us to assess if it was a suitable approach for FCR as well as to identify what people found most helpful. Participants essentially described their own internal processes as helpful, mostly valuing internal realizations during therapy sessions and positive feelings coming from it as well as the verbal expression of experiences and work on parts of self. Awareness/insight/self-understanding, exploration of feelings/emotional experiencing, relief, empowerment and reassurance/support/safety were precisely some of the core categories Timulak (2007) found in his meta-analysis of client-identified helpful events in psychotherapy. Given that chair work is a major and salient component of EFT work, it was not surprising that people identifying this as helpful. Chair work for working with different parts of self has been shown to reduce self-criticism and anxiety and depression symptoms in clients (Elliott et al., in press). Observing specifically the accounts directly related to FCR, we found that these are aligned with EFT's emotion change principles: awareness, expression, regulation, reflection, and transformation (Greenberg, 2011). Participants valued becoming more aware of their fear of recurrence (including of the impact it has in their lives) as well as expressing and differentiating their fears. Through two-chair work, some people also referred to the usefulness of "being face-to-face" and "talking with" their fear, coming to important realizations such as "fear isn't my enemy/fear is my ally" (Sophie) or linking it to traumatic experiences: "I realize[d] that what I'm going through is the fear I felt at the time of my surgery that is being activated again" (Tom). These two examples reflect the possibility of FCR being both an adaptive emotion (connecting the adaptive need of protection/prevention) and a maladaptive one (connected to past traumatic events; Elliott et al., 2004). Overall, EFT seemed to be an acceptable psychotherapy for helping patients dealing with FCR.

This study has several limitations, some also constituting eventual potentialities. The sample size was restricted and limited to the work of only two therapists, thus limiting the generalizability of the findings. However, the diversity of patients regarding cancer diagnosis, stage of disease, age, and level of education points to the possible usefulness of EFT for this cancer-related problem in a wide range of patients. In addition, the identification of patients from the larger sample was only based on the PQ items, not fully guaranteeing the specific relevance of FCR for each patient; some of the excluded patients could also have FCR as a relevant issue in their therapy even if this was not mirrored in the PQ. The fact that we could not find significative differences in pre–post PQ, PQ-FCR, and CORE-OM between the subsamples Main and Minor FCR might reflect this as well. More importantly, we did not use a specific or valid measure for assessing FCR (such as the Fear of Cancer Recurrence Inventory, Simard & Savard, 2009), which could be relevant for better distinguishing dysfunctional forms of FCR and providing a better understanding of pre–post FCR changes. It is also worth noting that there are not yet validated questionnaires for measuring FCR in Portuguese, which may be important in future investigations. In the face of this, we could equate the PQ-FCR items to existing brief FCR questionnaires (Thewes et al., 2012), including the single-item measure recently developed by Rudy and colleagues, which has shown promise as an assessment tool of FCR (Rudy et al., 2020). Considering that the study was done in a naturalistic, practice-based context and that the researchers/therapists were careful not to burden the participants, the psychological assessment in general was limited. We also acknowledge the limited number of HAT forms collected that restricted the analysis done.

Conducting this study in a regular clinical practice and without extraordinary resources suggests the possibility of using this psychotherapy approach effectively in cancer hospital settings in routine practice. At the same time, this limited the assessment procedures that could be used, preventing deeper exploration of the results found and their meaning. The great variability in the number of sessions held per person can also make it more difficult to replicate this study. The allegiance of most of the research team to the psychotherapy model studied (including the two therapists) has also to be considered in evaluating the results. Moreover, as 35% of the participants were under psychiatric medication, it is also not clear the role it might have had in the results found.

Some other challenges were identified while working with this specific population: doing therapy in the same hospital where the patients were treated for their cancers was itself a cause of anxiety (and of avoidance) for some patients, interfering with therapy compliance; some patients experienced physical symptoms or functional impairments related to the disease and/or treatments, which were sometimes difficult to distinguish from somatic complaints of anxiety; and having to deal with the real threat of recurrence and death related to cancer, which brought high levels of vulnerability and connected to deep existential issues in patients.

The effectiveness of EFT in this particular population, both in terms of having a specific cancer-related problem and in terms of nationality/culture, can also expand the use of EFT to populations yet understudied, contributing as well to increasing the diversity of choice in psychotherapy in Portugal.

In conclusion, based on this exploratory study and both the quantitative and qualitative data, we see EFT as a promising treatment for high levels of FCR, one that might provide an alternative to other well-established treatments (i.e., cognitive–behavioral). Deep empathic work combined with active tasks (such as two-chair work) can help people go through their intense fear experience and transform it, connecting to more adaptive emotions, which was validated by the qualitative data. The existential concerns the cancer experience can bring to people may be also properly addressed by this humanistic-experiential therapy. Further research is needed to replicate these preliminary results and to expand our knowledge related to the applicability of EFT to the FCR.

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