Developing Emotion Focused Therapy for CAD in Women with Breast Cancer: An Analysis of Six Case Studies

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by

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Declaration

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Abstract

Aims: The aim of the current study is to develop a variant of Emotion Focused Therapy (EFT) for Comorbid Anxiety and Depression (CAD) in women with breast cancer by presenting a series of case studies followed by a cross case analysis. The aim is to move from an EFT understanding of working with depression and anxiety (respectively), and to make the first steps towards understanding the application of EFT to CAD in the context of breast cancer. The study will collect qualitative and quantitative process and outcome data that should inform the development of EFT for CAD.

Method: This was a mixed methods study. Participants (n=6) were recruited from a psycho-oncology service in a radiotherapy hospital. Participant suitability for participation was based on their initial intake assessment, their score on the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) and the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). Participants underwent 14-21 sessions of therapy that were audio and video recorded. Quantitative pre-post outcome measures were completed pre, mid, post, and six month follow up. Descriptive analyses and t-test for dependent samples were carried out on the quantitative data. Effect sizes were calculated which were standardised pre-post differences. Qualitative data were collected at the end of each session from patients and at the end of treatment from both patients and therapists. Qualitative data were analysed in accordance with a descriptive and interpretive qualitative research method described by Elliott and Timulak (2005).

Result: Findings indicate that the pre-post difference in mean scores for the treatment group was statistically significant, with large effect sizes across all measures and suggests that findings are comparable with results for other currently accepted, empirically supported treatments of distress in women with breast cancer. Findings from qualitative outcomes are broadly consistent with the literature on the qualitative aspects of humanistic and experiential therapies to date (Timulak & Creaner, 2010). Case accounts establish core painful emotion schemes and track the transformation of emotion schemes across therapy sessions, with verbatim clinical interactions provided to illustrate change and explore the potential implications of these findings. The current study supports EFT's case formulation of depression and anxiety, and contributes a conceptual framework around the particularities of loneliness, shame, maladaptive guilt and disenfranchised losses that are part of the core painful experiences in women with breast cancer and CAD.

Conclusion: From a review of the six case studies, the results of the current study appear promising, suggesting that both EFT theory and CAD in women with breast cancer, and EFT theory of treatment for CAD in women with breast cancer warrant further examination. An examination of qualitative and quantitative results indicates that therapy appears to have been effective, to varying degrees across all cases. A significant amount of material concerning therapy process in terms of case conceptualisation and emotion transformation has contributed to the development of EFT as a treatment for CAD in women with breast cancer.

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Preface

The current study presents an analysis of the outcome of six cases of Emotion Focused Therapy (EFT) for comorbid anxiety and depression (CAD) in women with breast cancer. The aim of the current study is to develop a variant of EFT for CAD in patients with cancer that could be, if shown to have promising results, further validated in a randomized clinical trial.

While the initial research criteria included all cancer types for study inclusion, completed cases consisted of one cancer type- breast cancer- and reflect that this group is among those most frequently referred to the psycho-oncology service where the study took place. As a result, the literature review and subsequent thesis focuses on this cancer type, which may have overarching applicability across cancer types.

The dissertation begins with an introduction to breast cancer as a disease, followed by a history of breast cancer from a medical, sociocultural and feminist perspective, and its relationship to the psychological impact of the disease within a Western context. The dissertation will discuss prevalence rates of CAD in women with breast cancer and across cancers, describe CAD as an emerging diagnostic consideration beyond the existing suites of Axis I disorders, and its impact on healthcare service use and medical/treatment compliance. The dissertation will discuss current empirically supported psychotherapeutic models within psycho-oncology, and for distressed women with breast cancer. The dissertation will then look at Emotion Focused Therapy (EFT) as a contemporary form of psychotherapy, with increasing empirical support in terms of emotion theory, theory of dysfunction and therapy process. An examination of the EFT perspective on anxiety and depression respectively will be presented.

Six single case studies will be presented, followed by a cross case analysis of same, focusing on qualitative and quantitative findings. Discussion of qualitative findings will synthesise material regarding case conceptualisation and emotion transformation across cases, to illuminate common underlying processes that feature across women with breast cancer. Quantitative outcomes will be tentatively benchmarked against those reported in other studies focusing on psychological treatment of anxiety and/or depression in women with breast cancer, and should they appear promising when compared to existing treatments, it is hoped that this will support further investigation of a brief EFT treatment of CAD for women with breast cancer

1.0 Introduction

Compassion is an unstable emotion. It needs to be translated into action, or it withers.

-Susan Sontag, *Regarding the Pain of Others*, 2003

1.1 Introduction to Breast Cancer

Breast cancer affects one in eight families in the United States, one in eight in the U.K., one in nine in Ireland, one in eleven in Australia, and impacts communities worldwide (American Cancer Society, 2009; Lawrence, D'Arcy, Holman, Jablensky, Threfall, & Fuller, 2001; Cancer Research UK, 2009; National Cancer Registry Ireland (NCRI), 2013). The World Health Organization has found that breast cancer is the most common cancer among women globally; over 1.4 million women worldwide are diagnosed with the disease per year; breast cancer is one of the leading causes of cancer related deaths among women and will account for approximately half a million female death annually (World Health Organization, 2011; Ferlay et al., 2007; Stanley). Table 1 (NCRI, 2014a) demonstrates that in Ireland specifically, the annual average incidence for invasive breast cancer was 2805 cases per annum between 2009 and 2011, and the number of cases of female breast cancer is expected to increase by about 130% between 2010 and 2040 (NCCP, 2014). Table 2 (NCRA, 2014) highlights breast cancer as the highest rated invasive cancer diagnosed among women in Ireland.

Table 1 Annual average incidence for breast cancer in Ireland, 2009-2011
(NCRI, 2014a)

BREAST CANCER	CASES		
	Females	Males	Total
Breast C50** invasive	2,781	23	2,805*
Breast D05** in situ	340	1	341

*as annual averages have been rounded up to whole numbers, slight discrepancies occur
**C50 - Malignant neoplasm of breast; D05 - Carcinoma in situ of breast (ICD-10)

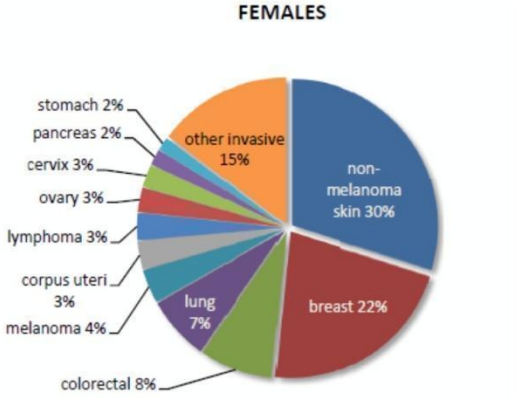


Figure 2 Relative frequencies of the most common invasive cancers diagnosed in females in Ireland, 2009-2011
(NCRI, 2014a)

Table 2 shows the ranking of the most commonly diagnosed invasive cancers in Ireland from 2009–2011, excluding non-melanoma skin cancer. Breast cancer was the most commonly diagnosed invasive cancer among women.

When one considers that primary breast cancer is one of the main public health problems worldwide, the implications of living with a breast cancer diagnosis warrant examination both from a psychological and healthcare point of view. For each woman living with the disease, the diagnosis, staging and treatment of patients with breast cancer requires multidisciplinary care in an acute hospital setting. The majority of patients will require diagnostic tests (radiology, pathology) and depending on the treatment plan may require surgery, chemotherapy, and radiation therapy. A proportion of patients may also require palliative care.

Largely, however, breast cancer is considered now as a very treatable disease (Young, 2013; Siegel, Naishadham, & Jemal, 2013), which is reflected in the increase in survival rates. According to NCRI statistics, the five year age standardised estimate of cumulative net survival for Irish female breast cancer patients has increased from 71.2% in the period 1994-1999 to 81.2% in the period 2006-2011 (NCCP, 2014).

Beyond the statistical evidence surrounding its prevalence, tension now rests between the increased treatability of the disease and the projected incident rates being predicted to rise, in that managing the illness as a chronic disease carries medical and psychosocial implications for those affected. Clearly progress has been significant in terms of the treatability of the disease, however it has left it its wake, in the words of Steven Wolff, "a pandemic of treatment success." (Wolff, 2007, p. 7).

The history of breast cancer as a disease is laden with a complex sociocultural and medical legacy that endures beyond its recent medical strides. The scholarship dealing with questions of embodiment, breast cancer and identity is vast and spans across studies in areas of health and nursing, semiotics, historical studies of disease, studies of sociopolitical activism, and affective histories of the breast cancer experience. What they all provide consistent commentary on is the undeniable particularities of living with breast cancer.

1.2 Introduction to Breast Cancer: Medical Treatment and the Illness Experience

A contemporary diagnosis of breast cancer is saturated with murky concerns about identity, body image, and broader social understandings of gender and medicine. Its history with respect to treatment, social understanding, and cultural symbolism illuminates multiple facets of the illness experience. In terms of physical treatment, Halsted introduced the radical mastectomy in 1882, which involved the removal of *all* breast tissue, axillary lymph nodes, and both pectoral muscles (Young, 2013). Revolutionary at the time, the method established a tradition of surgery that resulted in severe disfigurement of the patient, as well as weakened arm function and a disabling lymphedema (Feigenberg, Zen, & Dintsman, 1977). Remarkably, the

method was still widely used into the 1970's with a "one size fits all" approach (Veronesi, Cascinelli, Mariani-Greco, Saccozz, & Lambini, 2002). For much of the disease's treatment history, breast cancer remained a private issue, largely connected to attitudes about the breast as a private and sexualised body part (Olson, 2002; Leopold, 2006). As public education campaigns developed, military messages reflected the totality of the treatment approach. Women, according to Peterson (2004) were to "sacrifice" a breast(s) in order to "beat" a disease (p.538). The economy of sacrifice for survival is reminiscent of combat rhetoric. War language and imagery can be conceived as especially powerful linguistic motivators, since they define the situation as an emergency in which no sacrifice is excessive (Kuner, Matzkin, Quigley, Stroup, 1999; Sontag, 1978). The significance of this way of linguistically engaging with an illness are in the limits and constraints it sets up. Emotionally, it sets in motion an undercurrent of fear. Also, where surviving is the ultimate goal, grappling with the day to day reality of living with breast cancer is easily obscured.

1.2.1 Primary and Adjuvant Treatment of Breast Cancer

The day to day realities are decidedly challenging. Upon diagnosis patients experience a state of turmoil and severe stress, as psychologically they face a potentially life threatening disease and physically, they face difficult treatment choices including surgery, radiotherapy, chemotherapy and endocrine therapy. Apart from the information of having cancer being bound to impact the woman with the diagnosis and their family members, it can also cause a wide range of other psychosocial problems upon hospitalization or hospital procedures that are involved from the diagnosis process onwards. The common psychological and emotional responses to cancer undoubtedly contribute to the challenge of psychological

adjustment, arising from the very knowledge of a life threatening diagnosis, its prognostic uncertainty and fears around death and dying. Key dimensions that determine quality of life have been identified by Ferrell, Hassey, & Grant (1995) and adapted by Knobf (2011) into a model for breast cancer survivors. The model illustrates the interplay between components of wellbeing, where coping with cancer is a balance of the physical demands of the disease, its treatment and the psychological impact which will vary at different points and for each individual woman.

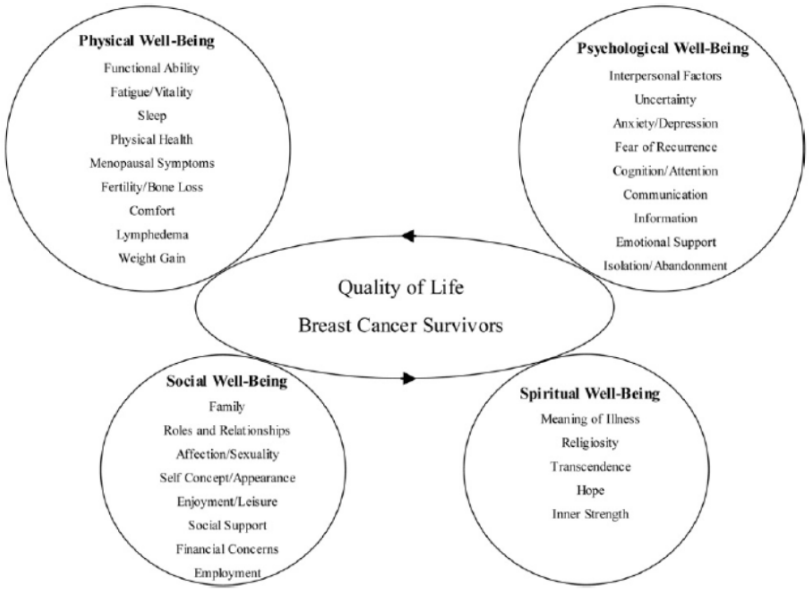


FIGURE 2. QOL model of breast cancer survivors. Adapted with permission from Betty Ferrell & Marcia Grant: Quality of Life Conceptual Model Applied to Cancer Survivors, City of Hope Beckman Research Institute (IOM 2006, page 68).

For example, post-surgery appearance concerns can contribute and form a part of the array of psychological responses. Dissatisfaction can surround the experience of the breast or breasts post treatment and can be related to absence of the surgically removed tissue, scarring, temporary redness and irritation, lack of sensation, lop-sidedness and deformity. These physical changes can result in feelings of shame or disgrace that can be profound, impacting not only on self-regard but by virtue of the social nature of appearance, contribute to increased levels of anxiety. Both shame and

depression are associated with negative subjective appearance evaluation, which is defined and reinforced both by the individual and others (Rumsey & Harcourt, 2004).

Meanwhile, there are complex decisions to be made about primary therapy, and for many women, the adjuvant therapy that will take place over the ensuing four to six months. Emotional responses can also be compounded by physical symptoms during treatment such as pain, nausea, lymphedema and other unwanted effects of medical, surgical and radiation treatment (Wilson et al., 2007). In particular, adjuvant therapy, chemotherapy, hormonal therapy, or a combined or sequential approach that is recommended for the majority of women diagnosed with treatable forms of breast cancer have physical side effects that are closely related to psychological responses and poorer Quality of life(QOL) outcomes (Ganz, Greendale, Peterson, Kahn, & Bower, 2003; Ganz, Kwan, & Stanton, 2004; Bower, Ganz, & Desmond, 2000; Glaus, Boeme, & Thurlmann, 2006), including persistent symptom distress associated with menopausal symptoms, musculoskeletal complaints, and peripheral neuropathy that endure well after treatment has completed. In fact, the first year after a breast cancer diagnosis in particular is accompanied by intense challenges for a woman and her family that cut across the physical, psychological, social and spiritual domains of life (Stanton, Danoff-Burg, & Huggins, 2002). Consistent with these challenging demands, women with breast cancer in the first six to twelve months report mood changes as an "emotional rollercoaster" (Allen, Savadatti & Levy, 2009).

1.2.2 Putting Words on the Illness Experience: the 6th Vital Sign in Cancer Care

In recent decades, women began talking about their experiences of having breast cancer more publicly, which helped to broaden understanding of its psychosocial impact. The clear benefit of increased awareness was the liberating

educational tools that emerged and the increase in dialogue about screening, diagnosis and prevention. However, integrating psychological health into medical care needed development, and a framework of language around the impact of the illness to reflect this emerging knowledge. Through a multidisciplinary panel from the U.S. (the National Comprehensive Cancer Network), psycho-oncology as a subspecialty made strides in the 1970's to incorporate mental health and the facilitation of adaptive coping into patient care by defining the field's dimensions. The panel sought to normalise the psychological stress experienced within the cancer experience by terming it non-pathologically "distress" (Holland, 2004). Psychological distress covers a wide continuum of emotions and is still considered to be a more easily understood, less stigmatizing construct than depression (Carlson, 2010; Dabrowski et al., 2007), yet its application is more holistic and utilised to include and capture psychological responses that are a normative part of a stressful and life threatening event. It is defined as:

> A multifactorial unpleasant emotional experience of a psychological (cognitive) behavioural, emotional, social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation and existential and spiritual crisis. (Holland et al., 2003, p. 98).

Distress is now recognized as the sixth vital sign in cancer care (Bultz & Carlson, 2005), and has helped progress research focused on understanding its nuances across cancer types. Psychological distress is common in the course of care for breast cancer specifically (Carlson, 2010; Dabrowski et al., 2007), and can vary in its onset and

longevity, as it can arise in the time between lump discovery, follow up appointments due to abnormal findings, and diagnosis, regardless of whether the diagnosis is a benign breast problem or breast cancer (Drageset & Lindstrom, 2003; Ekeberg, Skjauff, & Karesen, 2001). Such an understanding of distress is important in that it recognises that beyond the acute phase of illness, patients with breast cancer face a number of challenges, including the long term effects of toxic treatments, the possibility of recurrence, career interruptions, changes in body image, hormonal issues including the potential loss of fertility, sexual dysfunction, early menopause, and fatigue (Yurek, Farrar, & Andersen, 2000; Montazeri, Vahdaninia, Harirchi, Khaleghi, & Jarvandi, 2008). In fact, during critical moments of their cancer journey, patients with breast cancer rated their need for "help with any sad feelings" as higher than patients with other cancer diagnoses (McIllmurray et al., 2001). Similarly, one key result from an RCT by Lindberg et al. (2015) found the major part of breast cancer survivors remembered *psychological distress* (such as fear of recurrence or uncertainty about the future) as their worst experience, which demonstrates the heightened sense of vulnerability for this particular cancer population, and its enduring impact.

1.2.3 Public Portrayal of Breast Cancer: Psychological Implications of an Epidemic

While distress as a concept recognised the internal experience of living with cancer, there were also broader social changes taking place that were reflected in the way the marketing for fundraising shaped understanding of the illness. As breast cancer awareness has grown as a movement, combined efforts to raise awareness and funds, galvanize social support and impact the direction of research worked to make

breast cancer a priority for women's physical health. Successful efforts raised awareness to the point that breast cancer became a leading cause. A marketing framework that was driven to galvanise investment ensued with a narrative that privileges, in the words of Garrison (2007), "triumph over adversity, redemption, courage in the face of the unknown, recovery, optimism, hope" (p.52) is also a rhetorical framework that established normative responses (Kopelson, 2013; Garrison, 2007). Pink ribbon culture, for example, relies on imagery of pretty, happy, optimistic survivors who wear their survivorship with pride, elegance, sensuality, and frequently cosmetic enhancement (e.g. prosthetics, reconstructive implants) (Klawiter, 2004; Sulik & Deane, 2008). Negated in this dominant rhetoric is the welfare of the entire person, rather than the focus being the prioritisation of the aesthetic dimensions of sexual and gender defined characteristics. Problematically, for example, public portrayals of the disease have been observed to feature young beautiful women (Sulik & Deane, 2008) and not the median age of women diagnosed with breast cancer, which is age 61 (Howlader et al., 2013). These portrayals could be critiqued for their reinforcement of outdated gender roles alongside ageist marketing. The colour pink itself carries connotations of gender norms, and according to Sulik (2011) capitalizes on traditional femininity and normative assumptions about women's beauty, sexuality, emotionality, nurturance and mortality. These facets of public campaign movements bear relevance to the current study in that the ways that the disease has skyrocketed into public consciousness and the methods used to do so, shape how women *psychologically* interpret and apprehend their physical disease and the ensuing changes in their own bodies. Dominant pressures around cultural ideals are already understood to contribute to poor body image among women in western contexts to the point where body dissatisfaction is so prevalent it has been termed 'normative

discontent' (cf. Hardit & Hannum, 2012). Media exposure and modelling by sociocultural agents are predictive of body image dissatisfaction, since they invite social comparison and the internalization of ideals, and equally these processes seem to operate within media representations of breast cancer, and form part of illness appraisals that may contribute to the emergence of low mood and distress in this context. From a counselling psychology perspective within psycho-oncology, a critical examination of the political and cultural dimensions of the illness with a view to expanding the narratives available of is an important part of apprehending the meaning and idiosyncratic nature of living with the disease.

There are contradictions within campaigns as well along linguistics lines. The language of survivorship, "beat" "conquer" "win the battle" is consistent with only an acute model of illness that is largely incompatible with breast cancer, a disease characterised by the ongoing requirements for screening and medication, and enduring fears of recurrence (Frank, 2001; Rosembaum & Roos, 2002). In considering the discourse surrounding the disease, marketing and fundraising efforts for breast cancer have been vigorous participants propagating a rhetoric that is upbeat, positively oriented as a response to the disease (and recasts suffering as an opportunity for growth), leaving little room for the complexity of psychological responses that may include fear, uncertainty, anger and loss.

Each of the women in this study apprehend their diagnosis partially in relation to these larger cultural understandings, and their capacity to psychologically resource themselves to live up to these norms will invariably influence their perceptions around their own coping and adjustment. Where uncertainty and fear of recurrence predominate, is their psychological response perceived as contradictory to the narrative more commonly attached to what it means to be a survivor? (Beatty, Oxlad,

Koczwara, 2008; Kaiser, 2008). All patients who live with breast cancer, and therefore also the possibility of recurrence, represent and must manage a more complex reality where there is a blurring of boundaries between sickness, recovery and health. Leading attitudes and values embedded in the culture of survivorship may not reflect the delicacy within these dynamics. In fact, there is extensive scholarship around the "narrative hegemony of the positive story" (Garrison, 2007, p. 54) attached to breast cancer (see also Ehrenreich, 2009; Sulik, 2011; Belling, 2010; Lorde, 1980; King, 2006). This can be interpreted as consistent with the value in Anglo-Western societies that acquiescence, fear and denial are not socially acceptable ways of dealing with disease. While there is undoubted value in that positivity can be bolstering, when particular narratives become scripts, they become *prescriptive,* and limit or short circuit the scope for alternatives. Within Emotion Focused Therapy, there is an apprehension of the effects of narrative on emotion, whereby "emotion and narrative mutually influence one another" (Greenberg & Angus, 2004, p.331). Dominant social narratives impact on our awareness and perceived requirements can be a burden on the person with the illness. Qualitative accounts corroborate this pressure: "I would certainly deny the breast cancer I had last year changed my life for the better. I was already living a happy, fulfilled life and would have preferred to go on blissfully ignorant of my mortality. My overwhelming response was, and still is, anger at the whole thing" (Sylvia) (Segal, 2012, p.19). Perhaps consistent with these pressures, despite the fact that approximately one third of patients with breast cancer experience significant distress, they commonly do not disclose emotional concerns, and reciprocally, clinicians may not inquire (Coyne et al., 2004; Koopman, Angell & Tuner-Cobb, 2001; Fallowfield, Ratcliffe, Jenkins, & Saul, 2001). For women who are less able to mitigate their distress in relation to their diagnosis, their experience of

alienation, and resulting emotional tolerance may become more profound. Particular kinds of breast cancer stories that consistently involve messages that the illness requires an upbeat or positive attitude, constrains what is sayable and increases the isolating and alienating aspects of living with illness.

Similar to dynamics in clinical settings, norms within the culture of survivorship focus on a return from illness to normalised femininity (Lorber & Moore, 2002), optimism and personal empowerment (Ehrenreich, 2001; Sulik, 2011, 2013; Lorde, 1980). With an increased recognition of the emotional losses attached to the illness experience, war metaphor also continues to pervade the discourse on breast cancer (Garrison, 2007). As a metaphor of the disease, fighting implies control, and is appealing perhaps from a narrative point of view because it ascribes meaning in a familiar way, and certainly life changing events like a diagnosis of a chronic or serious illness incite a search for meaning and context. Fighting can also be used as part of language that inspires a sense of determinism and self-protection in the face of an external threat. According to Gayle Sulik (2012), the use of war metaphor in cancer rhetoric helps "demystify the uncertainty of cancer," (p.75) affording a known enemy to fight. War language, perhaps a way of motivating and uplifting, demonstrates one social method of coping.

Clearly all illness metaphors are idiosyncratic to the individual who uses them, and may be part of an empowerment context. As an advancement of the medical and treatment aspects of the illness has progressed so significantly in recent years, expanding rather than limiting available narratives around its emotional aspects would benefit those who must live with it. Exploring and empathically rendering the emotional experience of women with breast cancer attending psycho-oncology

services for distress, including the hermeneutic exploration of the case studies in this research study, may be one way of elaborating the ways the illness is articulated.

1.2.4 Medical Decision Making with Breast Cancer: Survivorship and Body Image

Changing mores are seemingly abound within stages of and identification with the disease. For example it would appear that women with breast cancer are taking back some power over the conceptualisation of life after treatment by eschewing the very label of survivor. In a sample of breast cancer survivors 3 to 18 months after treatment, 51% perceived themselves as survivors and 49% rejected the idea, feeling that they were either still living with cancer, felt their ongoing uncertainties and fears were not congruent with the survivor identity, or they did not want to be part of an identity defined by illness (Kaiser, 2008). Not only do some women reject the label and seek their own autonomy post treatment, the lack of identification with survivor suggests there is an experience of life after treatment that is not currently captured by existing frameworks and their associated narratives.

Control and autonomy also pervades and overshadows difficult decisions and bodily experiences of surgery both for breast cancer and cosmetic purposes. Undoubtedly, the emotional rollercoaster of the illness experience is linked to the consequences in terms of one's identity and experience of the body on a psychological level. Tangible, quantifiable side effects of the disease impact specifically on sexuality, sexual self-schema and body image such as vaginal dryness, pain during penetrative sex, musculoskeletal pain, hot flashes and vaginal atrophy (Broeckel, Thors, Jacobsen, Small, & Cox, 2002; Fobair & Spiegel, 2009; Ganz et al.,

1999; Wilmoth, 2001). Yet breast cancer is also laden with meaning attached to the tumour site. Its particular significance may be due to the fact that it concerns the breast, and is thereby inextricable from social understandings of femininity, motherhood and sexuality (Ehlers & Krupar, 2012). The research literature reflects the significance of the symbolic heft attached to the breast, as the universal experience among women diagnosed with breast cancer is one of profound loss; of their body's physical integrity and functioning, perceived femininity, self-esteem and confidence (Hewitt, Herdman, &Holland, 2004).

According to Wilmoth (2001), women with breast cancer experience what can be conceived of as losses in four areas, including missing parts, loss of bleeding (menstruation), loss of sexual sensations and loss of womanhood. Dominant breast cancer images could be criticised for their failure to represent the disease and treatment effects that are less easily digestible, such as non-anaesthetised injections at the tumour site or nipples inflamed from radiation. Similarly, post-surgery breast prostheses and reconstruction options promise the recovery of wholeness (and arguably seamlessness), yet the documented qualitative experiences of women using prosthesis, for example, including the daily minutiae of wearing and caring for the prosthetic breast, complicates these assertions (Gallagher et al., 2010). Described as "restorative options" (Gallagher, 2010, p.61), qualitative accounts of Irish women wearing prosthetics suggest that in fact prosthetics are worn to publically display "wholeness" (p.61) while the subjective experience of wearing them often underscores the awareness that the breast area is "hollow" (p.61) post-surgery. Accounts often involve mention of the discomfort and taxing nature of prosthetics. Crompvoets (2006) captures the bind as the "performance of normalcy" (p.121), whereby the absence of cancer tissue has been medically confirmed but

psychological, emotional and sexual recovery all remain connected to notions of the self post-treatment. In other words, normative physical conventions of femininity are maintained outwardly, yet the challenges of bodily experiencing and the ways that subjects contend with the threat of cancer at the corporeal, emotional and psychological level are braved as a much more private endeavour. For those in psychosocial care working with women affected by breast cancer, bearing in mind the complexity of dynamics attached to its symbolism, history, increasing medical treatability and the current context of marketed breast cancer campaign culture are all facets of the illness that need to be considered when understanding the experience of distress and adjustment.

These pressures also play out in the arena of medical treatment decisions. Despite consensus recommendations from Ireland's National Institute of Health (NIH) that lumpectomy plus radiation is the treatment of choice for early stage breast cancer, (NIH, 1990) (Irish Royal College of Surgeons Breast Cancer Management Guidelines (2000) similarly emphasize breast conservation in low risk cases), a large number of women who receive their treatment continue to choose mastectomy, the invasiveness of which exceeds current medical standards (Baxter et al., 2004). One cannot help but consider what insight might be provided by considering the underlying motivations for these decisions. The broader cultural discourses surrounding the disease surely bear relevance. Over the last thirty years, changes in the medical management of breast cancer and the de-stigmatisation of the disease with increased activism has generated a powerful and valuable solidarity amongst those affected. It is undoubted that the breast cancer movement has also shaped Western attitudes towards breast cancer and its public discourse in quite specific ways and with significant implications. Only a brief survey of common slogans in international breast-cancer-

awareness advertisements in more recent history highlights an imperative for individual responsibility: “Protect yourself against breast cancer”; “Cancer: If it takes you too long to find it, it may be too late”; “It’s in your breast interest to have both”; “Unfortunately we can’t test everything for you”; “Don’t let breast cancer eclipse your life: examine yourself today.” Such rhetoric emphasizes individual responsibility. It conflates early detection with prevention and cure. These slogans also place an emphasis on individual attitude (‘positive’) , and lifestyle change (diet and exercise), and prevention (mammography/early detection) that could potentially lead some women to blame themselves for getting sick. For example, while cancer is the second most common cause of death in Ireland, national statistics documenting the percentage of all mortality simultaneously cite that the leading causes of death in Ireland can be traced to lifestyle (Irish Department of Health, 2015). At the risk of emphasizing individual responsibility for health without illustrating the contribution of political, ecological, and societal settings that influences incidence rates, subtle messages about the possibility of personal responsibility are insinuated. As theorists of illness and critical medical studies have laboured to show, illness often resists the stability of binary oppositions, such as mind/body, inside/outside, and public/private (Rose, 2006). Diedrich (2011) observes that “illness might be said to transform the slash that separates these binaries, to make it vulnerable and porous” (p.19). In Ehrenreich’s view (2001), where there is a dominant survivor narrative, there is an implicit opportunity for women to improve their lives by “becoming strong” and “surviving” (p.53). Wendell (1996) voices a similar concern to Ehrenreich; “success at being healthy...is always partly a matter of luckand therefore beyond our control. When health is spoken as as a virtue, people who lack it are made to feel inadequate” (p.251).

When the wider medical and socio-cultural context of breast cancer is taken into account including attitudes, myths and social discourse, it forms the backdrop against which a woman constructs her own narrative about her illness and its relationship to her identity. These considerations are in keeping with the dialogical constructivist roots of EFT, which views narrative and emotion as equal, dynamic, mutually influencing components of therapy and where an individual's identity is a narrative achievement, established through the stories we construct about ourselves and share with others. Personal narrative, in other words, is both constructed and constrained by inequalities of power and culturally shared discourses. For those with psychological vulnerability, including the women who have taken part in this study, their illness experience seems largely muted within the larger context of dominant positive narratives. It is perhaps for this reason that recent research has called for future research to be directed towards depicting the phenomenology of cancer-related depression as a distinctive clinical sturcture, combined with the recommendation to accordingly tailor psychosocial approaches (Li, Fitzgerald & Rodin, 2012).

Combined with over a hundred years of public messages that have encouraged women to be vigilant in detection strategies and to take on aggressive treatment, there have also been pressures to be conformist in maintaining appearances in terms of reconstruction or the use of prosthetics post treatment/surgery (Casamayou, 2001; Crompvoets, 2006). With the popularity of narratives about reconstruction (and it's associated, implicit suggestion of restoration), the challenges of contending with aspects of the disease such as future risk (i.e. recurrence, or treatment complications such as lymphoedema or chronic pain), as well as the symbolic experience of irreparable loss are latent. When the dominant narrative associated with breast cancer survivorship appears clear cut and restorative, they confirm expectations about

looking good and being positive. It increases the likelihood that experiences that run counter (of loss and grief) become disenfranchised and unsayable.

1.2.5 Breast Cancer as an Experience of Loss

Scholarship in the area of loss has made recent strides in defining the arena of symbolic losses, which include the experiences inherent in chronic and life threatening illness in adulthood (Boss, 2009; Doka, 2002a; Walsh, 2012; Walter & McCoyd, 2009). Walsh (2012) defines symbolic losses as "not due to death, but rather represent the loss of relationships, intact systems and even dreams for the future (p.10). Illness related losses, according to Boss (2009) are often "ambiguous" in that they are "uncanny….confusing and incomprehensible" (p.138), open-ended and lack closure (Boss & Carnes, 2012). The lack of closure inherent in managing a chronic disease where past losses need to be carried alongside the future uncertainty attached to follow up scans and lifelong monitoring leaves grief "open-ended" and in so far as it cannot be socially sanctioned and publicly mourned, disenfranchised (Doka, 2002). Doka claims:

> Disenfranchisement can occur when a society inhibits grief by establishing 'grieving norms' that deny grief to persons deemed to have insignificant losses, insignificant relationships, or an insignificant capacity to grieve (p xiii).

Sexual losses examined by Sacerdoti, Lagana and Koopman (2010) capture the experience of the body post cancer, whereby "loss of maternal opportunities, wholeness, sexual desire, sexual pleasure, [and social/peer groups] (feelings of isolation/social alienation)" establish "loss as an overarching theme for cancer survivors" (p. 538). These losses jar with marketing campaigns that capitalise on a

cultural endorsement of the love of breasts (e.g. 'feel your boobies to save second base', 'save the ta-ta's' have appeared as pink ribbon slogans) and arguably, seem to aim at something breast cancer is not- humorous (Dueringer, 2013) as well as objectifying.

The breast cancer advocacy movement has created a consciousness of women at risk or diagnosed with breast cancer, and the 'pink ribbon' has become a global signature for breast cancer survivorship. Breast cancer, in other words, is a hyper visible disease, without the multidimensional representation of its lived experience. By the measure of treatments improving in the past thirty years and mortality rates having declined overall (Young, 2013), the movement is a success. In light of the disease's changing status as a treatable, chronic disease where survivors are multiplying, and the late effects of treatment are beginning to be investigated (Nekhlyudov, Aziz, Lerro, & Virgo, 2014), the women that bear the traces of breast cancer and its accompanying technologies demand our attention and responsible engagement, including at the level of mental health and incorporating how social attitudes and the history of the disease influences adjustment in both helpful and unhelpful ways and pervades public consciousness.

In Ireland, cancer care is managed primarily by hospital based services. An emerging challenge for hospital based services/specialists is to provide ongoing care for the growing number of survivors who have completed treatment, particularly as an understanding of their psychological needs is increasingly apprehended. Increasing survival leads to increasing responsibility for ongoing and survivorship care, across the trajectory of distress, but particularly for subsets of patients who may have heightened psychological needs due to multiple contributing factors.

1.3. Psychological Health in Women with Breast Cancer

Extensive research (Bower 2008; Kvillemo & Branstrom, 2014; Mehnert & Koch, 2008; Millar, Purushotham, McLatchie, George, & Murray, 2005; Nosarti, Roberts, Crayford, McKenzie, & David, 2002) has gone into determining rates of general distress and coping strategies among patients with breast cancer. This research has helped guide psychoeducation and therapy models that help with cancer as a particular stressor that places demands on a person's psychological resources and benefits from the fostering of good coping skills through psychoeducation or specific tailored intervention. The three major components contributing to how a person copes broadly speaking include social attitudes, the disease itself, and the personal qualities brought to the illness (Holland & Lewis, 2000). Lazarus and Folkman (1984) define coping with greater elaboration: "constantly changing cognitive and behavioural efforts to manage external and/or internal demands that are appraised as taxing or exceeding the resources of the person (p.141). These efforts include emotion focused coping that is recognised as having adaptive potential, alongside and concomitant with problem focused coping. In the majority of women with breast cancer, 'normal distress' will resolve with improvement in physical symptoms and time (Hewitt, Herdman, & Holland, 2004), presuming they can harness adaptive and useful coping strategies in response to the illness as a stressor. For women with heightened distress states that do not resolve with time, psychological therapy is warranted to facilitate coping with the demands of the disease and its treatment effects. At this level of intervention, a psycho-oncology service provides intervention to facilitate and normalise adjustment and healthy coping on this basis, typically with brief

psychological therapy models, including supporting entry into a new normal of living with the disease and its management post treatment.

While many women respond to more general psychoeducational input and therapy to help facilitate coping, a subset have a pre-existing history of depressive episodes and anxiety that complicates their adjustment process, which can perhaps be contextualised given that in the general population, women are affected twice as often as men by major depression (Kessler et al., 2003; Holsen et al., 2011). To compound issues, the prevalence of both anxiety and depressive disorders is often higher among people with chronic medical conditions (Scott et al., 2007). Thus, there is a need to understand the interplay between such disorders conceptually. Most empirical studies on the causes of depression support a diathesis-stress model (Hammen & Garber, 2001), suggesting that vulnerable individuals may become depressed when stressful external factors, such as a cancer, exceed their personal resources for coping. Research that considers not only present focused coping, but includes considerations around factors in the patient's life history that may be contributing to elevated distress, including prevalence rates of prior trauma (Probst et al, 2013; Green et. al, 2000; Banou et al., 2009) or past history of psychological morbidity (Koroukian et al., 2015; Fox et al., 2013), is only beginning to emerge as a consideration in psycho-oncology, and its relationship to a patient's needs and management of their illness. These aspects form part of the considerations within the current study, where past history is contributing and the fewer psychological resources as a consequence, heighten distress around breast cancer and further impairs adjustment.

1.3.1. Clinical Anxiety in Patients with Breast Cancer

Anxiety is commonly understood as a basic physiological response that is an activating and motivating state. The anxiety response is a series of behavioural and physiological processes designed to prepare a person to manage future threat (Bouton, Mineka, & Barlow, 2001). Clinical anxiety, including in the context of breast cancer, is characterized by high levels of distress and panic and behaviours such as worry and avoidance, and is further identified by being out of proportion to the level of threat, level of persistence, symptoms such as panic attacks, severe physical symptoms, and abnormal beliefs such as thoughts of sudden death and consequently, a disruption of usual or desirable functioning. The common diagnostic systems employed in psychiatry to define anxiety disorders are the World Health Organization's International Classification of Disorders (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-V), however ultimately, unacceptable symptoms and disruption in functioning are often useful in defining clinical anxiety.

For the psychologist working in an oncology setting, these criteria involve additional nuanced considerations. Given that cancer is always associated with some real threat, the level of anxiety must be judged against the proximity of threat. According to Holland (1989), it is normal to experience considerable anxiety for a period of approximately 7-10 days after receiving bad news, however as the degree of real threat will vary over the course of the disease and its treatment, so too will the levels of 'normal' anxiety. Breitbart (2002) further developed an understanding of anxiety in the context of a cancer diagnosis by distinguishing three main anxiety presentations: a) reactive anxiety related to the stresses of cancer and its treatment; b) anxiety that is a manifestation of a medical or psychological problem related to

cancer, such as uncontrolled pain (organic anxiety disorder) and c) phobias, panic and chronic anxiety disorders that predate the cancer diagnosis but are exacerbated during illness. The latter category forms the focus of the current study, where past history is contributing and the fewer psychological resources as a consequence, heighten distress around breast cancer and compromises adjustment. When one considers that primary breast cancer is one of the main public health problems worldwide, where over 1.3 million women are diagnosed annually with primary breast cancer and approximately 458,000 will die from the disease, the implications of living with identifiable, clinically significant depression and anxiety *and* a breast cancer diagnosis quickly becomes complex from a psychological and healthcare point of view (Oleske, Cobleigh, Phillips, & Nachman, 2004).

In terms of the idiosyncrasies of anxiety within a cancer context, persistent anxiety may be identified quite early after diagnosis, given that anxiety which persists only three weeks after a "bad-news consultation" is highly predictive of anxiety 6 months later (Nordin & Glimelius, 1999). Greater levels of anxiety are associated with certain demographic characteristics such as younger age, female sex, marital separation, divorce, widowhood, and lower socioeconomic status in both general psychiatric populations and patients with cancer (Brintzenhofe-Szoc, Levin, Li, Kissane & Zabora, 2009; Rasic et al, 2008). As a reaction sustained and heightened levels of anxiety can become cripplingly intense and chronic; impairing daily functioning, impacting on interpersonal relationships, and thwarts end points such as problem solving. For example, an anxious patient who fears breast cancer recurrence may expend significant thought, energy, and feeling on non-productive worry. Physical sensations may be amplified and misperceived as being a sign of breast

cancer recurrence, metastasis, or secondary tumour development, causing secondary worry and anxiety. With a reduced sense of self-the impact of potential threats, feelings of helplessness often manifest.

1.3.2. Clinical Depression in Patients with Breast Cancer

Major Depressive Disorder (MDD) is a form of depressive symptomatology in which patients display multiple depressive symptoms for at least two weeks and exhibit significant distress or impaired functioning. Similarly to clinical anxiety being proportionate to threat, intense sadness is an adaptive, normal, biologically based response to loss (or stress) and therefore is not by definition a mental disorder. Depression is deemed as dysfunctional when sadness is of disproportionate intensity, duration, and is harmful/distressing to the person. Unsurprisingly, a history of major depressive disorder prospectively predicts worse quality of life in women with breast cancer (Jim, Small, Minton, Andrykowski, & Jacobsen, 2012). In a study of 173 woman, Jim et al., found that patients with breast cancer with a past history of MDD displayed worse role functioning due to physical limitations, worse mental health than patients without a history of MDD, and displayed greater declines in physical functioning from pre to post chemotherapy. Such research highlights how important it is to consider and screen patients with breast cancer for a past history of MDD because of the associated impact on quality of life.

Equally significant, both cross-sectional studies and case control studies indicate that depression is considerably more common in patients with breast cancer compared with other women (Kissane, Clark & Ikin et al, 1998; Coyne, Palmer, Shapiro, Thompson, & DeMichele, 2004). Prevalence rates are estimated at 11% among newly diagnosed patient with breast cancer (Hegel et al., 2006) where

treatment effects are not yet influencing factors. Certainly, mental health professionals conducting an assessment around low mood must evaluate whether cancer related organic factors, such as corticosteroids, chemotherapeutic agents, brain radiation (where metastatic disease, lesions or secondary cancer is involved), central nervous system/metabolic/endocrine complications, and paraneoplastic syndromes that can present as depression are contributing factors (Breitbart, 1995). Where organicity is ruled out, prevalence rates of MDD beyond initial diagnosis is estimated to be 13% across a meta-analysis of oncology settings as measured by DSM or ICD, including breast cancer (Krebber et al., 2014). It would appear this subset of patients are psychologically more vulnerable to distress when encumbered by treatment side effects and complications. Adverse symptoms of chemotherapy, once they begin, are associated with increased depression (Longman, Braden, & Mischel 1996; Reyes-Gibby et al., 2012), and can often be amplified by pain (Reddick et al, 2005). Depression can also have its effects on treatment and treatment management, leading to difficulty with symptom control, hampered treatment decision-making, poor compliance with treatment, prolonged recovery times and impaired quality of life post treatment (Satin, Wolfgang, & Phillips, 2009; Hotopf, Chidgey, Addington-Hall & Lan, 2002; Jadoon, Munir, Shahzad & Choudhry, 2010; Stommel, Given & Given, 2002). The interaction between symptoms of depression, and its negative impact on management and tolerance of treatment course adds to the rationale for appropriate screening, assessment and intervention for this subset population of patients.

A recent review of detection and treatments of depression in cancer settings by Mitchell (2011) recommended that new frameworks are needed within psycho-oncology that emphasize survivorship as much as initial diagnosis (e.g. breaking bad news). Consistent with developing models of understanding disenfranchised and

ambiguous losses associated with the chronic illness experience, psychosocial factors including a history of psychological vulnerability including MDD, are helping develop a richer understanding of the needs of this particular cancer population and their implications in survivorship care. As one of the strongest determinants of health-related quality of life, as well as heavily influencing medical care and participation in treatment, depression is a clinical predictor of physical and psychological outcomes post treatment (Jim, Small, Minton, Andrykowski, & Jacobson, 2012). In a review by Jacobsen and Jim (2008), future directions highlighted included the observation that few studies have focused on the management of anxiety and depression in patients who have completed treatment, and stated; "the most glaring gap is the limited number of studies focusing on patients who are experiencing clinically significant levels of anxiety and depression. Conducting studies that address these gaps should be a priority for future research." Patients with cancer in Ireland, as well as internationally, would benefit from research that outlines a proactive approach to psychological treatment that attends to the detection and treatment of this presentation.

Meanwhile, existing guidelines in the UK do exist that stress screening as a central part of patient care (NICE, 2004), and the U.S. National Comprehensive Cancer Network (N.C.C.N) has evidenced-based guidelines on distress that also highlights screening (NCCN, 2014). Screening instruments that have been validated in a cancer setting (Vodermaier, Linder & Sui, 2009; Moorey, Greer & Watson, 1990) whereby features of depression/anxiety have been adjusted for medical factors (e.g. removing features of depression that may be conflated with fatigue, and putting greater emphasis on anhedonia), such as the Beck Fastscreen for medical patients (BDIFS; Beck, Steer & Brown, 2000) and the Hospital Anxiety and Depression Scale

Depression (HADS; Zigmond & Snaith, 1983). Much like in the amendments to screening tools used in an oncology setting, a diagnosis of major depressive disorder (MDD) carries nuanced considerations given that patients with primary breast cancer may present with physiological symptoms that mirror many symptoms caused by cancer or its treatment such as loss of appetite, weight loss, fatigue, sleep disturbances, the feeling of being slowed down, attention and concentration difficulties (Riba & Grassi, 2008). Such problems with the assessment of depressive symptoms in patients with breast cancer may be overcome by the psychologist focusing on the presence of dysphoria, anhedonia, hopelessness, worthlessness, excessive or inappropriate guilt, and suicidal ideation to determine the presence of major depression (Breitbardt & Alici, 2009). The presence of concomitant anxiety also needs to be assessed (Ballenger, Davidson, Lecrubier & Nutt, 2001) particularly given that when anxiety is present alongside depression, and occurs at a high intensity, coping is further hampered and distress is heightened.

1.3.3. Anxiety and Depression: Overlaps, Differences and Problems in their Categorization

The most widely used taxonomy of the distress disorders is described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V; APA, 2013). However the validity of this system has been questioned by many researchers (eg Joyce, 2008; Pies, 2008; Frances & Widiger, 2012). A central concern raised by critics of the DSM is that the system for any of its existing editions is not based on adequate empirical foundation and as a result, suffers many shortcomings (eg British Psychological Society, 2011; Joyce, 2008; Ben-Zeev, Young & Corrigan, 2010; Wakefield, 2013). One particular deficiency of the current taxonomy appear to be

particularly problematic. Namely, many DSM disorders are highly comorbid, that is, they tend to covary not only in patient samples but also in the general population (eg. Clark & Watson, 1999; Mitchell, 2013). This pattern not only complicates research on individual disorders- as researchers have to make decisions of whether to include or exclude comorbid cases, but also suggests conceptual problems with the taxonomy.

Historically, anxiety, depression and mood disorders have been categorized and conceptualized as discrete pathologies; yet increasing evidence demonstrating etiological and neurobiological parallels implicates common underlying constructs (Carleton, Abrams, Asmudnson, Antony & McCabe, 2009; Confer et al., 2010; McEvoy & Mahoney, 2012; Norton & Mehta, 2007; Starcevic & Berle, 2006; Taylor, 1993). In fact, even in physically healthy populations' comorbid anxiety and depressive disorders are commoner than anxiety disorders occurring alone (Kessler et al., 2005; Jenkins et al., 1998). Based on early research and pharmacological studies, the traditional perspective of anxiety and depression holds that these conditions are unrelated disorders that should be clearly separated in terms of conceptualization and diagnosis (Claghorn, 1970; Downing & Rickels, 1974; Mountjoy & Roth 1982a, 1982b; Roth, Gurney, Garside, & Kerr, 1972). The traditional perspective was primarily based on findings that each disorder has a distinct pattern in terms of prevalence rates, symptom profile, longitudinal course, and response to treatment. In this perspective, subthreshold presentations are not given clinical attention. Early pharmacological studies may have inadvertently reinforced the dichotomous perception of these illnesses by ignoring the overlap in clinical applications of the anxiolytics and antidepressants, possibly to avoid confusing clinicians as to the target symptoms of anxiolytic and antidepressant treatment (Stahl, 1997).

More recent research, however, is more interested in the middle ground between depression and anxiety disorders. Accumulated in recent years (see Rapaport, 2001), research would indicate that rather than presenting as isolated conditions, anxiety and depression coexist with such frequency that comorbid presentations may be more the rule than the exception. The 'problem' of comorbidity is particularly salient among the distress disorders. Major depression (MDD) with concurrent anxiety is common in treatment samples (Brown et al., 2001). Comorbidity rates for MDD and anxiety disorders are as high as 58% (Zimmerman et al., 2000) and rates of 'anxious depression,' or depression with high levels of anxiety symptoms, are as high as 46% (Fava et al., 2004). Of the anxiety disorders, panic disoder (PD) and generalised anxiety disorder (GAD) seem to co-occur most frequently with depression (although this varies across samples), and it has been found that the lifetime prevalence rates of MDD for patients with either PD or GAD can range up to 60% (Kessler et al., 1998; Kessler, DuPont, Berglund, & Wittchen, 1999). Zimmerman, Chelminski, and McDermut (2002) evaluated 479 patients with MDD and found that 57% had an anxiety disorder (with social phobia being the most frequently encountered anxiety syndrome in this sample). Symptoms are not just problematic during acute periods of depression or heightened anxiety, in fact higher levels of distress outside of acute episodes of anxiety/depression and decreased social functioning are part of the long term impact of a lifetime comorbidity of major depression and anxiety disorders in women in a community sample (Cyranowski et al., 2012). Lifetime comorbidity of depression with an anxiety disorder is estimated to be approximately 57-59% (Kessler et al., 2003; Lamers et al., 2011) which indicates a substantial association between these conditions. The implications of living with both anxiety and depression are significant. Specifically, patients with

comorbid anxiety and depression report greater severity of symptoms, chronicity of the illness, functional impairment, disability, suicidality, and more frequently seek health care services relative to patients with either disorder alone (Kessler, Chiu, Demler, & Walters, 2005; Roy-Byrne et al., 2000).

Given such high co-occurrence of these disorders, it seems appropriate to group them under one label (Rapaport, 2001). Depression and anxiety share considerable diagnostic and symptom overlap (Reardon & Williams, 2007; Nutt, 1999) to the extent that researchers have questioned whether depression and anxiety are, in fact, empirically distinct diagnostic entities. Allen, McHugh, and Barlow (2008), for instance, concluded that "what is common to emotional disorders outweighs what is not" (p. 218). Despite its ubiquity and negative consequences, research has largely failed to specify mechanisms driving anxiety depression comorbidity. Although several comorbidity theories exist (cf. Alloy, Kelly, Mineka, & Clements, 1990; Merikangas, 1990; see Mineka, Watson, & Clarke, 1998 for a review), the most prominent ones attribute anxiety-depression comorbidity to shared structural components. For example, Clark and Watson's (1991) tripartite model hypothesizes that anxiety is uniquely defined by physiological hyperarousal and depression by lack of positive affect, but that both disorders share the common thread of elevated negative affectivity. A person with generalized anxiety disorder, for example, may clench their hands to the chair while they talk about loved ones. A person with depression may fight back tears during an unpleasant family dinner.

High levels of comorbidity and recognition of shared features across mood and anxiety disorders have also led to the development of innovative transdiagnostic treatment approaches that focus on commonalities across these disorders (e.g., Unified Protocol for the Treatment of Emotional Disorders; Barlow, Allen, & Choate,

2004). Existing transdiagnostic therapy approaches take two forms currently; generic CBT that yielded promising outcomes in an open trial and a benchmarking comparison against disorder-specific CBT (Norton, 2008), and with Acceptance and Commitment Therapy (ACT) where randomised control trials of ACT, have yielded promising effects in comparison to waitlist and CBT (Twohig, Hayes, & Plub, 2010), however no research has applied a transdiagnostic approach to an oncology population. Given that depression and anxiety disorders have been consistently noted as the most common presentations across site and stage of illness in patients with cancer (Bultz & Carlson, 2006; Carlson, Angen, et al., 2004; Derogatis, Morrow, & Fetting, 1983; Kangas, Henry, & Bryant, 2005; Mehnert, 2004), the specialism may benefit from approaches that implement transdiagnostic approaches to treatment where clinically significant distress is identified through clinical assessment. Equally, with emerging evidence-based support for the efficacy of transdiagnostic approaches in the treatment of comorbid conditions (Barlow et al., 2010; Farchione et al., 2012), a question to be considered is whether EFT therapists may approach future clinical research and conceptualisation of cases with explicit recognition of the transdiagnostic approach to treatment.

Nevertheless, the common factor underlying these mixed psychological presentations is that each are experiencing high levels of distressing emotion and each are attempting to suppress/avoid the experience or expression of these emotions. The redundancy in symptoms between anxiety and depression suggests that an anxiety diagnosis contributes little to the prediction of outcome in depression, because many of the symptoms that qualify an individual for an anxiety disorder diagnosis are already accounted for by the diagnosis of depression. Lying at the heart of many types of psychopathology, emotions may also be key to their treatment.

1.3.4. Prevalence of Comorbid Anxiety and Depression in Patients with Breast Cancer

Although many studies mention the co-existence of depressive symptoms and elevated anxiety levels, there is not much information on the prevalence of comorbid anxiety depressive symptoms (CAD) in women with breast cancer. The findings of multiple other studies specifically looking at women with breast cancer are limited by the use of varying instruments and criteria, small sample sizes, lack of prospective data, inclusion of anxiety due to a medical condition (e.g., steroid induced) within the anxiety category, and cancer treatment confounders.

The tendency in study designs seems to broadly fall into three mutually problematic arenas. Firstly, to generalise distress as the basis for intervention without formal assessment. As a result clinical categorization or psychopathology is not distinguished from the more transient distress of an adjustment reaction, which impacts outcome in that such a design assumes all presentations of distress are equal and obscures cases where longstanding, potentially untreated complex pathology may be a contributing factor. Secondly, some studies separate the intervention on the basis of psychological therapy for cancer rather than establishing a specific psychological disorder as the focus of treatment that is exacerbating the individual's ability to cope with their cancer. Studies of this nature assume that cancer alone warrants psychological intervention, and fails to normalise the distress that is part of a healthy process of adjusting to the illness, but is not pathological and therefore does not constitute an adequate rationale for psychological intervention. Thirdly, where assessment and intervention does not incorporate comorbidity in its conceptualisation

or intervention. The gap in the literature obscures the formulation of clear guidelines for patients with cancer who have comorbid anxiety and depression alongside their medical condition.

In a major study by Burgess et al. (2005) found a significant decrease of depression and anxiety during the second and third year after diagnosis of breast cancer, the study problematically used a shortened version of the Structured Interview for Clinical Disorders (SCID), focusing on symptoms of depression and anxiety, and it remains unclear if dysthymia and different kinds of anxiety disorders were taken into account. Other studies have reported a consistent level of anxiety over time (Schou et al., 2004; Matsushita, Mastushima, & Marayuma, 2005; Hack & Degner, 2004) but did not use semi-structured clinical interviews as part of the intial psychological assessment, which are considered the 'gold standard' to register the criteria of a formal psychiatric diagnosis.

Brintzenhofe-Szoc et al., (2009) published a cross-sectional study where the prevalence of CAD in patients with cancer of varied types was presented; 2.8% had only depression symptoms, 14.9% had only anxiety symptoms, and 10.8% had CAD. A study by So et al., (2010) showed similar results, where 15.6% of patients with breast cancer had CAD. The prevalence of comorbid anxiety and depression with a breast cancer diagnosis is in the 13-20% range in a study by Linden et al. (2012) where symptoms of both conditions were provided at the same time point in the disease trajectory, after diagnosis but prior to treatment. The same study broke down prevalence rates by cancer type, and found that across all cancer types, females with cancer showed higher prevalence rates of anxiety and depression than men. As a result, the prevalence of comorbid anxiety and depression should be seen against the context of its ubiquity in the general population and where women in general are

affected more proportionally. Other studies in oncology specifically have captured prevalence rates that fit into a similar range (Boyes et al., 2011; Caminiti, Campione, Sivelli, Diodati & Passalacqua, 2004; Carlson, Speca, Patel, & Goodey, 2004; Hinz et al., 2010; Hopwood, Sumo, Mills, Haviland, & Bliss, 2010; Mitchell et al., 2011; Zabora, Brintzenhofe-Szoc, Curbow, Hooker & Piantadosi, 2001).

In adults with cancer, predisposing factors appear to play a role, including a history of mental health treatment before cancer, greater use of anxious preoccupation and helplessness-hopelessness coping strategies, and perceived low levels of positive social interaction are strongly associated with caseness for anxiety, depression and comorbid anxiety-depression (Boyes et al., 2011). A meta-analysis matching patients with cancer in survivorship to healthy controls found clinically significant anxiety and depression in 14% of women with early stage breast cancer (Hopwood, Sumo, Mills, Haviland, & Bliss, 2010; Gandubert et al., 2009; Burgess, 2004) suggesting that a sizeable portion of patients merit psychological intervention that takes premorbid history into account. About two thirds (69%) of depressed survivors experienced anxiety at the same time, which is consistent with findings from a large heterogeneous sample of cancer patients receiving treatment at one clinic (Brintzenhofe Szoc et al., 2009).

1.3.5 Medical Impact of Psychological Distress in Women with Breast Cancer

There is increasing recognition that depression and anxiety are commonly comorbid, complicating both diagnosis and treatment. CAD, like other psychological presentations, can develop at different points on the treatment continuum from the point of abnormal finding to diagnosis, initiation or completion of treatment,

progression of disease, survivorship, and throughout palliative care. According to Boyes et al. (2011), patients across all cancer types experiencing both anxiety and depression are likely to be in greater distress, and warrant active identification and targeted intervention. Patients with a presentation of CAD are not only facing the biological stressors of cancer, including pain, they are also now having to manage the aforementioned psychosocial stressors that come with the disease, including themes of uncertainty, loss of control, changes in life trajectory, increased dependency, as well as changes in role functioning, appearance and identity.

The ramifications of symptoms of anxiety and depression, regardless of onset, can be felt not only by the patient but can impact on the care team as well and the wider healthcare system. Economic issues are consequential in that depression and anxiety in patients with cancer is associated with increased physician time, more frequent hospital and primary care visits, and higher cost to the system (Carlson & Butz, 2004; Hewitt & Rowland, 2002). High levels of anxiety and depression can present numerous challenges to providing care since it can interfere with the ability of the patient to cooperate with cancer treatments (Fann et al., 2008). Naturally, research has looked at whether treatment itself can increase the risk of depressive and anxious symptoms, and only adjuvant chemotherapy specifically has been found to increase the risk of depression and anxiety, *during*, but not after treatment (Burgess, 2005) and therefore the etiological mechanisms of treatment do not account for the prevalence of CAD across treatment stages (and into survivorship) for women with breast cancer. The implications on a psychological and psychosocial level are multiple. In comparison to healthy controls, individuals with affective disorders report less acceptance of their emotions, less emotional clarity, and more attempts at emotion regulation (Campbell-Sills, Barlow, Brown, & Hoffman, 2006). The irritability, worry

and significant impairment in normal functioning can also carry the unintended consequence of alienating a patient's support network when they need it most, and this bears relevance given that interpersonal relationships play a key role in how people cope with and adjust to life crisis such as breast cancer (Holland & Holahan, 2003). Given the impact of depression and anxiety, the importance of developing and evaluating psychological interventions for patients with CAD has been identified as a pressing need (Spiegel & Giese-Davis, 2003).

1.3.6 Psychological Therapies in Psycho-Oncology

In terms of management, the psychological care of clinically significant depression and anxiety in women with breast cancer requires a comprehensive approach that includes assessment, treatment and follow up.[1] Several different psychological therapies have been successfully employed with patients experiencing both cancer and depression (Holland, 2003) and psychological therapy is often employed with pharmacologic intervention.

Most psychological therapies in psycho-oncology have been developed and used across cancer types and are not exclusive to breast cancer types but rather developed to ameliorate the broad stressors associated with cancer, including heightened distress. Today, psychological therapies are a core part of cancer treatment and are to be seen as adjuvant to medical and surgical treatments (Greer et al., 1992). For example, supportive expressive, cognitive behavioural, mindfulness and existential-behavioural group therapies have been studied in randomized control trials (RCTs) and used successfully in patients experiencing cancer across varying types

[1] [1] For the purposes of the current study, moderate to severe depression and moderate to severe anxiety (moderate to high risk) refers to patients with a diagnosis of major (clinical) depression or anxiety disorders through use of a structured clinical interview for DSM disorders (SCID).

and concomitant low mood, but often problematically have not used vigorous assessment tools to establish psychopathology (Baum & Andersen, 2001; McGregor et al., 2004; Ronson & Razavi, 2000; Fegg et al., 2013; Moorey & Greer, 2002; Lee, Robin-Cohen, Edgar, Laizner, & Gagnon, 2006). The most commonly studied interventions for patients with breast cancer are supportive expressive group therapy, cognitive behavioural therapy and Mindfulness based stress reduction (Hopko et al., 2009). Several meta-analyses of these interventions report moderate reduction in symptoms of depression, anxiety and pain (Fann et al., 2008; Lepore & Coyne, 2006; Newell, Samson-Fischer & Savolainen, 2002). Many methodological limitations characterise this research, the most significant being an over reliance on patients with breast cancer with subsyndromal depression not systematically diagnosed with major depression (Fann et al., 2008; Hopko et al., 2008).

Kissane, Maj and Sartorius (2011) reported the first RCT to demonstrate an effect of supportive-expressive group therapy in preventing the emergence of major depression in women with metastatic breast cancer. Research examining the efficacy of behaviour activation (BATD; Lejuez, Hopko & Hopko, 2001) and problem solving therapy (PST) for patients with breast cancer with major depression and anxiety symptoms (Hopko et al., 2011) indicates that both treatments were effective in reducing depression, anxiety, and bodily pain. Broadly speaking, available psychosocial interventions consistently show beneficial effects on emotional adjustment, functional adjustment, and treatment- and disease-related symptoms (e.g., nausea, pain). In aggregate, studies have shown that various interventions may be effective in reducing fatigue, sleep disturbance, depression, anxiety and emotional distress at large, while improving coping skills, physical functioning and quality of life.

In terms of psychological interventions specifically for women with non-metastatic breast cancer and depression/anxiety, RCT trials have often employed a cognitive behavioural approach in studying the effect of psychological intervention where there has been a reported change in depression and/or anxiety using outcome measures as well as coping scales. Cognitive behavioural interventions include cognitive, cognitive behavioural and behavioural methods focused on changing specific thoughts or behaviours or on learning specific coping skills and varied in their inclusion of progressive muscular relaxation training, meditation, systematic desensitization, biofeedback and behaviour modification or reinforcement (Andersen 2004; Dolbeault, 2009; Ferguson, 2012; Fukui, 2000; Garssen, 2013; Henderson, 2012; Kissane, 2003; Loprinzi, Prasad, Schroeder & Sood, 2011; Marchioro, 1996; Nunes, 2007; Yates, 2005). Lengacher et al., (2009) also employed a group based approach in an RCT using Mindfulness Based Stress Reduction (MBSR) for survivors of breast cancer. Psychological therapy including psychotherapy from a psychodynamic, existential, or supportive approach where there was a change in anxiety and depression using outcome measures was evaluated in three studies where there was a control and intervention (Badger, 2007; Classen, 2008; Marcus, 2010). All studies but one (Golden-Kreutz, & Andersen, 2004) did not include participants with comorbid psychiatric diagnosis such as clinically significant depression and anxiety and thereby excluded individuals who are arguably more difficult to treat.

Overarchingly for patients with breast cancer there is a paucity of research on the efficacy of psychological treatments as well as whether specific patient characteristics predict favourable versus unfavourable outcomes. It has been identified that social supports, empathic couple based communication, practitioner expertise, shorter latency from cancer diagnosis to initiation of psychotherapy and

less severe cancer stage are associated with more favourable treatment outcome (Baucom et al., 2009; Zimmermann, Heinrichs & Baucom, 2007). However it is also worth considering from the service user vantage point is that little is known about which treatments for depression and anxiety are most commonly used by breast cancer patients or which treatments are most preferred (Hewitt, Herdman & Holland, 2004). While recent CBT packages have been developed to address clinically significant transdiagnostic constructs across a range of disorders, including eating disorders, depression and anxiety (Crow & Peterson, 2009; Fairburn, 2008; Lampard, Tasca, Balfour, & Bissada, 2013; Lundh & Ost, 2001; Shafran, Cooper & Fairburn, 2002), they have not been evaluated in an oncology setting where a vulnerability to psychopathology contributes to heightened symptoms of depression and anxiety with the additional stressor of a cancer diagnosis.

Broadly, the impact of psychological intervention in oncology and psychosocial disease and symptom and treatment side-effect outcomes has been evaluated in relatively large numbers of trials that vary considerably in their research questions, methodology, settings and results. According to Jacobson and Jim (2008), only 5% of studies limited eligibility to patients experiencing some degree of clinical anxiety, depression or psychological distress. Apart from strategies often not meeting the criterion for clinical anxiety and depression, the lack of consistency can be attributed in part to differences across studies evaluating the same intervention strategy in the demographic, disease, and treatment characteristics of the sample recruited; the number and timing of the outcome assessments performed; and the outcome measures used. As a result, the lack of eligibility criteria based on current anxiety or depression raises questions about whether findings are generalizable to

patients experiencing clinically significant symptomatology that is most frequently of a dual anxious/depressive nature.

When one considers that self-blame and shame related to the stigma of a diagnosis and body image related difficulties post-surgery form part of the emotional challenge of recovery post breast cancer, a therapeutic approach that works to integrate these painful aspects of experience so that they become an integrated part of identity seems highly amenable. While first attempts in this direction were developed as meaning-centered group intervention and evaluated in a randomized control trial, demonstrating efficacy in improving spiritual wellbeing and a sense of meaning (Breitbart & Applebaum, 2011), it has not been adapted for non-palliative cancer patients.

In the form of couple therapy, emotionally focused therapy has been shown to be effective in a randomized control trial in cases of advanced cancer (across cancer types) (MacLean, Jones, & Rydall, 2008) yet it bears consideration that couple based interventions are not suitable for single, or more specifically, single and younger patients with breast cancer who are known to experience greater psychological morbidity and poorer quality of life (Mor, Allen, & Malin, 1994; Ganz et al., 2002). A more comprehensive model which specifically addresses the emotional experience of living with a cancer diagnosis remains to be further elaborated for individual therapy. Specifically, multiple losses such as loss of identity, control and certainty, loss of bodily integrity, as well as fears of dependency, abandonment/isolation from loved ones and mortality, are frequent themes in patient accounts and the psychologist must also incorporate premorbid psychological vulnerabilities such as CAD into their conceptualisation and intervention approach. Despite the strong evidence base in

emotion focused therapy (EFT) as a treatment for depression in the general population (Greenberg & Watson, 1998; Goldman, Greenberg, & Angus, 2006; Watson, Gordon, Sternac, Kologerakos & Steckley, 2003; Greenberg & Watson, 2006), and having been found to be as effective or more effective than a client centred approach and cognitive behavioural treatment, to date there has been no available research on how it might be developed for use in a cancer context and CAD. Emotion focused therapy has been found effective in depression and specifically targets loneliness, shame and traumatic fear (Timulak & Pascual-Leone, 2014), suggesting it would be amenable to addressing the psychological distress associated with the impact of a breast cancer diagnosis.

1.4. An Introduction to Emotion Focused Therapy

The role of emotion-related constructs and functionalist views of emotion have garnered increasing theoretical and empirical attention over the last two decades. While a traditional view of intense emotion as dysfunction and disruptive to rational decision making (see Averill, 1990) held a dominant place in discourse around coping, it conflicted with research in diverse fields documenting the adaptive potential of recognizing, processing, and expressing emotions. This growing body of theoretical, empirical and applied work based on functionalist views of emotion (Levenson, 2014; Morris et al., 2007; Zeman et al., 2006; Gross, 1999; Levenson, 1999; Mayne, 1999) includes the developmental construct of emotional competence (Saarni, 1990), the personality construct of emotional intelligence (Salovey, Bedell, Detweiller, & Mayer, 1999) and clinical emotion focused approaches from three major schools have been developed, including dynamic experiential approaches (Fosha, 2004; McCullough et al., 2003), cognitive behavioural (Foa, Huppert &

Cahill, 2006; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) and experiential, emotion focused therapy (EFT) which was developed as a general treatment approach to psychological problems (Greenberg et al., 1993; Greenberg, 2002; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2006).

A central premise to all experientially oriented therapies is that attending to and exploring internal subjective experience, typically feelings, is the primary source of information used in the creation of new meaning. Emotion is not only biologically based, it is motivational, and is motivation enhancing in that people have an inherent desire to have or not have certain affective experiences (Tomkins, 1962). Emotions are affiliated with a network of information in the forms of thoughts, feelings, beliefs, desires, bodily experiences and by accessing emotion this multimodal network becomes available (Paivio & Pascual Leone, 2010). Feelings are motivational in that they help in the setting of goal priorities and the obtainment of desires, self-preservation and efficient, adaptive functioning. For example, anger at violation promotes self-defence, while sadness at loss promotes grieving. According to Greenberg, Rice and Elliott (1993) a basic principle in life is to maintain coherence and adaptive viability in the environment, and affect is information as to how well this process is proceeding. In terms of the brain system, the amygdala is understood to be the part of the brain that is centrally involved in the rapid-fire, involuntary, processing and triggering of implicit heuristic learning and emotion based memories (Adolphs et al., 2003; LeDoux; 1993; Morris, Ohman, & Dolan, 1998; Whalen et al., 1998). When feelings and meanings that are related to problems, propositions or questions about the self are elaborated and explored through emerging content to resolve current difficulties at an experiential depth, the client is able to expand their awareness of their experiencing, possibly leading to feeling differently about a situation. Some

studies have shown that high experiencing ratings in therapy have predictive power of good outcome that goes over and beyond the therapeutic alliance (Pos et al., 2003), which suggests that psychologists should capitalise on the power of emotion to orient clients core content and facilitate healthy change, As well as simply having emotion, individuals also make sense of emotion. Put another way, psychologists work with both emotions and the narratives in which they are embedded.

Emotion focused therapy draws from both emotion theory and research (e.g. Izard, 2002; Lazarus, 1991) and developments in affective neuroscience (e.g. Damasio, 1999; Ledoux, 1996). It offers specific techniques for promoting ownership and expression of aspects of emotional experience that have been inhibited or suppressed. While there is emphasis on the value of viscerally *feeling* one's feelings, cognitions and behaviour are considered important; and in fact imperative, for meaning making and consolidating psychological change, however as an approach it places a premium on processing emotional experience. The approach regards emotion as central to psychological functioning, experiencing and change, and proposes that it is through altering the use of emotions that clients' problematic self-organisations can be changed (Greenberg & Paivio, 1997; Greeberg et al., 1993).

1.4.1 Classification of Emotions

Emotion focused theory allocates emotions into four distinct categories; primary adaptive, primary maladaptive, secondary, and instrumental (Greenberg & Safran, 1987). A highly differentiated perspective of emotion is one of the distinguishing facets of EFT as a model, which serves to guide appropriate intervention. The psychologist themselves uses this understanding of emotional-processing difficulties alongside knowledge of the patient, their personality style, and

an understanding of distress facets of clinical disorders to direct therapeutic tasks drawing from the model.

1.4.2 Primary Adaptive Emotions

Primary adaptive emotions are a person's healthy and immediate basic emotional response to a given situation. They are seen to help with the rapid processing and interpreting of environment that is necessary in everyday living and help organise appropriate action; a belief both supported and influenced by contemporary emotion theory (Greenberg, 2011). For example, an experience of sadness would signal a need for comfort, spurring the experiencer to seek nurturing from others (or self). This is referred to as an *action tendency*, whereby the individual is motivated to mediate their experience of the environment (Greenberg & Paivio, 1997). Examples of primary emotions include anger in response to violation, fear in response to danger, and sadness in response to loss. The information derived from such emotion is seen as a crucial guide for goal setting, relationships and decision making (Elliott et al., 2004). Restoring capacities for connection to affect and healthy relating is a central goal of EFT given that trauma and losses that often contribute to enduring or heightened/pervasive psychological distress frequently impair, or dysregulates these capacities to access emotion and fully experience it for its integration into current meaning and sense of self.

1.4.3. Primary Maladaptive Emotions

Primary maladaptive emotions are primary emotional responses that were once adaptive. Emotion becomes dysregulated typically where the experiencer has past negative or traumatic experience that remains unprocessed (Greenberg, 2002). As

a result, current events are filtered through the vantage point of unprocessed past emotional experience (emotion schemes), and trigger painful feelings. Essentially past emotion is overlearned from previous and often traumatic experienced. Grounded in the past and originally once adaptive, the resultant emotions in the here and now do not provide information that promotes adaptive responding, and often hold negatively tangential relevance at best to the current situation. There is a heightened sense of distress with primary maladaptive emotions, whereby they are typically experienced as overwhelming and often include shame and fear (Greenberg & Paivio, 1997). Core painful primary maladaptive emotions have more recently been identified to also have a distinct sense of loneliness and loss of connection that may or may not be linked to fearful abandonment (Keogh, O'Brien, Timulak, & McElvaney, 2011).

1.4.4 Secondary Emotions

Secondary emotions (Greenberg & Safran, 1987) are reactions to initial primary emotional experience and are often defensively employed to avoid such pain (Greenberg et al., 1993). Secondary emotions are often diffuse, including hopelessness, helplessness, and undifferentiated distress. In so far as they prevent the full processing of primary emotions and thereby prevent access to the adaptive information primary emotions provide, they are considered maladaptive. Essentially, secondary emotions obscure primary emotions from the experiencer. Secondary emotions have a function in that they serve as a route towards emotional regulation (e.g. self-interruption of contact with deeper, painful experience). As a means of protective it is understood to serve a purpose, but it is considered secondary to underlying, primary experience.

1.4.5 Instrumental emotions

Instrumental emotions (Greenberg et al., 1987) refer to emotions that are learned response that serve to influence the behaviour of others. Examples include using anger to gain power, or collapsing into tears to elicit sympathy from others. Instead of being a biological response to one's environment, instrumental emotions can be exercised with intent to meet one's ends interpersonally. They may also be used outside of awareness as part of a learned response for the same purpose of obtaining an outcome (e.g., comfort after crying).

1.4.6 Emotion Schemes

Emotion schemes form the foundation of the self (Greenberg, 2010). Schemes are a holistic construct made of affective, motivational and relational processes (Greenberg et al., 1993) that develop as a result of experience and continue to refine over time (Elliott et al., 2004). As acquired responses based on lived emotional experience, emotion schemes serve to generate emotional experience and responses and help the individual to anticipate future outcomes. It is a gathering of nonverbal and affective experience that represents a gathering of biology and autobiographical experience, including the beliefs or rules that govern these experiences (Greenberg et al., 1993; Greenberg & Safran, 1987).

Emotion schemes are considered adaptive when they are flexible and open to transformation as new experiences are encountered. Emotion schemes, however, can equally be maladaptive ("emotional wounds" put another way by Goldman, 2013) when they are resistant to change and confirm pre-existing emotion schemes along with their experiential landscape and result in behaviour that confirms this scheme (Greenberg et al., 1993). Put another way, emotion focused therapy makes its

assumptions about healthy individuals as being inherently composed of multiple selves (Markers & Nurius, 1986), and as dialogical and multivoiced (Dimagio & Stiles, 2007). Traces of earlier attachment figures and the beliefs, cognitions, feelings and memories associated with them contribute to these voices. Problematic experiences, such as traumas and destructive primary relationships, leave traces that cause emotional pain and result in self organizations that centre on feelings of vulnerability, worthlessness, inferiority and incompetence. Emotion schemes conceptually share some similarities and overlaps with existing psychotherapeutic concepts such as object relations or transference reactions, yet it is distinguished by apprehending emotion as a dynamic action plan rather than a fixed portrayal or structure, and its emphasis on emotions as the target gateway for therapeutic intervention.

1.5 Understanding Psychopathology and Emotional Distress

Emotion Focused Therapy takes the view that any emotional experience that has not been perceived as meaningful to the self and disowned can lead to dysfunction. This disownership can take a myriad of dimensions; divorcing oneself from personal shame is equally problematic, for example, to an unintegrated sense of one's need for connection (Greenberg & Paivio., 1997). With the self organised around emotional experience, healthy emotional regulation is one where an individual can be guided by their emotions as a source of information but not forced by them. A key developmental task in EFT is emotional flexibility (Greenberg & Paivio, 1997). Maladaptive emotion schemes, as a consequence, are often built to cope with difficult feelings, such as where there is inadequate care provided or where emotions are met with omission, rejection, or rigidity that limits their full expression. The learning that

constellates maladaptive emotion schemes often stems from untenable situations where emotions are heightened such as when a child has been abused and their primary source of safety is also a source of fear. The challenge for the child is not only to content with these conflictual feelings but also with an unavailable or inconsistent caregiver. Bowlby captured the centrality of emotions before EFT developed the interventions to help contend with attachment injuries:

> Many of the most intense emotions arise during the formation, maintenance, the disruption and the renewal of attachment relationships…Because such emotions are usually a reflection of the state of a person's emotional bonds, the psychology and psychopathology of emotion is found to be in large part the psychology and psychopathology of affectional bonds. (Bowlby, 1969, p. 60).

While perhaps adaptive or necessary as emotion based learning and survival within the experience, the lack of ability to resolve these emotions and their encoding into enduring emotion schemes that are activated in later instances of distress means their intensity remains high, and without full articulation or experience in detail (processing), they cannot guide adaptive action. It is important to note that while fear is an adaptive response to a situation of abuse, the perpetuation of the response across later relationships whereby the current relationship is blended by and responded to with emotions that are drawn from the past. The extent to which this results in dysfunction depends on a number of factors, including how frequently and powerfully these schemes initially were triggered in their formation, alongside factors from the present including temperamental and organic factors, physiological arousal and the individual's general mood or situation at the time of challenges (Greenberg, 2011). Consistently, maladaptive emotion schemes are understood to be resistant to change.

Additionally the degree of emotionality evoked by the new experience due to associations in the emotion scheme with earlier traumatic events may render a person unable to attend to any other information, again hampering emotional experience as a useful source of information.

Within an emotion focused framework, there are three broad emotional processing problem domains. What they share fundamentally is an inability to regulate one's emotions (Greenberg & Watson, 2006). Individuals can be in exile from most emotional experience and be unable to access the adaptive meaning that can be drawn from emotion. Extremely avoidant clients, for example, are often cut off from experiencing their basic needs and feelings. Alternatively, individuals may automatically experience the chronic activation of secondary emotion schemes when first (primary) occurring emotions are difficult to tolerate (i.e. fear of shame). A problematic emotional processing state involves shutting one's feelings down either in the form of self-criticism, self-interruption, or self-frightening. Lastly, primary maladaptive emotion schemes can cause 'false alarms' and reactions out of proportion to the present interpersonal context. Unregulated internal distress of this nature may become activated in situations where the person (mis)perceives abandonment/rejection from significant others. Across these three idiosyncratic presentations, an EFT therapist empathically draws links between current behaviour and warded off emotional experience (core pain) that, in its outlawed status, contributes to emotional distress. Greenberg has summarised the emotion therapy perspective on the broad underpinnings of anxiety and depression quite concisely:

> Anxiety and depression are emotional disorders of the self-organising process. The negative views of the self, world and future and the behavioural withdrawal that one finds in them are reactions to and avoidance of painful

> core maladaptive emotions often of fear, shame, lonely abandonment or anger as well as maladaptive ways of trying to cope with the events that evoke these painful emotions (2011, p.103).

While anxiety and depression share overlapping processes, within the EFT literature there are distinguishing features which merit their consideration as separate categories. Across therapy sessions, part of the corrective experience is the experiencing, acknowledgement and validation of primary emotion, which is achieved when emotion is sanctioned, received, and regulated.

1.5.1 An Emotion Focused Perspective on Depressive Disorders

Depression has been described by Greenberg (2011) as the result of the "vulnerability of a disempowered self" (p.38) whereby "early experiences of abuse, neglect or abandonment or consistent experiences of being misunderstood can attenuate the person's processing of emotional distress, so that emotion becomes overwhelming and cannot be affectively used as the basis for adaptive responding" (p. 38). From an EFT perspective, depression holds both self-critical and dependence elements (Greenberg & Watson, 2006; see also Blatt & Bers, 1993). The implicit emotion scheme is of the self as *deeply inadequate*, *insecure* and *unworthy*. As such, the self is organised around vulnerability and poor coping resources and collapses into feeling *powerless, trapped* and *ashamed.* Experiencing themselves as insecure and helpless; the emotional sense of self is as "bad" or "weak" (Greenberg, 2011, p. 38). In depression, the self is organised as *unlovable,* or *worthless, and helpless or incompetent* (Greenberg & Watson, 2005).

Depression is essentially a powerless state, and is often accompanied by a great sadness over not reaching one's full potential. It is important to note that the

experience of a core sense of a lack of self-worth is often out of awareness, and has to be unfolded through dialogue and brought to awareness in order to be transformed. Secondary emotions are often at the fore for the person, and feelings of tiredness stemming from helplessness/hopelessness are what maintain low self-esteem. As a result, depression is viewed as a complex *secondary emotion*, where bad feelings (or powerlessness, defeat or emptiness for example) are generated by cognitive affective sequences, yet they are global and diffuse. The work of emotion focused therapy then, is to access more primary cognitive affective components to arrive at more adaptive resources, such as sadness at loss, or avoided/suppressed anger at violation.

1.5.2 An Emotion Focused Perspective on Anxiety Disorders

Anxiety is viewed as a conflict fuelled position intrapsychically in which a person catastrophizes (critical aspect) emotional experience, frightening a vulnerable, experiencing self, which produces symptomatic anxiety (Greenberg, 2010, p.104). The self is organised as insecure and vulnerable (Greenberg, 2011), embodied as a "holistic, multicomponent, bodily felt sense of the self as ineffective and unprotected" (Greenberg & Paivio, 1997, p.198). Beneath the presenting anxiety there is a deeper fear of what might befall the emotionally vulnerable self in terms of unmet (emotional) needs. For example, a person with anxiety often experiences themselves as afraid, weak, unable to cope alone, and as a consequence, often react to situations with anticipatory anxiety, avoidance and dependence (Greenberg, 2010, p. 103). The internal relationship of fear mongering essentially serves as a self-protective strategy (Greenberg, 2004, p.221). In some measures, this maladaptive emotional strategy establishes itself as an attempt to protect the self from disavowed contact with painful emotions whose origins stem from emotion schemes organised by past experience.

Historically, anxiety as a response is often shaped by experiences of abandonment, neglect and failures in interpersonal soothing with significant attachment figures (p. 103), and can become chronically activated. Affectively laden painful memories, in other words, shape the experience of the self; "conscious appraisals of the self or situation are by-products of that core self-organising action that fuel but do not create the anxiety" (Greenberg & Paivio, 1997, p. 198). As a framework for understanding the development of emotion regulation across the lifespan (Mikulincer, Shaver, & Pereg, 2003), the attachment model underpinning EFT highlights how the working model of emotion-related expectations transfer from significant relationship dynamics to the larger social world. Studies fairly consistently yield a moderate degree of stability in attachment patterns from infancy to adulthood and throughout the adult years (Fraley, 2002; Waters, Hamilton, & Weinfield, 2000); however, discontinuity in attachment patterns can result to changing life experiences (Hamilton, 2000). Individuals who are high in attachment avoidance or anxiety in their adult relationships have, according to theory and attachment based research, learned that they could not always rely on primary caregivers for consistent emotional regulation in times of distress.

Due to these early experiences, insecurely attached individuals (whether avoidant or insecure) tend to engage in two different types of secondary attachment strategies in an attempt to regulate their emotions when they become distressed (Mikulincer, Shaver, & Pereg, 2003). *Deactivating strategies* may be employed by avoidantly attached individuals, wherein the primary aim of these strategies is to eliminate the experience of emotional distress. Having learned in their early development that they cannot depend on others when they are distressed, they tend not to go to others for support in times of emotional need (Shaver & Mikulincer,

2009). Deactivation is holistic in nature; these individuals tend to suppress experiences, thoughts and emotions that are distressing (Mikulincer et al., 2003). The strategy, while ineffective, represents an attempt to reduce the likelihood of experiencing an emotionally distressing experience that is too much for them alone.

Conversely, individuals who are high in attachment anxiety tend to engage in *hyperactivating strategies*, the primary aim of which is to gain proximity to attachment partners (Mikulincer et al., 2003). Hyperactivating strategies may include demanding the attention of others, experiencing exaggerated subjective negative emotional reactions to objectively minor threats, and ruminating over negative emotions. Anxiously attached individuals may believe they cannot regulate their own emotions and as a result, frequently rely on other in this area (Mikulincer et al., 2003). Such beliefs and behaviours are conceptualized as the result of the expectation that others will be inconsistently responsive to their needs (Shaver & Mikulincer, 2009). Significantly, individuals with insecure attachment styles classed as either avoidant or anxious generally experience a number of negative mental health outcomes including poorer well-being (Shaver & Mikulincer, 2009), poorer support seeking skills (Lopez, 2009), and perhaps most relevant to this research, symptoms of depression (Hankin, Kassel & Abela, 2005; Liu, Nagata, Shono, & Kitamura 2009; Lopez & Fons-Scheyd, 2008; Riggs & Han, 2009) and as Greenberg notes: "instead of feeling safe, secure, and confident, anxiety ridden people experience themselves as afraid, weak, unable to cope alone, and they react to situations with a lot of anticipatory anxiety avoidance and dependence" (2011, p.103). Greenberg further elaborates that "the self is organised as helpless, unable, dependent, and insecure because of the activation of emotion schematic memories of crucial experiences of abandonment, neglect and failures in interpersonal soothing" (p.103). Thus, anxiety as understood by EFT is

where the self is organised as insecure and vulnerable (Greenberg, 2011). Specific client presentation for tasks related to anxiety are described as including: longing for connection; interdependence; freedom; spontaneity; and more risk taking. EFT is thus focused upon facilitating the emergence of this self-organisation (Greenberg & Paivio, 1997).

1.6 Emotion Focused Therapy Process

1.12.1. Emotion Focused Therapy Treatment Principles

Through the central components of a building a secure therapeutic relationship and the facilitation of the expression of emotions, EFT places a focus on the transformation of emotion to work through emotional processing difficulties. The hallmark of the therapy are "markers" or client problem states that the client enters in the session. Specific problematic emotional processing states are identified in session (i.e. markers) that guide the session, in that they provide an opportunity for specific intervention techniques (i.e. therapeutic tasks) (Elliott et al., 2004; Greenberg, 2010, 2011; Pos & Greenberg, 2012). It could be considered that structured interventions could create a rather rigid or formulaic therapy, but with emotion focused therapy relational values draw from gestalt, person centered and existential therapeutic approaches, attunement and being in the moment as both therapist and patient are given precedence over interventions. Put simply, emotion focused therapy proposes we "have to feel things to heal them" (Greenberg, 2010).

By facilitating emotional changes, emotion regulation may promote coherence in personality functioning and personal growth (Beaumann, Kaschel & Kuln, 2005).

Creating meaning from emotion allows for the development of new self-esteem and helps strengthen perceptions of self and one's sense of coherence.

1.12.2. Case Conceptualisation during the Process of Therapy

Attending to the therapeutic relationship is central to good alliance formation and effective therapeutic work, however EFT utilises an empathic stepped process of case conceptualisation across and within each session as an important aspect of treatment. Eight steps have been identified (Greenberg & Goldman, 2007; Greenberg & Watson, 2006) which are as follows: 1) identification of the presenting problem; 2) exploration of the patient's narrative about the presenting problem; 3) gathering of information about past and current identity and attachment related experiences; 4) identification of the *'core pain'* (i.e. the most sorrowful, painful and poignant experiences; 5) observation and attention to the client's style of processing emotions such as under or over regulation; 6) identification of thematic interpersonal and intrapersonal processes; 7) identification of '*markers*' (EFT harnesses patient' in session presentations that contribute to problematic or unresolved experience) which inform the choice of therapeutic tasks (Elliott, Watson, Goldman & Greenberg, 2004; Greenberg et al., 1993) and 8) attention is paid to moment to moment process within the session and tasks. The insights the therapist observes, draws and infers from the patient's presentation, experiencing and their collaborative interaction within and across these eight steps guides the therapists' action moment to moment and marker focused responding.

Case formulation is a reflection of EFT theory in that it guides the therapist towards the emotional sources of the presenting problems, establishes treatment focus, and helps create a map for process formulation (Goldman & Greenberg, 2014).

EFT deemphasizes psychiatric diagnosis, but rather uses the client's emotional pain to guide case formulation. Painful events include abandonment, humiliation, and trauma. Naturally, this central focus can be challenging as many clients may have ways of habitually avoiding pain (a tendency that may be out of their awareness), but their chronic and enduring pain is viewed as an entry point for deeper exploration into his or her core concerns (Goldman & Greenberg, 2014).

Psychological pain can be defined as a feeling of being shattered and helpless in relation to the inability to getting an important need met (Goldman & Greenberg, 2014). Fear and shame are considered cornerstone maladaptive emotions, around which there could be a core sense of powerlessness, a deep sense of woundedness, worthlessness, or a feeling of invisibility or being unloved or unlovable, which if accessed and "arrived at" (i.e., fully experienced and symbolised) can generate access to alternate adaptive emotion-based self-organizations. While specific tasks are designed to shift emotional processing, it is the core painful maladaptive emotion schemes themselves that are at the heart of case formulation. Arguably, it might be tempting to interpret that EFT dwells unduly on painful emotions that are unresolved, case formulation and emotion theory facilitates core painful emotion to be elicited within the safety of the therapeutic alliance so it can be productively engaged and transformed. Part of the EFT formulation is identifying how painful emotions are avoided or blocked, often including the fear that these painful emotions cannot be survived. The therapist follows the clients' particular pain compass, which is illuminated by *process formulation;* which involves attending to verbal and nonverbal expression and displays of the client. Process formulation informs the therapist' decision making for deepening emotional expression and guides the identification of task markers for chair dialogues. After chair work resolves, the therapist facilitates

weaving the transformed emotion into the clients' narrative in order to promote coherence around the emotions and the specific events and memories attached to them. New emotion integrated into awareness automatically constructs new meaning. This narrative is formulated and becomes part of the explicit dialogue between therapist and client, where it is offered to the client to help organise what is being done in therapy and is developed further in tandem with the client. As a consequence, case formulation can be seen in EFT to focus on emotion process, but it also serves, in the words of Goldman & Greenberg (2014), to "build a picture of the case with the core emotion scheme at the centre," (p.141) from which interventions are scaffolded.

A conceptual framework model was developed by Timulak (Timulak, 2015; Timulak & Pascual-Leone, 2014) that elaborates the link between the emotion transformation model (Pascual-Leone & Greenberg, 2005) and the cornerstone emphasis in EFT on case conceptualisation (Greenberg & Goldman, 2007; Greenberg & Watson, 2006; Watson, 2010). The conceptual framework model allows for the therapist to tentatively capture several aspects of the patient's presentation and can guide therapist perceptions and actions within a session. Followed in proximate to the patient, the framework model (see figure 3) captures the initial narrative, triggers that catalyse emotional pain, the secondary emotions that make up global distress, the patient's negative self-treatment that contributes to emotional pain, emotional interruption strategies including the underlying fear(s) driving avoidance, the activated experience of core pain which are the focus of treatment, unmet needs and the facilitation of specific healing adaptive emotions.

Timulak (2012; Timulak & Pascual-Leone, 2014) tracks the narrative account of the patient with initial triggers that may be current or historical (or both) in nature, that have activated core painful emotions. The sheer difficulty of bearing these painful

emotions often leads to a generalised collapse into distress that is global and is expressed as feelings of helplessness and hopelessness. In response to the painful emotion, avoidance strategies that are emotional, behavioural and shape self-treatment are also captured. The core painful emotions and associated unmet needs then solicit adaptive emotional responses from the self, the therapist and people outside of the therapy. Adaptive emotions that the framework identifies include self-compassion, protective anger, grief and letting go (of unresolved pain), and empowerment and agency (Timulak & Pascual-Leone, 2014). Conceptually the framework allows for the therapist to reflect on the session in a way that is consistent with standard EFT practice including the necessity of continued emotional assessment, and also serves as a guide within session interactions with clients and thus serves to facilitate optimum change processing.

1.6.3 Markers and Tasks

EFT therapists are trained to identify markers based on problematic emotional processing problems and use tasks that are structured to serve as a map/guide for the therapist and patient to move towards a specific form of resolution. Besides being focused on processes of change, these models serve as experiments to deepen experience. The therapist takes the role of leading the tasks and coaches the patient emotionally through to resolution. At times, tasks move and shift from one to another as required by the patients' moment to moment experiencing.

Central markers include but are not limited to 1) *Conflict splits,* in which one aspect of the self is critical toward another aspect. Self-critical splits are opportunities for *two chair work*, where two parts of the self are put into a dialogue together that includes thoughts, feelings and needs which are communicated in a live dialogue. As

a softening of the critical voice takes place within the dialogue, resolution culminates in an integration between sides and a new awareness of self-functioning. *2) Self interruptive splits* wherein one part of the self interrupts or constricts emotional experience. The interruptive part of the self is seen as agentic and brought to life in a *two chair enactment* where a patient is guided to become aware of how they interrupt whether by physical display, bodily communication (e.g. shutting down the voice), verbally, or metaphorically articulated. The patient is then allowed to experience their own response to the interruptive part of the self and resolution is reached through expression of previously interrupted/blocked experience. *3) Unfinished business* takes place in the context of unresolved feelings towards a significant other. A dialogue is generated within a dyad where the patient activates and speaks from their own internal view of their significant other. This *empty chair intervention* involves the expression of unresolved feelings and needs, and allows shifts in views of self and other to be processed. Resolution can take a variety of forms, whether holding the other accountable, understanding, or forgiveness.

1.6.4. Model of Emotional Change

The theory of EFT therapy assumes that anxiety and depressive symptoms, first need to be accepted, contained and regulated (Greenberg, 2002; 2008; Greenberg & Watson, 2005). This is done through the empathic therapeutic relationship and through self-soothing strategies, using imagery and separating the maladaptive strategies and anxiety experience from healthy, more adaptive parts of the self. Then the therapeutic work focuses on targeting emotional/experiential avoidance through increasing awareness of internal experience as well as awareness of what is not met in life due to the avoidance (idiosyncratic unmet needs) and through the facilitation of

self-compassion with regard to those needs. Finally, therapy targets emotional avoidance by mobilization of determination (assertive empowerment) to have idiosyncratic unmet needs met. The therapeutic aim in EFT is to gain ownership of emotional experience, including those that have been renounced, so it can be felt and psychologically digested, leading to a more coherent and integrated self (Greenberg, 2011).

1.6.5. Emotion Transformation Model

According to Greenberg, (2010), "probably the most important way of dealing with emotion in EFT therapy involves the transformation of *emotion by emotion*." (p.11). In order to transform emotion, maladaptive emotion needs to be arrived at in order to make it accessible to change (Greenberg, 2010). Transformation is central to self-change. And change is achieved by activation, restructuring work through tasks where new experience is processed within the context of a safe therapeutic relationship. Defining and expressing a range of emotions that may include sadness, anger and pain/hurt, accessing core painful emotion is at the heart of the therapy, as its access can pave the way for the recognition of unmet needs. For example, where a woman was abused as a child by a parental figure, experiencing the painful sense of feeling unloved and consequently hurt, angry and worthless might be followed by a recognition of needing to be accepted. This recognition may be experienced with a sense of pride (in the self as worthy) and anger (at the abuser), as well as grief at the loss. This aforementioned combination of emotions undoes core shame (Greenberg, 2002). As a consequence, the belief that the abuser's failure was not because she was not worth loving begins to shift. More adaptive emotional responses and new

understanding is added to the old situation, achieving a reconsolidation of memories with a fresh assimilation.

Once a core primary emotion is aroused and if it can be tolerated, it will naturally involve a peak and dissipation and intensity. The ensuing drop in intensity allows for reflection on the experience, which helps consolidate meaning and translates into a kind of "hot learning," experientially felt and explicitly making sense of aroused emotions. Emotion transformation can be seen as involving a combination of arousing, regulating, symbolising, and reflecting that carries forward the process of change (Greenberg & Goldman, 2008). The EFT therapist explicitly communicates to the client the dynamics that contributed to the core pain, and this shared case conceptualisation is vital so the client build a sense of self understanding related to the conceptualisation and uses it as a guide to understand what is happening in therapy, for use outside of therapy in times of emotional pain (Timulak, 2014). In this way the case formulation forms a part of the therapeutic process and dialogue with the client, and helps tie together the presenting relational and behavioural difficulties (that define pathology) with the events that trigger the core emotion schemes that are part of the problem (Goldman & Greenberg, 2014). The lower half of figure 3 (see next page 64)

It is important to note that given emotional avoidance is central to anxiety and depressive processes, the therapeutic alliance and a sense of collaboration that builds the clients' trust and emerging capacity to focus on, feel, name and express painful (e.g. loneliness, shame, and fear/terror), previously avoided emotional experience means the therapist has a very active role in accessing the client's pain. It is only after painful emotion is evoked, experienced and expressed, that adaptive emotions

can be harnessed as a kind of "antidote." (Greenberg, 2011, p.13). Adaptive emotions often include compassion, pride, and validation of self-protective anger.

1.7 Emotion Focused Therapy Evidence Base

Emotion Focused Therapy has twenty years of empirical support as a treatment for psychological disorders. As a psychological therapy EFT has been shown to be effective in treating a number of presentations including marital discord (Johnson, Hunsley, Greenberg, & Schindler, 1999), complex trauma (Paivio & Pascual-Leone, 2010), and complex trauma for adult survivors of childhood abuse (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001). EFT has a rich research evidence base as a treatment for depression, with randomised controlled trials indicating that it is highly effective (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003) and was found to be effective in preventing relapse (Ellison, Greenberg, Goldman, & Angus, 2009). In an RCT comparing the effectiveness of EFT with Client-centered therapy; certain EFT tasks over the course of the individual therapy accelerated and improved recovery (Greenberg & Watson, 1998). In an RCT between EFT and CBT for depression, both conditions improved in relation to depressive symptomatology (Watson, et al., 2003), with EFT also found to be effective in preventing relapse (Goldman, et al., 2006).

Emotion focused therapy is currently being adapted for other mental health disorders for which central problems lie in maladaptive emotions (see Elliott et al., 2008; Paivio et al., 2001). There are existing frameworks for EFT based on clinical experiences and empirical investigations of this therapy with anxiety disorder (MacLeod & Elliott, 2012; MacLeod, Elliott & Rodgers, 2012), and specifically with EFT as a treatment of social anxiety disorder (Shahar, 2014). Work by Timulak and

colleagues has focused on generalised anxiety disorder (Timulak & McElvaney, 2014; O'Brien, Timulak, & McElvaney, 2012).

1.8 Case Study Research and EFT

The current study aims to contribute to the development of an EFT model of treatment of comorbid anxiety and depression (CAD) in women with breast cancer by presenting a series of case studies (of the first six patients to complete treatment), followed by a cross case analysis of those studies. While the study had a broader context across cancer types initially, one male participant with a different cancer type (not breast cancer) completed therapy but requested not to have his data included in the research findings. The second non-completer opted out of therapy after the first few sessions, and also withdrew from the study, so data cannot be reported. As it wasn't initially clear whether there would be a homogenous sample from the patients who were eligible and consented to the research, the initial ethics approval for the study included all cancer types, however it was later limited to breast cancer in line with the completed case studies.

Case studies provide specific information as to what implementation of a given treatment looks like by describing the background information to the patient and the therapist as well as the process of therapy, providing a detailed illustration of a given treatment or therapeutic approach (Dettilio, Edwards, & Fishman, 2010). It is worth noting that as a consequence of discrepancies between efficacy within a randomized controlled trial design and real world realities, there have been many obstacles to the successful translation and dissemination of empirically supported psychological treatment, especially for chronic and mixed patient populations (Campbell, Hien, & Cohen 2009) such as women with breast cancer and CAD which

are the focus of the current study. The conflict between the time it takes for a given psychological treatment to progress through years of development and testing to definitively receive the designation of an "efficacious or "probably efficacious" treatment (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and the importance of providing treatment for vulnerable or at risk populations is a core dilemma. Psychological therapy is a highly complex set of processes, and correspondingly, research should convey its nuance and dynamic nature. A series of intensive case studies is one first step method for evaluating a promising new treatment (Chambles & Hollon, 1998). In addition, it is recognized in research on clinically meaningful and scientifically rigorous psychotherapy effectiveness research that naturalistic clinical settings maximizes external validity (Borkovec & Ruben, 2001), adding to the suitability of a case study approach as a first step of treatment development.

A historical overview of psychological literature reveals many currently empirically supported practices first began with evidence in case study design (e.g. behavioural approaches for chronic pain, CBT, psychoanalysis). For example, Aaron Beck published his first psychiatric article as a case study on the treatment of delusions, which was later recognised as a significant precursor to the development of cognitive therapy (Morrison, 2002). Equally, Binswanger documented his most outstanding clinical cases (e.g., Binswanger, 1958) to further develop the phenomenological position in psychotherapy as well as what would become existential therapy. According to Eelles, the core building block of a study in psychotherapy is the "case" (2007; p.4). Whereas traditional clinical case studies were usually a therapist narrative account of what happened during treatment with interpretations from a particular theoretical perspective, the narrative in contemporary

systematic case studies is grounded by both qualitative and quantitative data obtained from multiple sources. The focus of a case study can vary, from a single episode within a single session, a distinct session, a particular phase or group of sessions within the therapy or an overview of the entire therapy. This approach investigates the content of therapy sessions, measuring what patients and/or therapists are saying, feeling, or doing and evaluating how these relate to each other and ultimately to clinical outcome. Mackrill and Iwakabe (2013) make the valuable observation that psychotherapeutic sessions are not equally measurable across time. As Elliott (1985) identified, some moments, which vary in duration, are so condensed and richly poignant that they are "significant moments" (p. 249) which call for detailed description. Case study research facilitates access to these moments and seeks to capture them in a way that quantitative or large scale research cannot.

Rather than traditional or nomothetic designs which are used in other disciplines, case studies have gained renewed value within psychotherapy research because of their capacity to illustrate change processes and serve as a reliable medium of evidence for the impact of therapy in effecting psychological change. Influential and central to shaping existing approaches to psychological therapy, case studies a) lay the reflective ground for developing or testing exploratory hypotheses and methods within a therapeutic approach, b) build evidence as to the effectiveness of that therapeutic approach and, c) illustrate central features of the therapy for other practitioners (Widdowson, 2011; Mcleod, 2010; Berne, 1961). This capacity is strengthened through replication on a case by case basis (Hilliard, 1993; p.373-4).

Subject to criticism due to small sample sizes compared to control trials, previously subjection to methodological scrutiny in the past from the wider psychological research community obscured at times the value of case study research,

however a paradigm shift involving greater formal recognition for their value was arrived at with the APA document published from the Presidential Task Force on Evidence Based Practice (2005) that explicitly acknowledges clinical observation and case studies as legitimate evidence. Clinical case studies are also recognised as contributing to the scientific literature because they provide documentation of psychological assessment and the application of psychological interventions in naturalistic settings. The knowledge drawn is concrete and context dependent, and is considered more valuable within the behavioural sciences and humanities in so far as it reflects how human behaviour can only be understood in context. For example systematic case studies allows the researcher to account for additional factors and complexity in the participants life, such as the influence of external or extra therapy changes (e.g. changes in relationships) and other variables in a way that is not present in large scale quantitative research (MacLeod, 2010). It also allows for the presentation of complex data in a way that conveys the rich and complex components of the dynamic nature of therapy with context and within an account that respects the uniqueness of the individual in therapy in a way that is philosophically and ideologically compatible with a humanistic approach to psychological therapy.

As Westen, Nowotny and Thompson-Brenner (2004) noted, "there can be no more powerful way to create a gulf between clinical practice and research than to compare laboratory-derived interventions with everything but what clinicians practice in the community" (p.641). McKinley (2011) expands on this stance by stating that pre-post outcome designs generate "probabilistic generalisations…that seems at odds with what is pertinent to practitioners who seek to understand the unique qualities, the idiosyncratic meanings, and the specific contexts of their patients' lives" (p.28). While the current studies incorporates pre-post outcome measures into the analysis of

each case, it also draws from multiple other sources to inform and illustrate change processes. In essence, the value of case studies is contingent on their capacity to be deeply rich in their description of the participants, complex, and integrative in their understanding of therapy, drawing from the individual and the interpersonal components of the therapeutic work captured in the research in order to fully complement larger scale RCT research.

While it must be acknowledged that it is difficult to apply a strict logic to sampling numbers in case study research (MacLeod, 2003), the number of participants proposed in the current study is substantiated by Morrow's (2005) review of quality and trustworthiness in qualitative research in counselling psychology, who as a qualitative methodologist and research, points out; "*Adequate amounts of evidence* are not achieved by mere numbers, though sufficient numbers of research participants are important" (p. 255). The numbers considered in the literature vary dramatically, from Pollio, Henley, and Thompson's (1997) recommendation;

> Although not a formal methodological rule, the situational diversity necessary for identifying thematic patterns is often provided by three to five interview transcripts —to hundreds. Ultimately, what is far more important than sample size are sampling procedures; quality, length, and depth of interview data; and variety of evidence (p.51).

Patton (1990) similarly recommended that "validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (p. 185).

Increasingly mixed method case study designs are recommended as a means of drawing on the strengths of both qualitative and quantitative research methods. It

has been noted in the literature that qualitative case study results can be generalized to broader theory when researchers study additional cases and generalize findings to new cases. This is the same as replication logic used in experimental research. Crucially, in order to repeat a case study's findings in a new case setting requires good documentation of qualitative procedures (Yin, 2003). The above is also consistent with strategies recommended to address generalisability in case study research (e.g. Kazdin, 1981; Yin, 1994). Ideally a series of case studies will be carried out over time in which tentative generalisations and conclusions drawn from earlier cases are checked out against later cases (Mc Leod, 2003).

Put another way, case studies put a focus on process, which can be defined as all that precedes outcome that affects and effects therapeutic change (Morrow-Bradley, & Eliott, 1986). As Wachtel (2011) points out, "what is needed [for advancing the interests of prospective patients]…is research [broadly defined] that illuminates the *processes and principles* that account for meaningful therapeutic change" (p. 463). Similar to small sample experimental design, case based research methodology is an important complement to methods that use surveys or group comparisons (Edwards, Dattilio & Bromley, 2004). The current study borrows from Iwakabe and Gazzola's (2009) discussion of metasynthesis of qualitative studies, wherein common themes across the six cases are identified as a means of EFT theory building and development. Taking a descriptive interpretive approach (Elliott & Timulak, 2005) to the qualitative data analysis across the cases, the processes and patterns in psychological change that capture patients' progression through therapy are captured, alongside pre-post outcomes drawn from quantitative instruments.

While methodological problems have previously been associated with clinical case studies, a systematic case approach (also named "pluralistic" (McCleod, 1998),

"pragmatic" (Fishman, 1999), "single-subject" (Eels, 2007), "systematic" (Edwards, 2007) and "hermeneutic single-case efficacy design" (HSCED; Elliott, 2002) has been considered to rectify design limitations. The current research study is largely informed by the Hermeneutic Single-Case Efficacy Design (HSCED; Elliott, 2002) approach, whereby a formal structure of analysis stems from a single client's process in therapy. The analysis stems from a quasi-judicial model of gathering, presenting and evaluating evidence to make inferences about the efficacy of therapy (e.g. Elliott et al., 2009). Consistent with the original model, Elliott further elaborated that qualitative and quantitative methods are applied to gather a rich and multidimensional account of the therapeutic process (2002). These data include at least two semi-structured qualitative interviews where the client's own perspective of their therapy process is heard and recorded, as well as a battery of quantitative measures gathered at multiple time points (pre therapy, mid therapy, post therapy and follow up). Gathered as a whole these data form the Rich Case Record. In the present study, data collected included standardised self-report outcome measures (HADS, SCL-90R, FACT-G, DERS), a questionnaire administered at the beginning of each session where the client self-identified and wrote down problems they wished to address in therapy (Target Complaints), an open-ended questionnaire soliciting important helpful and unhelpful events in therapy which was administered at the end of each session (Helpful Aspects of Therapy form), and an interview investigating client experiences of change was administered at the mid-point and end of treatment (Client Change Interview). All of these measures are described in full in the method section and further detailed in narrative description by the therapists' process account of the progression of therapy in the results section.

In the traditional research design of the HSCED, the case record forms the contextual "evidence" from which a panel of adjudicators consider whether there is enough gathered from the data to make an informed conclusion about client change, whether the observed changes were the direct result of therapy, and identifying mediator and moderator variables, which may account for changes observed. Previous HSCED studies have indicated that Emotion-Focused Therapy (EFT) can be an effective treatment for both panic disorder (Elliott et al., 2009) and social anxiety (SA) (MacLeod & Elliott, 2012; MacLeod et al., 2012), which suggests that therapeutic conditions used in conjunction with EFT can provide beneficial therapeutic gains for persons with these forms of anxiety.

This study does not involve the use of an adjudication panel, and consequently deviates from traditional HSCED methodology, because as a process applied to each of the cases (six cases as opposed to a single case) would be so lengthy as to be beyond the conceivable scope of the current project. The current research, however, does draw on multiple perspectives in the presentation of each case, and is systematic, replicable and transparent as part of adhering to hermeneutics as a philosophical tradition and a methodological resource, where the phenomenology of experience provides the grounding for how people experience and make sense of the world, in this case in the context of living with breast cancer (Dilthey, 1961; Ricoeur, 1981; Gadamer, 1975, 2001). Rather anecdotal, the somewhat looser structural design of the research is partially due to the fact that the wider body of research in psychotherapy is silent on the topic of recommended methodology for treatment development as a first step.

Nonetheless, in accordance with guidelines outlined in Mc Leod (2003) and Iwakabe and Gazzola (2009), the current study is methodologically supported in its

pragmatic qualitative approach through the incorporation of the following recommendations. Firstly, the use of *multiple sources of information* including questionnaires, observations, and interviews. Interviews include a) a screening assessment to confirm that the patient meets the criteria for CAD b) two assessment interviews to furnish information on current presenting problems, developmental and family history, c) a mid-treatment research interview that is conducted by the research assistant explores the patients' experience of therapy and whether there has been an alleviation of symptoms and d) an interview six months at treatment termination that included an assessment of current symptoms. Multiple sources of information help construct a rich and comprehensive case account. Secondly, the construction of a *team of researchers*, so that interpretation of the material is less likely to be dominated by bias or counter-transference arising from an individual investigator or therapist. This allows for competing interpretations of the material to be discussed and tested. A team of researchers also allows the quality of the relationship between the subject and investigator to be taken into consideration, as the team reflects on the cases. Thirdly, the integration of *quantitative and qualitative measures* and observations, gleaning both types of data, to be taken into consideration by the research team when evaluating findings. Fourthly, the use of a *multiple case study design* with a small sample group allows for treatment development. Lastly, a review of 135 RCT's of psychotherapies treating adult depression included the recommendation, (which the current study incorporated), that reporting a patients' physical and psychological morbidities were considered desirable in that they indicated increased similarities between participants in the research and in actual clinical practice (Chen et al., 2014).

As a treatment development study, the therapy transcripts and data allow for a process analysis of emotional change across a course of EFT as a treatment for CAD in women with breast cancer, informed by Elliott's (2002) single case efficacy design model as well as being partially informed by Stiles' (2007) theory building case studies. There is little precedent from the wider literature on treatment development, however in learning from the cases and making transparent the process of therapy for each case study, the aim is to move from an EFT understanding of working with depression and anxiety (respectively), to make the first steps towards understanding the application of EFT to CAD in the context of breast cancer.

1.9 Rationale for the Current Study

Comorbid anxiety and depression is a debilitating and prevalent psychological presentation in the general population, and can become exacerbated distress when it is compounded by a breast cancer diagnosis. While EFT views psychopathology as idiosyncractic, there are core emotional processes that underpin all pathology as well as emotional trends that can be identified to be disorder (e.g. depression or anxiety) specific. With a strong emerging evidence base to support the use of EFT in the treatment of affective disorders, where emotion focused therapy principles for anxiety and depressive disorders have been outlined by several authors (e.g. Elliott, 2013; Greenberg & Paivio 1997; Greenberg & Watson, 2006; Shahar, 2013; Timulak & McElvaney, 2015; Wolfe & Sigl, 1998), it would be amenable to adaptation in the context of comorbid anxiety and depression, but has yet to be examined with an oncology/cancer population. In light of the absence of identified emotional trends that may be specific to living with breast cancer, the currently study follows from the existing knowledge base around anxiety and depression in EFT as separate and

overlapping pathological contructs and seeks to further understand the painful core maladaptive emotions for women with breast cancer. Additionally, the rationale for applying EFT specifically to the management of distress such as CAD in women with breast cancer is partially informed by intervention research that suggests emotion focused coping strategies are useful in circumstances where one has little or no control over the specific situation, such as living with fears of disease recurrence or death and dying (Carlson & Speca, 2007). Given a framework has yet to be developed that concentrates on conceptualising CAD in an illness context, this can be seen as an opportunity for contribution to knowledge. In the interest of framing comorbid anxiety and depression within the evidence based theoretical framework of Emotion Focused Therapy, the current research seeks to develop EFT as a treatment for a breast cancer population through a series of intensive case studies, following a recommended first step in the development of empirically supported interventions (Chambles & Hollon, 1998).

1.10 Research Aims

The aim of the current study is to move from an EFT understanding of working with depression and anxiety (respectively), and to make the first steps towards understanding the application of EFT to CAD in the context of breast cancer. Individual and cross case analysis w ill include an examination of the impact of treatment in terms of pre-post outcome, measured on quantitative outcome measures (i.e. HADS, SCL-90-R, FACT-G, DERS). The aim is then to benchmark the results of the current study against the findings of other research studies which have investigated the efficacy of psychological therapy for women with breast cancer. The study will also collect qualitative data on the outcomes of therapy as well as helpful

and unhelpful aspects of the therapy process. This will involve collating and analysing data from patients' retrospective recall of the entire experience of therapy (Client Change Interviews) and post-session helpful and unhelpful aspects of therapy (Helpful Aspects of Therapy form) along with the therapists' retrospectively recalled and process note observations on case conceptualisation and emotion transformation.

The aim of the current study is to establish the processes that may or may not contribute to therapeutic change across the six cases, offering tentative and preliminary evidence as to whether EFT may have potential efficacy for CAD in women with breast cancer. Patients providing comments on their experience of therapy will facilitate the identification of whether and how therapy has brought meaningful change to their lives, and allows for a descriptive account in their words of their experience of therapy. Therapist accounts will provide a conceptualisation of CAD in the context of breast cancer from an EFT perspective, establishing core painful emotion schemes, and tracking the process of emotion transformation, with the aim of developing a conceptual framework around the particularities attached to core painful experiences in women with breast cancer and CAD.

2.0 METHOD

2.1 Introduction

The current study presents an analysis of the outcome of six cases of Emotion focused therapy (EFT) for comorbid anxiety and depression (CAD) in women with breast cancer. The current study is being conducted by the author of this dissertation, in addition to Dr. Natalie Hession (St. Luke's Hospital Rathgar), Dr. Niamh Coleman (St. Luke's Hospital Rathgar) and Dr. Ladislav Timulak (Trinity College Dublin), with the collaboration of Professor Leslie Greenberg (York University Toronto), who provided a portion of the initial training for the therapists involved in the project and support from a radiation oncology perspective of Professor John Armstrong (St Luke's Hospital Rathgar). The current study presents the first six completed cases, drawn from eight cases in the wider project, of which two patients did not complete their psychological therapy as part of the research project and opted out of the research, meaning their results cannot be reported as part of the study's findings. The cases are presented in chronological order (i.e. Client 001 Jane, was the first client to engage with the project and complete treatment, Client 002 Ruth was the second, and so on).

The aim of the study is to develop a demonstrably effective, empirically supported variant of EFT (a brief version, up to 25 sessions), which can be applied specifically to the treatment of CAD in women with breast cancer. The research is funded by the St. Luke's Cancer Research Fund. The principal investigator on the project is the author, Allison Connolly, Counselling Psychologist and PhD candidate of co-investigator Dr. Ladislav Timulak, Counselling Psychologist and Doctoral Course Director in Trinity College Dublin, and Dr. Natalie Hession, Counselling Psychologist, who contributes to two of the cases as therapist. Dr. Professor

Greenberg is a collaborator on the project, who is provided EFT training. Clinical trainees undertaking their placement in the department as well as a counselling psychologist working in the psycho-oncology department contributed to the study by collecting some of the data. The project is hosted and supported in the Psycho-oncology department of an urban radiation oncology hospital by Dr. Niamh Coleman and Dr. Natalie Hession, during their respective terms as Principal Psychologist for the Department. Doctoral trainees and a Counselling Psychologist in the Psycho-Oncology Department also contributed to the research study by collecting some of the data. Dr. John Armstrong, Consultant Radiation Oncologist in St. Luke's Hospital, provided medical expertise within the research study.

As stated above, this research presents the first six cases in the project where therapy and the cases have been completed and will present them in temporal order. The framework of the research methodology was informed by McElvaney's research on the application of EFT as a treatment for Generalised Anxiety Disorder (GAD) across eight cases (2014). Individual case analyses are informed by the principles guiding HSCED (Elliott, 2002) to provide an analysis of each case based on a rich data record with a specific focus on outcomes and the processes responsible for them. A further cross case analysis, informed by Iwakabe and Gazzola's (2009) paper on the metasynthesis of single case studies offers further rendering of the cases within this dissertation.

2.2. Participants

2.2.1 Patient Participants and Setting

The participants were recruited in the Psycho-Oncology Department of the radiation therapy hospital providing psychological services to patients referred by

their consultant radiation oncologists. Women with a breast cancer diagnosis who were being treated in the hospital and referred to the Psycho-Oncology service were be eligible to participate from the start of radiotherapy treatment and beyond radiotherapy completion with the rationale that CAD occurs across the continuum of care and post treatment (Mitchell et al., 2011). Patients with a diagnosis of breast cancer who were ordinarily referred to the service were asked to participate once they have been assessed by the psychologist as meeting the criteria for CAD according to clinical assessment and their score on the Hospital Anxiety and Depression Scale (HADS; Bjelland et al., 2002; Costantini et al., 1999; Hopwood et al., 1991). In terms of usual care, patients who present with CAD may be treated with Emotion Focused Therapy, Cognitive Behavioural therapy, or Integrative therapy as a psychological intervention. This study applied Emotion Focused Therapy to those who agreed to participate in the research. Each patient was informed both verbally and in written form about the goals of the study, the voluntary nature of their participation and the confidentiality of the information shared. Further assessment then commenced once they elected to proceed with the research, which is described in the Procedure (2.4) section. General demographics and clinical characteristics, including age, sex, tumour site, and UICC state (Union Internationale Contre le Cancer) and type of therapy were obtained from patients' medical charts, whereas socio-demographic attributes such as income, educational level, having a partner or family and religious and national affiliations were retrieved using additional questionnaires and clinical interview. For inclusion patients were required to meet the following criteria 1) started radiotherapy treatment 2) be competently English speaking 3) have been referred to the Psycho-Oncology Department 4) meet the criteria for Comorbid anxiety and depression as determined by Clinical Assessment, the Structured Clinical Interview for DSM

Disorders (SCID-I/P; First, Spitzer, Gibbon, & Williams, 2002) and the Hospital Anxiety and Depression Scale (HADS; Bjelland et al., 2002; Costantini et al., 1999; Hopwood, Howell, & Maguire, 1991). Exclusion criteria included 1) the patient being actively suicidal 2) current severe substance abuse/dependence, domestic violence or other current severe crisis 3) brain tumours and/or metastatic cancer whereby the patient is deemed too ill by the medical team or by themselves to participate in psychological therapy 4) prognosis of less than six months (where shorter term therapy would be more appropriate) 5) not for patients who clearly prefer a cognitively-oriented, exclusively problem solving approach, who need marital or family therapy, or who can't tolerate being taped or filling out questionnaires. Participants were included whether they were presently taking an antidepressant or anti-anxiety medication, but only if they had been stabilised at a consistent dosage for 8 weeks prior to study assessment.

The patients with breast cancer that participated who make up the study sample (n=6) were the first six to have completed therapy, and their ages ranged from 41 to 57 with a mean age of 50. Individual details of participants is included in greater detail in the results section. The initial pilot participant was excluded from the findings of the study when her follow up scans revealed a second tumour that resulted in immediate, complex surgery. Her need for medical treatment and further chemotherapy clearly shifted her most significant concerns and priorities that she had been addressing in therapy. The decision to discontinue her involvement in the research study and to be discharged from the psycho-oncology service was made voluntarily by her and supported by the psychologist who was seeing her for therapy as part of the current research study, and she was referred onto psychological services in the hospital where her surgery took place.

All of the patients participated in psychological therapy as part of their multi-disciplinary medical care and none was offered any financial incentive to do so. In the event that a patient was unable to complete their psychological therapy due to a decline in their physical health due to treatment side-effects, they would not be included as part of the study results, and participants were aware that they could withdraw from the study at any point during the proceedings, without prejudice, in the knowledge that they could be seen by the psycho-oncology department service to receive treatment as usual or as negotiated based on their preference of psychological therapy with their psychologist.

2.3 Therapists and Therapy

Emotion Focused therapy (up to 25 sessions) was offered by two counselling psychologists with full training in EFT on a once weekly basis. The rationale for individual therapy was to offer flexibility in terms of time and place for scheduling sessions (e.g. office that is suitable for therapy or mobility requirements) given that group therapy for patients with cancer are associated with attrition due to scheduling conflicts with other hospital appointments, diagnostic tests and brief hospitalizations. Allison Connolly, the author, acted as therapist for four of the patients in the study (Jane, Laura, Kate, and Emily) and also served as coordinator for the study as a whole. Dr. Natalie Hession, a co-investigator, acted as therapist for two of the patients in the study (Ruth and Sophie). Both Allison Connolly and Dr. Natalie Hession had been trained by the co-investigator, Dr. Ladislav Timulak, a Counselling Psychologist, EFT therapist, supervisor and trainer, and by Professor Leslie Greenberg, the originator and developer of EFT. Supervision ensuring adherence to Emotion Focused therapy was provided by Dr. Ladislav Timulak.

2.4 Measures

2.4.1 The Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P; First, Spitzer, Gibbon & Williams 2002)

The Structured Clinical Interview for DSM-IV-TR (SCID) is a semi-structured interview for making the major DSM-IV Axis I diagnoses. The interview is used for establishing the diagnosis of any mood and/or anxiety disorders. Good psychometric properties have been demonstrated repeatedly and a number of studies have used the SCID as the "gold standard" in determining the accuracy of clinical diagnoses (e.g., Shear et al., 2000; Steiner et al. 1995).

It was administered to assess psychiatric morbidity and to cover a broad range of information about patients' psychiatric disorders in a standardized way. The variant used in the present investigation was the Structured Clinical Interview for DSM-IV, Research Version (SCID-1, SCID-2, Version 2.0). The interview provides the diagnosis of affective disorders (including major depression and dysthymia), anxiety disorders (including panic disorder, social phobia, specific phobia, and generalized anxiety disorder), stress disorders (including acute stress disorder and adjustment disorder), and screens for substance abuse (including pharmaceuticals, drugs, nicotine, and alcohol). To constitute a diagnosis, certain criteria have to be met, including severity and duration of symptoms and their impact on everyday activities-taking into account that symptoms should not be the direct physiological result of intoxication or general medical factors. The SCID is widely accepted for Axis I diagnoses, with inter-rater and test-retest reliabilities falling within ranges considered to be fair to good (Zanarini et al., 2000). All clinical disorders are based on DSM-IV (American Psychiatric Association, 1994) criteria. The diagnosis of comorbid anxiety

and depression is contingent upon the existence of 1) Major Depression (MDD) or dysthymia (minor depression), following DSM-IV criteria and 2) one of the distinct anxiety disorders [Generalised Anxiety Disorder (GAD), panic disorder, social phobia, and phobias]. It is worth noting that the more recent DSM 5 (2013) made amendments to the classification system, where it emphasised the importance of the dimensional assessment of psychological disorders. For instance, "with anxious distress" was added as a specifier for depressive disorders, allowing psychologists to record the presence of and severity of sub-threshold but clinically significant anxiety symptoms in individuals who meet the criteria for a depressive disorder.

2.4.2 The Structured Clinical Interview for DSM-IV-TR Axis II Disorders (SCID-II; First, Spitzer, Gibbon & Benjamin, 1994)

The SCID-II is a clinician administered interview for the assessment of personality disorders (PD's). It begins with an overview of a patient's patterns of behaviour and typical relationships, including information on the patient's capacity for self-reflection. Typically the SCID II is administered after the SCID I for Axis I disorders is completed, which allows interviewers to determine the presence of conditions that might potentially interfere with personality disorders assessment (e.g. psychosis, extreme psychomotor agitation). The SCID II consists of 119 items and involves a 60-90 minute interview between psychologist and patient, covering each personality disorder category in turn; each criterion is evaluated by specified questions and subsequent probes. The interview can be preceded by a self-report questionnaire covering the same items. Lobbestael, Leurgans, and Arvitz (2011) established the inter-rater reliability of the DSM-IV SCID II overall as excellent.

2.4.3 The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983).

The HADS (Zigmond & Snaith, 1983) is structured as a self-report questionnaire that was specifically constructed in outpatients in hospital clinics for specific use in physical illness to measure symptoms of depression and anxiety. It is widely used in hospital settings, particularly in Europe (Lowe, Spitzer, & Grafe, 2004) and has been translated into more than 30 languages (Bedford, de Pauw & Grant, 1997). It assesses cognitive items associated with depression and anxiety and thus avoids the confound of physical symptoms in medically ill patients. The HADS is a 14-item measure that includes a 7-item depression scale and a 7-item anxiety scale. The HADS has shown good validity and test-retest reliability in a variety of medical populations including patients with breast cancer (Bjelland, Dahl, Haug, & Neckelmann, 2002). Good psychometric properties have been demonstrated repeatedly (internal consistency 0.80 for both subscales; retest reliability r=0.81-0.89). As suggested by Morse et al. (2005), lower thresholds should be used for cancer patients. A meta-analysis by Vodermaier and Milliner (2011) identified an empirically derived cut off was a ⩾11 score, for example, instead of the ⩾16 score recommended by Zigmond and Snaith (1983). In terms of reliable change index (RCI), a movement of 3 points would be required to demonstrate reliable change, which was calculated with Jacobson and Truax's (1991) formula using Puhan et al.'s (2008) data.

2.4.4. The Symptom Checklist 90-Revised (SCL-90R; Derogatis, Lipman, Cavi, 1994)

The Symptom Checklist (SCL-90-R) is an established measure of psychological distress. The inventory includes a large span of psychiatric symptoms, ranging from cognitions, emotions, and behaviour to activities (habits, relationships and diet). It includes 90 self-reporting questions and each question has a likert scale (0 for not at all, 1 for a little bit, 2 for moderately, 3 for quite a bit, 4 for extremely). The nine subscale dimensions are 1) somatisation (SOM) 2) obsessive compulsive (OC) 3) Interpersonal Sensitivity (INT) 4) Depression (DEP) 5) Anxiety (Anx) 6) Hostility (HOS) 7) Phobic Anxiety (PHOB) 8) Paranoid Ideation (PAR) & Psychoticism (PSY). The SCL-90R can screen people who possibly have a psychiatric symptom, the type of symptom and to what extent. A higher score on the SCL-90R indicates a more urgent need for individual intervention. This instrument has demonstrated internal consistency coefficient alphas for the nine symptom dimensions ranged from .77 for psychoticism to a high of .90 for depression (Derogatis, Rickels, & Rock, 1994). Test-retest reliability coefficients range between .80 and .90 after one week of therapy. Validity studies of the SCL-90-R showed good convergent and divergent validity on the SCL depression and anxiety scales (Koeter, 1992; Morgan, Wiederman, & Magnus, 1998). Niemeyer (2004) reported alpha internal consistency of .96 for the GSI. For the purposes of this study a cut-off score of ≥0.8 was used to determine a clinical range on the measure (Tarascavage & Pen-Porath, 2014), and in terms of establishing the reliable change index (RCI), a movement of 0.19 would be required to demonstrate reliable change, which was calculated with Jacobson and Truax's (1991) formula using Tarescavage and Ben-Porath's (2014) data.

2.4.5 The Functional Assessment of Cancer Therapy-General, (FACT-G; Cella et al., 1993)

The FACT-G evaluates health related quality of life (HRQOL) and is targeted to the management of cancer. It is a self-administered inventory that covers four core domains of HRQOL; physical (PWB, seven items, score range 0-28), functional/role (FWB, seven items, 0-28), emotional (EWB, six items, score range 0-24), and social (SWB, seven items, 0-28). The standard FACT-G scoring algorithm is simply to sum responses of component items after reversing selected items such that the higher score represents better HRQOL overall. The FACT-G has satisfactory reliability and good validity, as reported by Brady et al. 1997, and subsequent studies (e.g. Ratanatharathorn et al., 2002). As a self-administered scale it can be administered in 5 min, is statistically strong and sensitive to change over time. It is considered appropriate for use with patients with any form of cancer, and has also been used and validated in other chronic illness condition (e.g., HIV/AIDS and multiple sclerosis) and in the general population (using a slightly modified version). Caseness for the measure is put at 78 (Webster et al., 1999), and in terms of establishing the reliable change index (RCI), a movement of 17 points would be required to demonstrate reliable change, which was calculated with Jacobson and Truax's (1991) formula using Webster et al.'s (1991) data.

2.4.6 Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)

The DERS is a 36-item self-report measure of emotion regulation difficulties. It is based on a conceptualisation of emotion regulation that distinguishes adaptive emotion regulation from emotional avoidance and expressive control. It has the following six subscales: (a) Non-Acceptance of emotional responses (Non-Acceptance); (b) Difficulties engaging in goal-directed behaviour (Goals); (c) Impulse control difficulties (Impulse) measuring the problems in behavioural control and

regulation in time of experiencing (negative) emotions; (d) Lack of emotional awareness (Awareness) subscale assessing the lack of attention to emotional signals considering feelings as unimportant; (e) Limited access to emotional regulation strategies (Strategies); and (f) Lack of emotional clarity (Clarity). Respondents are asked to indicate on a 5-point Likert-type scale how often the items apply to themselves, with 1 = almost never (0–10%), 2 = sometimes (11%–35%), 3 = about half the time (36%–65%), 4 = most of the time (66%–90%), and 5 = almost always (91%–100%). Higher scores indicate greater difficulties in emotion regulation. The DERS has strong concurrent and predictive validity, is used extensively in psychiatric research as a predictor of psychopathology, in treatment trials as a mediator variable and as a primary outcome variable. The scale demonstrates good internal consistency (Cronbach's alpha from 0.80 to 0.89, test-retest reliability (r=.88), and adequate construct and predictive validity in adult psychiatric patients. Specifically the measure had demonstrated sensitivity to change due to successful clinical intervention (Gratz & Gunderson, 2006; Gratz, Lacroce, & Gunderson, 2006). For the purposes of this study a cut-off score of ≤ 78 was used to determine a clinical range on the measure (Gratz & Roemer, 2004), and in terms of establishing the reliable change index (RCI), a movement of 16 points would be required to demonstrate reliable change, which was calculated with Jacobson and Truax's (1991) formula using Gratz and Roemer's (2004) data.

2.4.7 Helpful Aspects of Therapy Questionnaire (HAT; Llewelyn, 1988)

The HAT (Llewellyn, 1988) is a frequently used measure of client perceptions of significant events in the therapeutic process (Elliott, 2002) and uses both quantitative evaluation and open-ended qualitative questions. It is a brief (7-item)

questionnaire completed by participants after each session that takes approximately five minutes to complete. Participants are asked to describe in their own words and in an open-ended fashion the most helpful events in the session. They are then asked to rate how helpful it was on a 9-point scale. Other helpful or hindering events in the session are also queried with an invitation for description and rated on a 9-point scale.

2.4.8 The Target Complaints Scale (TC; Battle et al., 1966)

The Target Complaints (Battle et al., 1966) is one of the self-report instruments assessing change in clients' issues over the course of therapy (Timulak, 2008). This idiographic instrument requires respondents to identify three target complaints that are currently bothering them (they can state more if they wish). After identifying the target complaints, they then rate to what extent these complaints bother them on a scale of 1– 13. The instrument can guide discussion regarding clients presenting issues as well as being used as a rating tool (Timulak, 2008). The Target Complaints Scale has been used in a variety of studies (e.g. Erlandsson & Eklund, 2006; Greenberg & Watson, 1998).

2.4.9 Therapists' Perspective on Case Conceptualisation

Therapists were asked to write a brief retrospective account of their understanding of each case, based on recall and session notes, with a focus on case conceptualisation utilising the framework developed by Timulak and Pascual-Leone (2014). The purpose of gathering the therapist perspective on case conceptualization was to compile their understanding of the case dynamic through considering presenting global distress, its triggers, the self-treatment in the context of the triggers, avoidance strategies employed to avoid the core painful feelings, the core painful

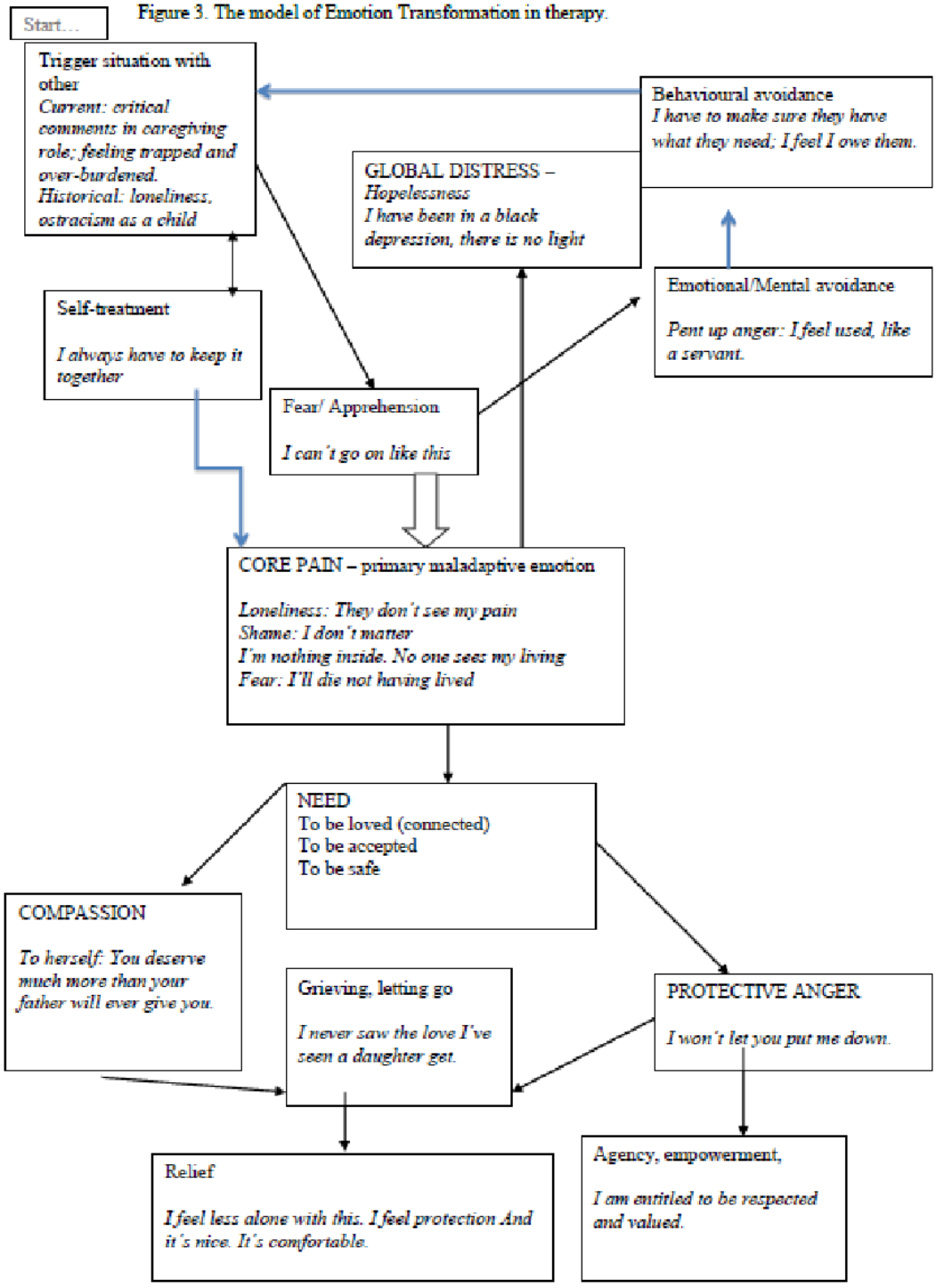
feelings and associated unmet needs (see figure 3). The therapist also considered the role of cancer in their understanding of the client's problematic experiencing.

A conceptual framework model was developed by Timulak (2012) that elaborates the link between the emotion transformation model (Pascual-Leone & Greenberg, 2005) and the cornerstone emphasis in EFT on case conceptualisation (Greenberg & Goldman, 2007; Greenberg & Watson, 2006; Watson, 2010). The conceptual framework model allows for the therapist to tentatively capture several aspects of the patient's presentation and can guide therapist perceptions and actions within a session. Followed in proximate to the patient, the framework model (see figure 3) captures the initial narrative, triggers that catalyse emotional pain, the secondary emotions that make up global distress, the patient's negative self-treatment that contributes to emotional pain, emotional interruption strategies including the underlying fear(s) driving avoidance, the activated experience of core pain which are the focus of treatment, unmet needs and the facilitation of specific healing adaptive emotions.

Timulak (2012; Timulak & Pascual-Leone, 2014) tracks the narrative account of the patient with initial triggers that may be current or historical (or both) in nature, that have activated core painful emotions. The sheer difficulty of bearing these painful emotions often leads to a generalised collapse into distress that is global and is expressed as feelings of helplessness and hopelessness. In response to the painful emotion, avoidance strategies that are emotional, behavioural and shape self-treatment are also captured. The core painful emotions and associated unmet needs then solicit adaptive emotional responses from the self, the therapists and people outside of the therapy. Adaptive emotions that the framework identifies include self-compassion, protective anger, grief and letting go (of unresolved pain), and empowerment and

agency (Timulak & Pascual-Leone, 2014). Conceptually the framework allows for the therapist to reflect on the session in a way that is consistent with standard EFT practice including the necessity of continued emotional assessment, and also serves as a guide within session interactions with clients and thus serves to facilitate optimum change processing.

Figure 3. The model of Emotion Transformation in therapy.



2.4.10 Therapists' Perspective on Emotion Transformation

Therapists were asked to write a brief, retrospective account of their understanding of each case, based on recall, session notes and notes taken in supervision, again using the framework developed by Timulak and Pascual-Leone (2014; see also Timulark, 2015; Timulak & McElvaney, 2015). The purpose of these written accounts from the therapists' perspective was to encapsulate their understanding of the patient's emotion transformation, or change, in therapy, i.e., how global distress, avoidance strategies, problematic self-treatment and in particular core painful emotions (including experiences of cancer) and association unmet needs are transformed in therapy through accessing adaptive emotions.

2.4.11 The Client Change Interview (CCIv5; Elliott, 2008).

The Client Change Interview is a 30-60 minute qualitative interview that can be administered at mid-therapy, and at the end of therapy. It includes questions about what the client sees as having changed over the course of therapy, what the client attributes those changes to, and helpful and unhelpful aspects of therapy. The interview also includes the option of asking the client to review and talk about his or her pre-treatment self-ratings or target complaints. This type of research interview can be a highly effective and a flexible way of gathering detailed and personal research data (MacLeod, 2003). The advantage of qualitative interviews such as the Client Change Interview is their sensitivity to the wider impact of therapy, including negative or unexpected effects. This allows for a greater understanding of the client's experience of therapy (MacLeod, 2001). The qualitative approach permits the client to talk about their experiences of therapy without the restrictions of specific research instruments (Timulak, 2008). An emphasis is placed by the developer on empathic

exploration of the clients responses in order to fully facilitate their account of their experience of therapy (Elliott, 2008).

2.5 Procedure

2.5.1. Data Collection

Each patients' suitability for participation in the research was based on their initial assessment session with their psychologist in the psycho-oncology department at a radiation oncology hospital where they received their radiotherapy treatment for breast cancer. Both the initial clinical assessment and the patient's score on the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) (where a cut-off score of ⩾11 was used) determined a probable diagnosis of comorbid anxiety and depression (Cosco, Doyle, Ward, & McGee, 2012; Saboonchi, Wennman-Larsen, Alexanderson, & Petersson, 2013). If a patient met these criteria, they were invited to meet with a member of the research team who conducted a Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002), and a Structured Clinical Interview for DSM-IV-TR Axis II Disorders (SCID-II; First, Spitzer, Gibbons & Benjamin, 1994) with them, in addition to a battery of pre-post therapy outcome measures comprising, a) Functional Assessment of Cancer Therapy General (FACT-G; Cella et al., 2002); b) Symptoms Checklist 90-Revised (SCL-90-R; Derogatis, 1983); c) Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) to confirm their suitability for participation in the research and substantiate their meeting the inclusion criteria of a diagnosis of Comorbid anxiety and depression (CAD).

Patients who are assessed and meet the criteria for other DSM disorders (e.g. PTSD) would not be eligible to participate, and would be seen by one of the Psychologists in the Department as normal. Similarly before a diagnosis of depression or anxiety could be made, assessments needed to rule out medical, substance abuse, bipolar and adjustment disorders. All patients are seen on a weekly basis by the Psychologist, although flexibility is allowed should medical needs warrant rescheduling.

When criteria were met for inclusion in the study, the psychologist would present them with detailed written information about the project, and describe verbally the nature, purpose and components of the research study with them in person. Patients were asked to take home the consent form, the information package and a general description of emotion focused therapy, to consider whether they wished to participate in the research. If patients chose to do so they would return the signed consent form at the first arranged appointment for therapy.

The same battery of pre--post outcome measures would be repeated at the mid-point of therapy, and then again at the end of therapy. The measures would then be administered at a six month follow up subsequent to the completion of therapy. In addition to the pre-post outcome measures, patients were invited to participate in a semi-structured interview, the Client-Change Interview Schedule: Version 5 (CCISv5; Elliott, 2008), conducted by a member of the research team. The same Client Change Interview was administered at the end of therapy.

Before commencing each session of therapy, patients were requested to complete a Target Complaints (TC: Battle et al., 1966) form and upon the completion of each session they were asked to fill out a Helpful Aspects of Therapy Questionnaire (HAT; Llewelyn, 1988). All therapy sessions were video recorded, and

audio recorded. Technical mishaps on occasion meant that a very small number of sessions failed to record on both audio and video recorders. As a result, for some session, there is only a video or audio record. Data were stored on an encrypted external hard drive. For each session, the psychologist would write their session notes including a summary of the session with a perspective focus on case conceptualisation and emotion transformation.

2.5.2 Data Analysis

2.5.2.1 Quantitative Pre-Post Therapy Data Analysis

For each participant, data from pre-post and follow up outcome measures was collected and presented and across the group of six participants as a whole. IBM SPSS Statistics software package was used. Descriptive analysis and t-test for dependent samples were carried out. Effect size was calculated, which were standardised pre-post differences (Cohen's d).

2.5.2.2 Qualitative Retrospective Recall (CCISv5) Data Analysis

Data from the CCISv5 (Elliott, 2008) was analysed and contributed to cross-case analysis, which was described methodologically as a descriptive and interpretive qualitative research method by Elliott and Timulak (2005). The author gathered from her own cases and that of the other psychologist who saw patients in the study, the data from the CCISv5 interviews. As part of the analysis process, data is combed through to distill *meaning units* once any repetitive or digressive components have been removed, and the meaning units are coded sequentially. All steps of the analysis are captured in an *audit trail* for auditing at a later stage in the analysis. In this study, the analysis was audited by the supervisor of the dissertation.

Participant responses are structured by the identified emerging domains, which are influenced by the questions on the semi-structured interview tool used in the study. Meaning units are then assigned to the fitting *domain*, and then sub-grouped into the appropriate *categories.* The process of analysis is dynamic and both subjective and interactive, drawn from a fidelity to capturing the participants' meaning, whereby the author strives to organise the data in a way that honours and reflect the meaning and significance conveyed by the participant, yet is also shaped by an awareness and attempt to make explicit the impact of the theoretical knowledge of the author, creating a tension which the author attempts to balance with transparency throughout the process of analysis.

2.5.2.3 Qualitative Data Analysis of In-Session Helpful Aspects of Therapy

HAT forms underwent a process of analysis in the same method as was applied to the CCISv5 (see section 2.4.2.3). Meaning units were gathered from the data, and subsequently grouped into categories that were informed by the broadly suggested within the questions on the form.

2.5.2.4 Qualitative Data Analysis of Therapist' Perspectives on Case Conceptualisation

The author gathered and sequentially edited the therapists' retrospective recall of case conceptualisation for each participant. All cases were reviewed individually and then were apprehended together for the purpose of cross-case analysis, whereby content and patterns were identified across the predetermined domains established…. The value of structuring each case individually in terms of case conceptualisation and then across cases is to highlight a potential, tentative model that tracks factors that

appear to contribute to the generation and maintenance of CAD in women with breast cancer from an EFT perspective.

2.5.2.5. Qualitative Data Analysis of Therapists Perspectives on Emotion Transformation

In line with the process described in section 2.4.2.1., the author received (or in the case where the author was the therapist for the patient, gathered) and edited the therapists' retrospective recall of emotion transformation for each patient, and then across patients as part of the cross case analysis. While this process of analysis was undertaken for each individual participant and tracked according to their own personal emotion transformation, the model was generated to also capture the wider and shared processes that were present across cases. Commonalities and themes across the predetermined domains (captured in the model of Timulak & Pascual-Leone (2014; see data collection section above) were apprehended in the analytic process, with the purpose of generating a model of emotion transformation across therapy.

2.5.3. Ethics

The current study went through a rigorous process of ethical approval in both institutions involved in the research (St. Luke's Research and Clinical Trials Unit, and Trinity College Dublin School of Psychology). In devising the methodology and research proposal, the research team investigated and considered all measures that would safeguard and uphold the ethical integrity of participants in the research. A detailed application was submitted to the St Luke's Research and Ethics Committee as well as presentation to the committee itself in order to gain ethical approval from the body holding clinical governance over this patient group. Ethical approval was

awarded (See appendix A). Subsequently, a formal ethics submission was made to the University regulatory body; which was also approved (See appendix A).

As described in Section 2.4, all patients were given detailed written and verbal information regarding the research and its components. Included in the standardised information was clarity and confirmation as to the confidential and anonymous nature of the cases; in short, that the cases are presented in a masked manner, whereby details such as precise age, family makeup, work context, and any other concrete aspects of individual stories have been altered). On completion of psychological therapy and the client change interview (CCISv5; Elliott, 2008), patients were given a debriefing sheet, that included the contact details of relevant members of the research team, and in particular the contact details of the principal of the department where the study took place, should a patient wish to discuss any aspects of the study, or if there was subsequent distress or concern after participating. In line with the voluntary and consensual nature of the research, patients were informed at the beginning of research in written and verbal format that if they chose to withdraw from the research they would be given treatment as usual without delay within the psycho-oncology department and by the psychologist they were attending. No patients availed of this.

Typically a psychologist in clinical practice makes choices about the level of detail in which a case is documented, balancing patient care with legal and ethical requirements and risks. In the hospital setting where the research took place, participants providing informed consent included that video and audio recordings of each session, which provided a detailed and sensitive record of therapy that became part of the patient's psychology file. Both psychologists involved in the research as therapists (see section 2.3 Therapists and Therapy) followed normal procedures of providing relevant entries into the patient's medical record and recorded only

information in the medical records that was congruent with organisational requirements and necessary to accurately portray the services provided. Permitted within the hospital's established policies on psychological services, the psychologist kept more sensitive information, including the therapy notes, assessment results, outcome measures, audio and video recordings and all data for the purposes of the study in a separate and confidential file.

Psychologist notes and files are kept as a separate "supplementary record", which is documented to exist in a patient's general medical record so that it can be tracked and accessed if necessary. Under the Freedom of Information Act (FOI, 2014), patients can request their entire medical record, including the additional supplementary record. The psycho-oncology department in the host hospital where the research took place has a general policy that when an FOI request is made, the psychologist is present during the record review of psychology notes during the record review to offer elaboration, explain psychological terminology, or attend to the patient's feelings related to the material. With regard to the audio and video recordings where there is sentitive material and where close others may be discussed or enacted in imaginary chair dialogues, the psychologist would be cognisant that if an FOI request was made by a relative (i.e. where the patient is deceased), that they would disclose information only to the extent necessary to provide the relative with documentation that psychological therapy was provided, and equally hold in account the Irish Psychological Society of Ireland's (PSI) code of professional ethics, particularly point 3.5.3, which states that under extended responsibility the psychologist must "guard against misuse or misinterpretation of others of psychological data (PSI, 2014, p.13). All participants were informed of the

department's procedures for handling FOI requests in their initial therapy session with their psychologist.

3.0. Results

3.1. Case Study 1, Jane

3.1.1. Introduction

Jane is 55 year old Caucasian female, who was referred to the psycho-oncology service by her radiation oncologist. The stated reason for referral on her referral form was anxiety and a sense that she was not coping with her diagnosis of breast cancer.

Initial intake in the department suggested she was presenting with low mood and high distress as a result of historical and current stressors in relation to changes in her body, and her anxiety was contributing to current worries about the likely success of her radiotherapy treatment, which she had just completed at the time of referral. History taken during her clinical interview with her psychologist indicated that Jane was exhibiting longstanding anxiety and depression, which had become exacerbated since her diagnosis and treatment for breast cancer. Consequently, she was asked if she would be interested in participating in the study.

Jane had been diagnosed with complex bilateral breast cancer that required a number of surgical procedures, including double mastectomy. Beyond surgery her systemic treatment for breast cancer included chemotherapy, radiation therapy and hormone treatment. There is a history of breast cancer in the paternal line of her family. Jane has other medical comorbities, including that she had multiple repeated surgeries throughout childhood and adolescence relating to a congenital condition. She had previously undergone additional major surgery with a full hysterectomy ten years previous (non-cancer related). Jane was also being treated for chronic pain in her shoulder that stemmed from complications post double mastectomy.

Jane is single and has no children. A carer for her elderly parents, she was on sick leave from working an administrative role at the start of her attending the psycho-oncology service. Jane has one sibling.

Jane's GP had prescribed Fluoxetine (Prozac; a selective serotonin reuptake inhibitors (SSRI) class of antidepressant medication) for the past ten years for symptoms of depression in addition to painkillers for her chronic pain and Alprazolam (Xanax; a short acting anxiolytic of the benzodiazepine class), to assist with panic attacks. She engaged in 20 sessions of psychological therapy with the Principal Investigator of the research study, who was experienced in using an emotion focused therapy approach.

Prior to commencing therapy, Jane completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for current Major Depressive Disorder and Panic Disorder with Agoraphobia. Her score on the Hospital Anxiety and Depression scale was 25, which indicated symptoms of anxiety and depression in the severe range. Jane also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Passive Aggressive Personality Disorder, Avoidant Personality Disorder and Depressive Personality Disorder.

3.1.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective: General Observations

Jane was referred through a multidisciplinary team, and in a medical setting where Jane perceived traumatic injury to have taken place on the basis of her treatment for breast cancer, it was palpable for the therapist that she harboured feelings of mistrust, violation and anger. By acknowledging the tentativeness of her investment in the therapeutic process and with repeated empathic validation of her feelings of violation post treatment, there was a shift over times in terms of her willingness to trust and disclose the historical triggers that contributed to her emotional pain. The tentativeness was also partially attributable to the fact that privacy had always held a premium value for Jane, making self-disclosure unfamiliar. Prepared narratives seemed a way to partially buffer herself from therapeutic process and reflected her fearfulness around a painful depth of emotion and loss. The therapist found that Jane as she began to witness her own progress and change take place in therapy, she was better able to empower herself around her needs within the therapy. Collaborative goals for therapy were agreed early on, as Jane felt she *"could never relate to my [her] body"* and viewed therapy as the place where she could work towards being able to express herself *"without so much fear."* The therapist felt that Jane demonstrated a great capacity for tenderness with others and this also translated into the therapeutic relationship, which had warmth and humour alongside the expression of profound pain and loss.

The therapist felt there was significant emotional change across the 20 sessions. By the end of therapy, Jane resumed volunteer work she was passionate about with a renewed sense of purpose and meaning. Her panic attacks ceased, allowing her to engage in a music group and participate in performances with pride and a sense that there was value and pleasure in looking after her own needs, alongside those of close others in her family.

Case Formulation

The account of Jane's case formulation is based on the reflections of the therapist and is informed by a conceptual framework model developed by Timulak (Timulak & McElvaney, 2015; Timulak & Pascual-Leone, 2014) that elaborates the link between the emotion transformation model (Pascual-Leone & Greenberg, 2005) and the cornerstone emphasis in EFT on case conceptualisation (Greenberg & Goldman, 2007; Greenberg & Watson, 2006; Watson, 2010).

Triggers of Emotional Pain

At initial intake, Jane expressed a poignant sense of isolation post treatment, stating the belief *"no one sees that it's a struggle"* and described feeling emotionally overwhelmed with grief and sadness following her double mastectomy surgery. Jane reported multiple complex side effects as a result of her breast cancer treatment, including chronic fatigue. High intensity symptoms such as pain, mean that she often took sick days from her part time work and socialised infrequently. Her greatest exertion was relegated to caring for her parents, the physical demands of which exacerbated the chronic pain in her shoulder. As stated in her target complaints form Jane was preoccupied by her illness, and felt overwhelmed by fear, chronically collapsing under the perception that she was unable to cope, and experienced periods of low mood that were characterised by hopelessness and irritability.

Jane's narrative included extensive physical trauma from a young age. Her early history was significant; Jane was born with disfigurements and had more than a dozen surgeries as a child. Her adult presentation of warm submission with the medical team reflect her childhood coping strategies of behaving as the "good

patient" which she reported were linked to fantasies of having disfigured parts of herself transformed to "normality" through surgery. Her parents' messages from a young age regarding secrecy communicated implicit shame, which she relayed through her memories of childhood wishes to be "just like" her idealised sister. The tone of disgust with which she spoke about her own body mirrored how she internalised these messages, and her emotional pain was deepened by a high degree of perceived responsibility "*I laid down in the womb wrong."* Her body underwent further physical changes in early adulthood with a full hysterectomy (non-cancer related), deepening her feelings of bodily loss.

Her parents historically, were highly authoritative. She reported her father was overbearing in relation to her physical disability, and developmental stages through adolescence and early adulthood seemed blunted by their protectiveness and concerns about her capability. Frequently not included during social visits in the home as a result of the family's secrecy, Jane characterised her childhood and adolescence with a sense of being rejected, ignored and ostracised. Feeling unacceptable was further reinforced by a physical beating that resulted in injury by her mother during her early adulthood that violated her perception of her mother as protector.

Throughout her life, Jane shared her family's views of maintaining privacy around illness/disability. No one outside her immediate family had any knowledge of her congenital condition, nor any of her subsequent hospitalisations and surgeries. To the therapist, there seemed to be a conflict between the implicit shame of never speaking about her chronic hospitalisation and surgery, and her lifetime of having been (medically) examined. While traditionally, psycho-oncology services work to support the patient with their current diagnosis and the impact on their ability to cope

and adapt, for Jane medical trauma experienced since childhood contributed to the distress and grief she presented with under the stress of her breast cancer diagnosis.

Prior to her surgery for breast cancer, available photographs about what to expect in terms of bodily change from the clinical nurse specialist were of single mastectomies only. Jane described her double mastectomy (where both breasts are removed) as a "*mutilation*" and "*violent*", struggling with its aftermath "*I have to look at myself every day."* Jane could not recall her surgery without deep distress and a sense of violation: "*the surgery felt vicious, serrated, straight across, just get all that badness, and then stitch her up- like a stitched up cabbage patch doll…the ugliest looking doll."* Jane recounted the sudden, unexpected horror of her diagnosis and the surgery it would require, and defined the experience as both deadening and terrifying, "*I closed my eyes to what was happening*." The main trigger of her cancer diagnosis reinforced belief that the world (including other people) was not a safe place and the intolerable expectation of further harm. The multiple losses in relation to her body generated a cumulative effect of primary sadness and grief, which was experienced as unbearable. In response to her inability to deal with her primary core painful feelings of loneliness, shame and fear, her secondary emotions were hopelessness, rejecting anger at her family, and existentially, Jane had profound feelings of dread and fear of the future.

Global Distress

Jane would often spoke in therapy with a blaming tone, chronically collapsing into either global distress, or rejecting anger (directed at her oncology surgeon, father, mother, sister, and herself). The cost of avoiding and suppressing her feelings was described somatically; *"hollow…a heaviness, a deadening"* and alternatively a *"vice-*

like grip" in her chest and a visible flowering rash across her face. One could interpret that Jane's experience of surgery and loss lent itself to somatisation, in that the events themselves were traumatic in nature and necessarily focused on bodily symptoms, and occurred in a medical context that deemphasizes psychological experience. Her personal resources, taxed from an expenditure of energy and emotional burden that comes with living with negative core schemes of self, exhausted and fuelled her hopelessness.

Reflecting on Jane's emotional transformation across sessions revealed how in the early stages and middle stages of therapy she was frequently helplessly in contact with feelings of sadness and upset, but lacked the ability to cope with it in a way that could be seen to define global distress. With core emotions of isolation, fear and uncertainty, as well as implicit self-blaming, a dialogue was structured in her third session of therapy so that Jane could have an imaginary dialogue with the cancer, which she felt terrorised by and that she perceived as further evidence of inner defectiveness:

Jane (as the voice of cancer): *You thought you were going to get a bit of fun in your life but I was always around and I decided one day I would creep up on you. I did give you a few tip-offs—you were tired, for months, but you didn't cop on.*

Therapist: *So it's like I blame you for doing nothing*

Jane: *You missed me just like you missed all your other chance in life [Jane becomes tearful].*

Therapist: *Ah, and this is what hurts so bad…you missed out. What do you feel towards her? Tell her directly.*

Jane: *You are a stupid cow [enacting self-critical voice]. A god-awful….arrogant…you have no right to feel good about yourself. Ever.*

Therapist: *It's like you are easy prey…and the tone?*

Jane: *You are so stupid. I'd like to shake the living daylights out of you.*

Therapist asks Jane to switch chairs: *What happens inside when you get that? [Jane collapses in tears]. Yeah, it hurts to feel this inside.*

Inviting Jane to "speak as the cancer" is a task that was utilised specific to Jane's feeling that it had the ability to make her feel like she had failed, and in this instance highlighted a self-invalidation process whereby her belief in her own core inadequacy was enacted. Put another way, the cancer was a kind of "projected introject" that embodied her own self-criticism. Conceptually, the perceived "stain" of a breast cancer diagnosis, which was reinforced by the familial beliefs of keeping illness secret, evoked and heightened the distress associated with her pre-existing core shame and feelings of worthlessness. Difficulty accessing core pain prevented her from emotional processing and lead to chronic worry and anxiety, alongside perceived helplessness and hopelessness that further reinforced her self-directed contempt.

Negative Self-Treatment

Jane was quite self-loathing and critical and had difficulty with self-soothing. The self-imposed judgement of "*not having any right to feel good*" captured in the aforementioned dialogue from session 3 distils how self-critical processes so inherent in depression serve to isolate and alienate the emotionally fragile self from seeking connection. For Jane, seemingly, the crisis of breast cancer threatens an estrangement from others with the damning judgement "*you are stupid*" and more fundamentally,

from herself. More delicate dynamics surrounded her relationship with her sister, whom she idealised, but whom she would attack for failing to recognise her need for affection. Consistent with a more complex personality presentation that combined avoidant traits with passive aggressiveness, when her sister did offer her nurturance, Jane would angrily reject the help, accusing her sister of seeking to compromise Jane's independence.

Anticipatory Anxiety, Emotional and Behavioural Avoidance

Across sessions, Jane was facilitated to connect to feelings around her physical symptoms and explore how her cancer treatment left her alone, scared and angry. Emotionally, Jane described how she often "*pushes feelings down"*; and believed she needs to be inhibited with others outside of therapy (*"I have to keep it in me")* about the extent of her fear, anger and sadness.

While Jane went to extreme lengths to provide for her parents, she described how she was frequently in conflict with her father and conveyed a deep sense of resentment towards him. Her mother, in poor health and in cognitive and physical decline, was no longer the soothing intermediary she had once been. Frequent rumination combined with "anniversaries" of her diagnosis, surgery and follow up appointments and scans are profound experiences of crisis. Jane's anxiety was also experienced as acute panic attacks with residual anxiety symptoms between full blown episodes. Jane engaged in a number of avoidance strategies that were emotional (numbing, moving into secondary blaming and anger) and behavioural (taking painkillers, sleeping tablets and overeating). Having always struggled with overeating and self-medicating, her emotional pain was hidden to those outside the immediate family behind a warm and cheerful demeanour.

Interpersonally, when Jane was anxious about the effects of her cancer on her life, which was saddled by perceived abandonment on the part of her family, her intense emotional displays included both tears and anger that mitigated and interrupted her primary fear. At times Jane became combative with her sister whom she relied on heavily for emotional and practical support. Her sister's subsequent self-protective withdrawal was unbearable for Jane. In her own words, she felt *"they took my heart out with the cancer"* and believed she was *"lost, all over the place, I don't know anything anymore."*

Dialogues across sessions demonstrated that Jane's self-critical thoughts were underpinned by strong feelings of shame and self-disappointment. The feelings of shame led to further critical and abusive thoughts about herself, which maintained her symptoms of anxiety, depression and anger that both reinforced her interpersonal distance from others and her own sense of isolation. Typical markers for two chair dialogues to address an internal conflict split (i.e. internal splits involve a harsh internal critical voice that criticises and admonishes their own self as defective or lacking in some way) emerged as Jane spoke about the surgery that was part of her cancer treatment. Chair dialogues involved speaking as the "critical" voice as if it were a fully articulated, volitional dialogical self. From that position, Jane told herself "*It's all your fault, you were all wrong from the start* [from birth]." By bringing fully alive the self-blame and self-critical beliefs she found too painful to tolerate, Jane could articulate to the therapist the impact of such criticism; "*I feel a vice like clamp in my chest.*" By placing these selves into a dialogue, conversations moved from out of awareness emotional reactions into full blown, coherent, cognitive and emotional appraisals whereby Jane had clearer awareness of self-self-relating. Through these

chair dialogues Jane also became aware that she had also internalised the "*bullying*" voice of her father, which contributed to her becoming so self-critical.

Core Emotional Pain

A great deal of Jane's core pain was linked to her relationship to her body, which was largely shame based. Initial empathic responses from the therapist helped Jane's awareness of how her life story, including the experience of feeling defenceless in the face of multiple, painful and frightening surgeries as a child ("my childhood was spent in plaster caste") contributed to her current core pain. The core painful emotions underlying her depression were feelings of invalidation and abandonment. With an extensive history of stigmatisation, ostracism and interpersonal rejection within her family of origin, Jane's core emotion scheme was described as being dominated by *loneliness*, related to her feelings of having missed milestones of adult life (partnership, marriage, children) which left her prone to bitterness, envy and despair; *shame and trauma*, related to her experience of neglect and physical abuse, as well as her double mastectomy which she experienced as a humiliation; further injury to her belief in herself as loveable. Lastly, *loss* contributed to her core emotion scheme, including loss of bodily parts, bodily scarring, sense of womanhood and sexual self.

Unmet Needs

Jane's need to feel loved, accepted, safe and able to accept herself with self-directed compassion was in conflict with her life experiences, including her breast cancer and its treatment. The unmet need in the context of her experience of loneliness and isolation was a craving for closeness, love and caring from her mother,

father and extended family, as she often felt lonely in their presence. Jane also had an unmet need for acceptance, which would involve a break from self-directed criticism to be freer in herself and to experience herself as worthwhile and valued. In the context of her shame, she needed to hear that there was nothing wrong with her, and that she was deserving of belonging and validation. In relation to her fear and terror, Jane needed to feel safe and protected, and strong enough to withstand and face fear provoking circumstances, including follow up scans and care in relation to her breast cancer.

Emotion Transformation

Transformation of Emotional Pain

The account of emotion transformation was based on the therapist' report. Jane's CAD symptoms obscured her primary core feelings of loneliness/sadness, the trauma attached to the loss of body parts, loss of her reproductive self, and the shame associated with feeling a lack of self-worth.

As sessions progressed more imaginary dialogues unfolded Jane's core pain, often in connection to memories that carried parallel themes of over-protectiveness, vigilance, and force; sources of core maladaptive emotion schemes that magnified Jane's childhood self-perceptions of inadequacy and failure. Jane articulated how as a child she experienced her (medical) institutionalization as a painful experience and felt it as the temporary loss of a loving and protective mother. Experiences in hospital had also triggered shaming feelings and fear/terror that formed part of her core pain and had been previously chronically avoided. By witnessing core pain and unmet needs, this elicited her to respond based on internalised positive others (e.g. her

grandfather, aunt, sister) with compassion. Jane could express her need for safety and protection, and for the needed strength to face frightening surgeries and medical settings. Compassion generated in the chair dialogues soothed her pain and provided a sense of caring and connection. A more soothing parental listener, for example, would respond to her fearful, anxious self, assuring her "*I would protect you. I would give you time to heal*." Over time, Jane became increasingly able to access core painful feelings, articulate unmet needs in relation to painful feelings, and respond with self-compassion. In relation to her breast cancer, the expression of compassion paved the way for grieving over her incurred bodily and symbolic losses. Unmet needs were also articulated; "*I needed to be able to say stop.*" Her core pain of fear and sadness and the associated unmet need to have some control (i.e. being able to say stop, or take time to adjust or prepare herself for the losses) in relation to her double mastectomy could also be seen as being related to her experience of earlier surgeries within her [medical] life history. Throughout the sessions Jane was facilitated to express and stay with her experience of adaptive grief, which previously was maladaptively interrupted by secondary anger in the form of blaming others and feeling victimised. This grief had a healing *letting go* quality, and Jane subsequently evidenced greater emotional flexibility, and was increasingly able to speak about her breast cancer in therapy and with others without emotional collapse, but rather with a tolerance of the core primary sadness, partially soothed by increasing interpersonal and emotional connection as she reached out to others and shared her experience.

Equally contributory to transforming core pain, chair dialogues that highlighted mistreatment were also conducive to transforming core pain, in that assigning responsibility for harm done (experienced within her family or origin and also in relation to traumatic surgeries) was integral to transforming the shame based

feelings of diminishment and powerlessness. Early on in therapy, Jane would often express rejecting/blaming anger, and collapse into global distress characterised by despair and hopelessness. By visiting triggers including experiences of rejection/abandonment/mistreatment that highlighted the emotionally hurtful aspects of her breast cancer journey (and as Jane became more emotionally flexible with a sense of worthwhileness stemming from feeling compassionately supported by herself and significant others), she was better able to harness assertive anger to protect her sense of bodily and emotional coherence and integrity. Dialogues with medical doctors who Jane felt had violated her trust were a part of these chair (imaginary) dialogues as well as close others (e.g. father, mother). Expressing her strength increased her sense of empowerment and agency, and she established a resolve to live *"for me, because I'm proud of Jane…I'm proud of the person I am."*

Building protective anger involved working through, "unfinished business", which in one instance involved Jane having a (empty chair) dialogue with her (imagined) father in her 18th session of therapy, and from that relational perspective, to reflect on how she felt smothered in the context of their relationship as a child:

Jane speaking to father: *You never held my hand. You grabbed. You were so overprotective. I felt I must have been bad…I wasn't worth the time out. And now, with all the put downs.*

Therapist: *What do you feel as you say that?*

Jane: *Angry, frustrated.*

Therapist: *So tell him. I won't let you treat me this way (promoting protective anger).*

Jane: *I'm taking no more. I won't let you put me down.*

Therapist: *What do you feel inside as you say that?*

Jane: *I feel stronger*

Therapist: *It feels good to have limits.*

Jane was encouraged to articulate her relational position and express her previously unacknowledged and unvoiced experiences of being unloved and treatment as a "*thing to be hidden*." Her access to protective anger within the dialogue provided a sense of entitlement to be recognised and accepted. Increasingly able to tolerate core primary maladaptive emotions, Jane was able to express pride in herself for all that she had survived, identifying and connecting to the sense of *"wholeness"* with inspiring recognition of *"how much of a woman I still am."*

Gradually developing the capacity to stay with underlying loneliness, shame fear/trauma, and loss, Jane also accessed transforming experiences of compassion. In a dialogue with her (imaginary) mother during the 14th session of therapy, Jane expressed unmet needs for closer relationships:

Jane: *I still find it so hard to look in the mirror. I'm still so concealed. That concealment is so damaging. It's stopped me in the past…I could have asked so many people. I am tired of the concealment.*

Therapist: *I'm lonely because I'm craving connection.*

Jane: *I feel so alone…there's nobody….[tearful]*

Therapist: *Who would understand that concealed part of you?*

Jane nominated her mother in the imaginary chair dialogue. Two minutes later:

Jane, as her mother says: *I know you. When you say you need help you must mean it. Seek it. I will support you all the way.*

Therapist: *What happens inside?*

Jane: *It melts the fear. It breaks the ice. It's such a warmth. A comfort (taking in compassionate other).*

Therapist: *Yeah, not just I'm here for you but I'm here with you.*

In dialogues such as the one above, core feelings of hurt and loneliness were symbolized and witnessed. Present to her own pain, Jane's adaptive need for nurturance and soothing paved the way for the generation of compassion. Her emotional transformation was marked with a move from unbearable core pain and sadness to one where there was a bearable tolerance for sadness around illness related losses and also the establishment of a sense of herself as worthwhile and empowered within her relationships and in terms of her emotional recovery from breast cancer. Alongside a pride in herself Jane could let in expressed compassion from others and experience feeling supported. Jane subsequently became less inclined to collapse into global distress, no longer blaming close others and more inclined to reach out, with notable improvement in the closeness and sense of healthy connection she felt with her sister.

Building her internal self-appreciation was two dimensional ("others" appreciation of "me") and the internal ("my own" appreciation of "me"). By exploring her core painful emotion of loneliness related to feeling unloved and unsupported by others close to her, she began to feel deserving of love and of having her needs met. She was able to access her assertive anger associated with her need for recognition/openness about her illness experience and was able to articulate it; "*there is nothing wrong with me*", which facilitated a transformation of emotion pain that allowed her to mourn the self that had believed and reinforced her shame. These moments of releasing emotional pain were experienced over time by Jane of positive vulnerability, as well hope that she could equip herself emotionally to live with her

bodily losses. In fact Jane, described a strong connection to herself as a *"whole woman"* in her 16th session of therapy that was significant in demonstrating her increased sense of healthy body image and transformed shame. She was also able to articulate her need for closeness (loneliness related) and feel validated as a person worthy of love and support.

Increasingly able to be compassionate to her needs and assert her value, Jane's emotional transformation translated into her behaviour and communication, as she shared with friends and extended family her breast cancer diagnosis and treatment journey for the first time, "*I've come out, as though I'm standing at the balcony, and it feels good to get the air in*." She could connect with others in a way that did not deny her reality, inasmuch as she recognised, shared and talked about her losses with others and could experience their sharing in her sorrow. Jane's gains were reinforced by the love, compassion and acceptance she was then able to experience in her relationships beyond therapy, and her seeking community support services to help care for her parents, which freed her up to resume pleasurable hobbies.

Jane moved from being highly distressed, prone to emotional overwhelm and self-medicating with painkillers and food, to being able to articulate her grief and relate to herself and others with diminished shame and fear. Jane had felt unloved and bullied by her father all of her life, nevertheless towards later sessions she was able to hold her father accountable as well as let go of the wish to gain his acceptance, in turn able to express acceptance towards herself. Mobilizing an extraordinary capacity for renewal, an image of resilience was spontaneously offered by Jane near the end of the session; an internal "flame" that glowed "deep inside" no matter what came from the outside. Seemingly, Jane's increased ability to access and tolerate painful emotions as well as express compassion and a sense of emotional resilience was encapsulated by

the image of the flame. By the end of therapy Jane reported feeling a sense of "*wholeness*" and capacity to face emerging life challenges that with a greater sense of self-efficacy and confidence to live her life.

3.1.3 Measures

3.1.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Jane's scores are presented for pre-, mid-, and post-therapy and at her 6 month follow-up assessment in Table 3.1.1.

Table 3.1.1

Jane's Pre-Post Outcome Scores

Scale	**Caseness**	***RCI***	**Pre-Treatment**	**Mid-Treatment**	**End of Treatment**	**6 Month Post**
HADS	11	3	25	31	12	9
Anxiety			14	20	8	6
Depression			11	11	4	3
FACT-G	78	17	18	28	74	87
SCL-90-R GSI	0.8	0.19	1.96	2.28	0.3	0.3
DERS	78	16	128	104	72	60

Note: Caseness= the cut off for determining whether the client is clinically distressed. HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

At the beginning of therapy, Jane's score on the HADS was 25, indicating she was in the high range for both clinical anxiety and depression. By the mid-point of therapy, Jane's score had increased, which placed her in the severe clinical range for

anxiety and depression. By the end of therapy, her score had reduced to 12, which was still in the clinical range of CAD symptomatology. Jane's pre-post differential of 13 indicates that she had recovered on the HADS (using Jacobson & Truax [1991] criteria for reliable and clinically significant change). Jane's 6 month assessment placed her score at 9, which was in the nonclinical range for symptoms of anxiety and depression.

Jane's pre-treatment score on the FACT-G 18, indicating that she rated her Quality of Life across the four measures as poor. By mid-therapy, Jane's score had increased to 28, indicating some improvement in her perceived quality of life. By the end of therapy, Jane's score of 74 suggests clinically significant and reliable level of change across subscales. Six month after therapy, Jane's score was 87, another improvement in overall Quality of Life and satisfied the criteria for clinically significant and reliable change (Jacobson & Truax, 1991) and thus she can be considered to be recovered on this instrument.

Jane's score on the SCL-90 pre-treatment of 1.96qualified her as a positive clinical case, and indicated symptomatic distress levels that were high and penetrated the clinical range. Overall the intensity of her distress was elevated and demonstrated that she had endorsed a marked number of symptoms, which continued to be elevated in the high range when she reached mid-treatment with a GSI score of 2.28. Her score mid-treatment would corroborate her HADS score, suggesting that she was experiencing anxiety and low mood at a significantly elevated and clinical level. Jane's pre-post differential of 1.66 meets the criteria for reliable change (Jacobson & Truax, 1991). By the end of therapy, Jane's GSI score had dropped to 0.3, which placed her in the non-clinical range and suggested she can be considered to be recovered on this instrument. Six months post therapy, Jane's score remained at 0.3,

meaning that improvement was still evident at follow up and demonstrated a reliable reduced level of overall distress.

On the DERS, Jane's pre-therapy score was 128 which demonstrates that she had deficiencies in the capacity to experience (and differentiate) the full range of emotions and respond/attenuate and modulate strong negative emotions. By mid-treatment, Jane's score had reduced to 104, suggesting that she was beginning to make strides in terms of her ability to use emotion regulation strategies. By the end of therapy, Jane's score dropped to 72. Her pre-post differential on this measure demonstrates reliable and clinically significant change (recovery) (Jacobson & Truax, 1991). Jane continued to improve 6 months after treatment with a score of 60 on this measure, and her scores across therapy indicate she continuously improved her ability to regulate her emotions effectively across her therapy sessions and following on from therapy.

Target Complaints (TC)

Prior to each therapy session, Jane completed a Target Complaints form. The information provided by this measure is presented in Table 3.1.2

Table 3.1.2

Jane's Target Complaints Data

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post Therapy**
Fear/Panic	11	12	3
Ability to Live with Cancer & Embarrassment of Body	13	9	3
Loneliness and Sadness	11	10	4
Anger/Frustration	13	9	4

Lack of Energy	13	10	5

On the first day of treatment Jane was asked to fill out a TC form, detailing the issues which were causing her the greatest distress and to rate how much they bothered her on a scale ranging from 1= not at all, to 13= it's couldn't be worse. It can be seen in the data provided (see Table 3.1.3) that Jane broadly referred to her target complaints listed when describing helpful events in therapy. Jane rated these issues with scores that indicated they were causing her maximum distress, which continued largely mid-way through her therapy. When asked about the continued high level of scoring, Jane expressed a fear about therapy ending too soon, which illustrates the feelings of vulnerability she experienced in opening up about her experiences emotionally. Reassurance about the therapy being a collaborative and jointly agreed process with a focus on her feeling safe appeared to facilitate Jane to translate into her scores by the end of therapy, which suggest these issues had been addressed.

3.1.3.2 Analysis of Process Measures

Helpful Aspects of Therapy (HATS)

At the end of each session Jane was asked to fill out a Helpful Aspects of Therapy form, the data from which are presented in Table 3.1.3. Table 3.1.3

Jane's Post Therapy Helpful Aspects of Therapy form Data

Session	How Helpful?	Helpful Event	What made it helpful?	When in session?	How long did it last?
1	9	Help I got form how it would be/could be when I open up with mam. I realised that I can handle my conversation	I was able to realise how we both "might" feel and "handle it" by me telling my cancer story to members of the family.	Mid Way to End of Session	Whole session

		with greater confidence.			
2	9	The chair work concerning my grandma and grandad being my "allies" and understanding my reasons and attitude.	Speaking about my relationship with my sister. She is my one and only sister and I need to resolve my jealousy and work on my understanding of her. Recalling and remembering granny and grandad- I call my granny my guardian angel.	Mid Way to End of Session	Whole session
3	9	Being the "cancer voice." Realising the connection with cancer and grief going back to birth and hysterectomy and now.	"I spoke" from how I rule and behave as the cancer and I as myself responded and told the cancer the damage it was doing. I was able to say I want peace from that torment.	Whole session	Whole session
4	9	Talking to myself in the chairs and hearing from myself.	Hearing, listening and receiving the words made me realise how strong all these emotions and feelings are. No wonder I feel exhausted all of the time.	Whole session	Whole session
5	9	Describing my emotional needs from my father (and others) in the weeks prior to my surgery.	Talking out and to my father was something I've never done- he would never sit down for it. It was very helpful telling him what I needed and wanted over my years.	Whole session	Whole session

6	9	Discussing how my confidence has disappeared, and my need to enjoy me time/outside of the home.	Recognising that my time with choir is not just something I enjoy but something I need. A great realisation today is the need for peer time.	Mid Way to End of Session	30 minutes
7	9	Speaking out to my surgeon in the chair task about how I felt our conversation went when we told me my diagnosis of breast cancer.	Being able to tell my surgeon what I felt and how I thought he saw me- how he judged me and I was able to say I am none of those things, and stand up for myself.	Mid Way to End of Session	30-35 minutes
8	9	Without a doubt telling the therapist about the weekend situation and how the discussion went with the family.	Being open *and able* to discuss what occurred. Being encouraged and realising how *I can* handle things.	Mid Way to End of Session	Whole session
9	9	Doing the chair task with my surgeon.	I said out loud to him that I needed and wanted respect and compassion, as much as I needed his expertise and medical treatment. Speaking out loud how I felt; what I needed from him and also hearing how I prepare when I'm going to visit him- this has all helped me realise what I do, what I want and how far I've come.	Whole session	Whole session

10	9	Chair task where I realised how dark and low I can get- I can feel in a freefall and feel totally black sometimes. Also talking to "little" me (younger).	Telling myself and feeling that I am lovely, and that I shouldn't feel so unworthy of beauty- I definitely lost a layer/burst through a layer of armour- that kept me feeling strong- I'm feeling less strong but now okay! It's the realisation that these two sides of "me" can be one.	Whole session	Whole session
11	9	Speaking about "permission" with my mother in the chair.	Discussing and letting mum know her constant control; on "keeping things to ourselves" has created a very lonely, sad, strangled and distressed and angry woman (me) who is living with all the feelings that go with cancer too. Feeling supported.	Whole session	Whole session
12	9	Talking to my grandma	Hearing and knowing her love, understanding and total unconditional comfort/love/affection is helping me to "call on" her for support. I know I'll be able to do this.	Mid Way to End of Session	30-35 minutes
13	9	Discussing with my sister how I always felt her dreams and life were discussed openly with pride at home, and the same didn't take place in the home for me.	Discussing how I felt the pressure, burdening load I must have put on the family as a child. Telling my father how I needed his love, his tenderness and his help emotionally.	Whole session	Whole session

14	9	Definitely talking to my mother in the chair. I feel far more relieved and far less burdened then how I arrived today.	Telling mum that I am going to continue to look after her, but I'm also going to look after me and I'm going to let go of the guilt about that- I don't need to feel guilty about that.	Mid Way to End of Session	30-35 minutes
15	9	Discussing the pressures on my life, both physical and emotional life and my difficulties in recovery from breast cancer.	Speaking to the therapist about how I feel, knowing how I worry about the care mum gets, and this talk really helped me realise that some change is essential- for me to recover and for me to live a full and meaningful life.	Whole session	Whole session
16	9	Definitely hearing younger me talk out loud about her dreams and having me now and mum now telling her how loved and precious she was. She was never a burden to other people.	Being able to feel the words that I was never a burden and even though I was different to other people growing up because of my foot, that didn't mean I was any less or worse. Somehow I feel I've reached "full circle"- the warmth and love I felt physically and emotionally towards the end of the session made me realise how much of a woman I really still am. This is possibly the first time I've felt this connection. The love, feelings and care are still in my heart and chest, even without breasts. I am so thankful.	Mid Way to End of Session	Whole session

17	9	Outlining my pure fear and worry of getting to the concert last night.	Talking about my sister's support, suggestions and solution to my fears. Being able to freely speak to a former work colleague that I was recovering from breast cancer. Realising my ability, now and today to move on and the way I didn't I was no longer fearful around therapy with the therapist coming to an end soon.	Whole session	Whole session
18	9	Telling the therapist about my father's behaviour and treatment.	Talking it out and hearing my own fear and sadness out loud, and what I'm living through. It made me realise it is a real and honest issue. Also listening to what granddad would say and feeling how he would treat me- with love, protection and safety when I need it.	Whole session	Whole session
19	9	Explaining to the therapist what I'm feeling around medical appointments.	Realising that I get annoyed with medics and I may not actually be letting them know I am petrified.	Whole session	Whole session
20	9	Talking out loud made me realised a point I've reached.	Being able to feel pride towards myself, and that I can have confidence and wholeness going forward.	Whole session	Whole session

In Session 1, Jane identified that she found the imaginary chair dialogue helpful experientially in so far as she became aware that she was unnecessarily

avoiding speaking about her cancer with significant others, and drew "*confidence*" from the process. In Session 2 Jane describes feeling positively connected to imaginary dialogues with her grandmother and grandfather, and implies drawing strength from their (imagined) supportive and loving responsiveness to her. Naming her unmet needs for safety, acknowledgement, and connection were identified as helpful across sessions 3 to 6. Across chair tasks Jane named the encouragement to speak out about her feelings and assert herself as key to emerging sense of confidence. Jane also identified qualities of the therapeutic relationship as helpful, including openness, support and acceptance of difficult emotions (e.g. jealousy, grief and loss in relation to her cancer) as helpful components of therapy sessions. Feeling *"able"* to communicate with significant others was named in Session 8 as helpful, and feeling supported or naming her need for support within the chair dialogues was identified positively across session 11 through 14.

In Session 15, Jane felt reflections on current life stressors alongside her recovery provided the motivation that *"change is essential"* with a value placed on living a life that's *"full and meaningful."* Session 16 included commentary that for *"the first time"* Jane felt connected to being a woman, and that came with a sense of love and care that was in her heart despite her cancer related losses and a sense of being "*thankful*" was named. In her final sessions (17-20), Jane focused on feelings of pride, love, protection in the face of illness related fears and confidence as helpful parts of therapy that culminated in the experience of feeling *"wholeness"* that would continue to carry her forward beyond the sessions.

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

When asked about helpful aspects of therapy post therapy, Jane described opening up as the most helpful experience. She also cited realisations that developed early in therapy, including becoming aware that she was "sensitive" and "tender", and these insights of how she can be towards others helped develop her own capacity to give that to herself. Feeling that at the start of therapy, there "*was so much down here [pointing to chest and stomach] that needed airing",* a major and unexpected change came from being able to somatically feel "*air was finally coming into this blocked part of me. I'd never had that air, and only from my therapy would that have come and cleared itself out."* Jane reported that the experience was a process that was *"exceptionally and deeply emotional…and tiring."* Her reflectiveness included a sense of grief over the extent of her own emotional pain, yet she also attributed growth; "*I hadn't understood [before therapy] what talking about emotions was, I didn't know what really talking openly was, and what rest and relaxation was. And I needed to realise all of that, that I needed it.*" This was identified as a source of sorrow and regret, whereby Jane stated, "*Sometimes it hurts me to think that it took me to get cancer to have found such help…if only I had spoken to someone of [the therapist'] ability and nature at another earlier time in life, it would have opened up so much to me."*

This helpful aspect also came with challenges, as Jane found speaking about her emotions would increase her fatigue, and also found talking about her own life experience was painful, *"it was difficult to share how painful it was to go through cancer, and hearing from myself, about all my own life experience."* She cited the chair work in particular as demanding, in that it brought her feelings into sharper

relief, "*I really felt the person was there…sometimes it was very sad, and sometimes I was exceptionally angry."* Viewed as part of the larger whole, however, Jane felt therapy had been a "*life saving, fantastic process…there is nothing I would change."*

Her relationship with her sister, and authentically expressing herself in relation to her, was also a difficult part of the therapy, as Jane felt taking ownership of her jealousy towards her sister was *"dark"* and that it was *"painful to hear back my jealousy for someone I loved."* Yet Jane also found that speaking about jealousy facilitated her in opening up to her sister, and being able to acknowledge the longstanding jealousy, including talking about her feelings to her sister outside of therapy, was an important experience in being seen and recognised for feelings she would have previously *"kept hidden."* Jane made changes in other relationships on the basis of her increasing frankness, sharing with her extended family and close friends her breast cancer diagnosis, which she previously was unable to speak about.

Jane further elaborated that through focusing on her emotional health, she was able to lose the sense of shame she had always carried about her body, perhaps most strikingly losing the *"hatred"* she had felt from childhood, about a disfigured body part (from birth), "*I called it awfully derogatory names- I had that disregard because it made me different from any other child."* Always having been ashamed of her body, Jane cited that the therapy helpfully drew her awareness to her self-treatment, and part of becoming more self-compassionate, "*Now I regard my (body part) as a part of me, and I'm proud of it. I'm proud of it. It's part of who I am and I'm okay."* Her softened view of her body reflected her more holistically supportive stance on herself; *"I know now I'm alright, so I was able to discover the value in me."* Jane was adamant these changes would not have come about without therapy, *"I would not be able to sit here in a room with another adult and be able to speak this way without therapy. And since*

the changes have happened I look back and wonder how I dealt before. I feel so different about me now and I've come so far."

Asked whether there were any disappointing, hindering or negative aspects to therapy, Jane was unable to pinpoint anything. While Jane did find speaking about her emotions draining, she also felt it was an important avenue for regaining a sense of control, and that it helped *"build the confidence back up,"* imparting that ultimately, "*it's such a small part that I don't really feel I can complain about it, because what I get is so much more."*

Jane reported that she did not find being a part of the research study problematic, and that it helped her feel the findings could be beneficial, viewing her participating as a contribution towards *"a form of therapy, that's demanding, but that's extremely powerful, and has been so helpful for me after being shattered after my cancer diagnosis."*

3.2 Case Study 2, Ruth

3.2.1 Introduction

Ruth, is a 51 year old Caucasian female, who was referred to the Psycho-oncology department by her Radiation Oncologist. Ruth had been diagnosed and treated for high grade ductal carcinoma in situ (DCIS) breast cancer. The stated reason for referral on her referral form was that she was finding it difficult to cope with her emotions, and that she reported that she got very angry and upset at home, and felt guilty about having these emotions.

Ruth had originally been diagnosed with breast cancer that required surgery only. Ensuing treatment plan changes meant that she did require radiation therapy, which complicated the reconstruction surgery she already had and resulted in chronic

pain and extensive physiotherapy. Medically there was a family history of cancer, and there was a history of sudden death in the family on the paternal side relating to heart disease.

Initial intake in the department suggested she was presenting with low mood and high distress as a result of historical and current stressors, including extensive recent bereavement in her family. Terminal cancer had affected both her family of origin and family in law in the recent past, and her own mother had died a year previous.

History taken during her clinical interview with her psychologist indicated that Ruth was exhibiting longstanding anxiety and depression, which had become exacerbated since her diagnosis and treatment for breast cancer. Quite avoidant at intake and throughout therapy Ruth had difficulty using the word cancer. Her weekly physiotherapy served as a partial reminder that her diagnosis was not going away which caused her significant distress. Consequently she was asked if she would be interested in participating in the study.

Psychosocially, Ruth is the mother of three children, who lived in the family home with herself and her husband. She is a full-time mother, and one of her children has a complex illness that requires a high level of care and regular medical monitoring.

Ruth's GP had prescribed Escitalopram Oxalate (Lexapro; a selective serotonin reuptake inhibitors (SSRI) class of antidepressant medication) to treat her low mood two years previous in addition to painkillers for her chronic pain and Alprazolam (Xanax; a short acting anxiolytic of the benzodiazepine class), to assist with panic attacks. Prior to the research study, Ruth had engaged in one to one integrative therapy, however her symptoms of distress remained high, which made her

eligible for the research study. She engaged in 21 sessions of psychological therapy with the Principal Psychologist of the Department, who was an experienced EFT therapist.

Prior to commencing therapy as part of the research study, Ruth completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Dysthymic Disorder. Ruth also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Obsessive Compulsive and Avoidant Personality Disorder.

3.2.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective: General Observations

Overall the therapy progressed well but was not without some challenges as Ruth encountered crises including family bereavements alongside navigating a volatile marriage and financial difficulties. Initially, the therapist was struck by the level of physical discomfort that Ruth portrayed throughout the earlier sessions. At times she wriggled in her seat and would report that she was pressing her nails into her thighs to distract herself from her emotional experience. Her bodily discomfort lessened over time and seemed to be an overt reflection of her reduced avoidance and increased emotional tolerance.

Attending therapy was a challenge for Ruth, as her husband restricted her in coming to the sessions as therapy continued by not giving her a lift (a long distance car journey) and taking her money. However, again Ruth's developing assertiveness and sense of worth was reflected in her determination to make long journey on public

transport to the sessions. The therapist was very fond of Ruth and this demonstrates how Ruth was able to make connections with people (which was also evident with the reported fondness secretarial staff felt towards her). The therapist felt that Ruth had such 'love to give' and was determined for Ruth to have a better quality of life. This positive regard for Ruth was very apparent in the sessions and the strength of the therapeutic relationship assisted Ruth in tolerating the emotional pain the sessions often brought, adding a sense of reward for the therapist involved in the case.

Case Formulation

The account of Ruth's case formulation is based on the reflections of the therapist.

Triggers of Emotional Pain

There were multiple triggers, both past and present, which brought Ruth to therapy at this time. Identifying Ruth's core pain, the therapist focused on her experience of loss, trauma, loneliness, shame and sadness. Ruth recalled a sense of feeling unprotected from a young age, reporting that her father's drinking was associated with aggression and memories of broken or smashed items around the family home. Ruth would often hide while her parents argued, and she witnessed her mother berating her father after his bouts of drinking, which failed to instate change in his behaviour, creating tension and resentment within the household. Bullied at school, Ruth learned to appear stoic, which would later similarly manifest in her marriage to her husband, who also bullied her in front of their children. Ruth had great difficulty reporting early experiences that suggested sexual abuse, which remained vague but indicated negative experiences that were violating in some capacity. Ruth struggled with a sense of defectiveness, which was also linked to her

mother's emphasis on pragmatism and emotional unavailability in the aftermath of her father's sudden death and the high degree of uncertainty that pervaded the family afterwards. The loss of her father, a significant attachment relationship in her life, had left her feeling abandoned and uncertain, with a heightened need for a sense of security and safety in an unpredictable world. Ruth married in the same year as the death of her father, and the controlling dynamics of that relationship left her vulnerable to feelings of shame, humiliation, and a sense of ongoing failure in her expected responsibilities.

Losses, both physical and symbolic after her breast cancer triggered her re-experiencing the void of her father's sudden death as a young adult, and having lost the close connection with her mother after her recent death, Ruth felt a sense of profound despair around missing that attachment bond and its associated security; "*others can't relate."* With extensive bereavement in the family, Ruth felt that *"normal is lost,"* which was also mirrored in her experience of her own body, now seen as a source of pain, disfigurement, and threat in relation to future cancer recurrence.

Her breast cancer diagnosis involved chronic pain post-surgery that compromised her physical and emotional, which removed her from her role in the family business. An oppressive and painful marriage meant that Ruth had little opportunity for emotional support or community interaction. Ruth was also ashamed of her cancer, with an existential awareness of her mortality (*"*I could die*"*) she hadn't experienced prior to her diagnosis. In the aftermath of her breast cancer Ruth experienced the sudden death of several family members, both by illness and accident. Ruth had lost her own mother a year previous to her entering therapy. Ruth also had to manage her daughter's unpredictable and life threatening chronic

condition, which added to her pervasive sense of threat and danger. Her description of her daily life involved little pleasure and was primarily tied to the family business, running the household as a full-time mother, and recent withdrawal from these demands based on chronic pain and anxiety.

Global Distress

Ruth's global distress was connected to triggers including her controlling marriage, her breast cancer diagnosis, multiple bereavements, and financial trouble that put the family home under threat, further destabilising her sense of security. Hopelessness pervaded Ruth's narrative in sessions, and she presented as extremely vulnerable to the therapist, in terms of her panic attacks, a sense of emotional overwhelmedness and her capacity to suppress more fundamental core schemes of feeling unlovable and unworthy. Ruth always attended her session without removing her coat, conveying her shame based need to "cover up." Across early sessions, Ruth had an inability to hear compassionate words come from her imagined others (e.g. sister, mother) and protective anger was met with a collapse into global distress and emotional avoidance due to difficulties feeling entitled to self-assertion.

Negative Self-Treatment

In order to cope with her core emotional pain, Ruth's presentation included avoidance of difficult emotions such as shame, loneliness, sadness and loss, through strategies such as self-silencing and withdrawal, putting on a façade or brave face, fearing that if she exposed her grief, her children would be burdened instead of protected. She had evident difficulty upholding her right to occupy a space within the therapy session without self-criticism, often invalidating herself as "*silly and stupid*"

for having feelings. Her difficulty with assertiveness was evident in her relationship to anger, and the limited access she had to its healthy expression (e.g. in her marriage). Suppressing emotional experience served as a way of maintaining standards "*you are not pulling your weight if you are not doing everything and have everything covered…if you are not pulling your weight, you are weak."* Ruth's experience of herself as weak and inadequate was propagated by self-criticism, which was reinforced by her high conflict marriage and the shame she felt in relation to bodily changes/losses from her breast cancer. Ruth made sense of these painful losses with further self-criticism, expressing blame with statements such as "*I should be able to cope at my age"* and *"I should know better, I feel pathetic because I'm doing it to myself."*

Anticipatory Anxiety, Emotional and Behavioural Avoidance

The initial sessions of therapy with Ruth conveyed her avoidant strategies in that she was prone to minimising her recent struggles and the enormity of competing challenges she continued to face, with minimal practical or emotional support. Ruth at first found it difficult to accept that her conditions of daily living were difficult and involved isolation, ridicule, and power dynamics that contributed to her feeling "*small.*" Ruth found it difficult to stay with her core pain of sadness, loneliness and shame. Strong emotion felt threatening, as Ruth associated it with conflict "*I don't want to be seen to be making trouble."* Underneath her secondary anxiety, Ruth felt isolated, lonely and stuck "*I'm not happy but everything is about keeping things right."*

Ruth's anxiety was mostly informed by her fear that something bad would happen to a member of her family and that she was perceived to be and felt

inadequate, particularly in relation to her husband, who was characterised as aggressive, demeaning and controlling. Financial trouble in relation to the home was also experienced as exposing, as it threatened the appearance of the family as "perfect" outwardly, and undercut Ruth's preferred way of coping through avoidance and shame driven veiling of difficulties.

Feelings of threat and terror also contributed to her avoidance, which was visibly evident as she struggled to look directly at her imagined husband in the empty chair in front of her due to an immense fear. She found it difficult to tolerate uncertainty, "*things get out of control very easily*" and described living in constant fear of further loss following a number of recent bereavements in the aftermath of her own cancer diagnosis and treatment. She was reluctant in sessions and during assessment to use the words breast cancer and was extremely fearful of the possibility of recurrence.

Ruth managed her anxiety by cleaning and ordering the house, often waking in the middle of the night to *"keep on top of things"* and found it difficult to relax. Her primary method of mitigating her feelings involved distraction, *"I'm trying not to think about it."* Ruth's physical presentation in therapy was characterised by uneasiness, constant fidgeting and/or clutching her hands together or to the chair armrests when emotionally aroused. Ruth also spoke in an uninterrupted stream, and would often completed descriptions of painful events with minimisation and deflection (e.g. giggles).

Terrified by her experience of breast cancer, when she was anxious about the effects of cancer on her life Ruth would avoid more primary painful emotions through ritualised cleaning and repeating household chores. In session, it was possible to witness that she found these activities maladaptively soothing, as in times of core

painful emotion she would begin folding her tissues into squares and smoothing them in her lap. Her partial disengagement from contact within the dialogues or with the therapist in these instances also demonstrated the dearth of interpersonal soothing Ruth had experienced, and her early sense that soothing or protective support from others would not be forthcoming.

Grief and trauma associated with family bereavement contributed to worrying and other forms of avoidance (behavioural, in the form of self-silencing and withdrawal; and emotional, in the form of hyper-vigilance over her body and distraction/compensatory talking/giggling). Ruth's avoidance of core pain was compounded by her fear of emotions *"I will not be able to come out of it [emotions]"* and limited access to emotion regulation strategies. These maladaptive coping strategies 'protected' Ruth from her core pain, which was constituted by loss, fear, loneliness, shame and sadness.

Core Emotional Pain

Ruth's needs were related to unmet emotional requirements from childhood, such as unconditional love, safety and reassurance. Her breast cancer and accompanied losses exacerbated her core pain of loneliness and isolation, and her difficulties overwhelmed her in the context of a controlling marriage. Problematic emotional self-regulation served as a strategy to strangulate painful affect related to unmet needs for support and connection.

With the encouragement of her therapist across sessions to stay with her primary core sadness, Ruth could be facilitated to connect with core pain; "*I'm desperate…and it's sometimes so sad and lonely* (voice cracking)." Other dialogues within therapy focused on the pain, hurt and fear experienced in her marriage. The

marital dynamic was fraught with fear and humiliation in front of others that reinforced her perception of herself as "*a weak person*" and "*defective/flawed.*" During her therapy sessions and with the empathic validation of the therapist Ruth would fleetingly connect with unbearable sadness, describing a deep hurting at her core. More specifically, in her dialogues (imaginary) with her husband, she expressed the pain and rejection that came with his demeaning behaviour; "*it frightens me because I think it's deliberate, he does it to hurt me."* Self-criticism further invalidated Ruth when she experienced hurt stemming from rejection within the marriage; "*I feel so stupid, when I feel I have nobody, like I'm a silly person."* Her harsh self-criticism demonstrated the internalisation of the demeaning and dismissive characteristics of her marital relationship as well as her own internalised beliefs that judged her need for love as unacceptable. This dynamic upheld her feelings of hopelessness and powerlessness, which was reinforced when she felt betrayed in the marriage by her partner's secretiveness and covert behaviour.

Ruth response to her husbands' *"shouts and roars"* was to feel that it confirmed her as worthless, an emotional pain so profound that it scattered her sense of self as coherent or agentic; "*I get bombarded…I get so lost."* Core shame compromised Ruth's ability to communicate the extent of her feelings of hurt and betrayal in the marriage, "*if the truth was known I'd be so ashamed,"* indicative of the self-blame that left her without a sense of entitlement for respect and enforceable boundaries. Fears associated with her illness experience (e.g. medical follow up appointments related to pain and her own fears of recurrence) added to Ruth's sense of herself as weak and defeated.

At the start of therapy, Ruth's core pain was exacerbated by the feeling that she was unprotected and vulnerable to further losses relating to her breast cancer, which she felt unequipped and unsupported to cope with. Her core emotion scheme was described as being dominated by *loneliness*, from loss of closeness after the death of her mother, rejection from her husband, and isolation from friends and family since her breast cancer (enforced by the controlling marriage) which left her feeling unsupported and unloved. *Shame and trauma* associated with the emotional abuse and feelings of being controlled within her marriage, as well as her physical changes (scarring, disfigurement) from her breast cancer that reinforced her perception of herself as defective. Lastly, *loss* contributed to her core emotion scheme, including loss of bodily parts and health.

Unmet Needs

Ruth's feelings of sadness stemmed from unmet needs to be close and connected within her marital relationship, as well as a missing acknowledgement of the emotional burden of her breast cancer within the marriage. In the context of her overwhelming fear and threat in the aftermath of multiple bereavements and her cancer diagnosis, Ruth's needs included to grieve losses and obtain comfort and support. Her sadness was also conflict related, in that the marriage dynamic of emotional control and humiliation left her missing out on the need to be recognised and validated, as well as to have a sense of control and healthy autonomy.

Emotion Transformation

The account of emotional transformation for Ruth is based on the therapist's reflection. The conceptual framework model of Timulak and Pascual-Leone (2014)

was employed throughout therapy as a supervisory tool and was then also used by the therapist in her reflection on the progress (if any) in therapy.

During initial therapy sessions, Ruth's capacity to speak about her breast cancer diagnosis was low, reflecting her difficulty tolerating distress. An imaginary chair dialogue highlighted her avoidance as partially stemming from her self-treatment, which was as harsh and critical and suppressed emotional experience as a way of maintaining standards. Across (imaginary) chair dialogues with Ruth her self-criticism served as a way of attempting to mitigate the disappointment stemming from criticism by her husband as well as a form of self-punishment. Her harsh inner critic would emerge specifically when she came in contact with vulnerable emotions such as hurt, loneliness and sadness that perpetuated her sense of being defective. In other words, there was a relationship whereby self-criticism activated shame. While often diminishing the extent of her emotional experience with giggles or smiles, Ruth was encouraged to stay with her the emotional salience of her negative self-treatment. Feeling over-burdened, monitored, and diminished by the messages from her harsh inner critic, Ruth felt inadequate and enslaved.

As she let in her feelings of hurt stemming from this self-critical process, empathy began to emerge. Ruth came to acknowledge *"I can't meet these expectations"* with a tone of dawning awareness that her own standards as a mother and carer for the family home in the aftermath of her illness was too unyielding. By highlighting and heightening feelings of worthlessness and deep hurt that resulted from her harsh self-attack, the therapist facilitated Ruth to recognise the debilitating effects that came with painful self-treatment. As Ruth built an inner awareness of her self-critical processes, she became increasingly able to resist the tendency to self-attack. Contact with the painful aspects of her self-treatment gradually softened her

critical voice, and gave way to allowing her experiencing self to express unmet needs to feel safe, supported and accepted. Her recognition of the painful burden of these expectations elicited self-directed compassion in response to the deep hurt it triggered in her non-dominant, experiencing self. For example, during an imaginary chair dialogue with her internal critic, Ruth acknowledged the difficulties that come with self-punishment; *"you were never going to be finished, with all these expectations to meet."* Ruth was able to let go of some of her harsh and absolutist self-treatment, and tentatively recognise her accomplishments, "*you should give yourself a pat on the back for what you do, and it's not all or nothing [in a chair dialogue with self]."* Ruth acknowledged the need for more self-directed compassion; "*I'm going to try to appreciate you more [to the imagined experiencer-self in the empty chair]*" which felt *"totally different"* as she was able to set clear boundaries with her internal critic. These shifts in self-treatment required gradual consolidation behaviourally (e.g. taking breaks during the day for herself, spending time with a hobby for relaxation) as a new way of relating to herself.

As therapy progressed, chair dialogues for unfinished business with her husband highlighted her unmet need for protection and love. With the therapist's empathic validation Ruth stayed with her feelings of mistreatment within the marriage in the aftermath of her breast cancer diagnosis and subsequent feelings of core primary sadness and shame. Connected to her experience of loneliness, shame and fear, Ruth's feelings of inadequacy were articulated as needs for safety and security, and contact with these emotions facilitated access to self-protective anger; "*I deserve to be treated with respect."* Acknowledging the maltreatment she had faced stimulated adaptive, protective anger within sessions that helped build a resolve to protect herself, free of the previous self-judgement that deemed assertiveness to not

be acceptable. Asserting and experiencing herself as meriting respect was a defining moment that also came with core primary adaptive sadness. Alongside her experience of empowerment, Ruth felt a parallel grief over the emotional losses within her marriage, the life she/they could have had and the connected sense of loneliness. However with a decreased fear of vulnerable feelings (an inner critic less trenchantly deeming them as a sign of weakness) she was adaptively grieving with primary sadness. In the imaginary chair dialogues, her sister, and then herself, responded to her core sadness with compassion and soothing, the validation of which gave Ruth a sense of relief, "*you are not alone, I want you to tell me how you feel."* In a subsequent (imaginary) chair dialogue with her husband, her connection to and witnessing of her primary core pain of loneliness and sadness at mistreatment elicited the articulation of unmet needs:

(Husband in imaginary chair dialogue):

Therapist: *Really look at him and say how you feel as you say what you need.*

Ruth (speaking to imagined husband): *I need to be my own person (tearful)*

Therapist: *It's so painful…let those tears come*

Ruth: *This is what I'm missing. I just feel really trapped. I long to have my own space.*

Therapist: *Now I know what I want.*

Ruth: *It's sad, but it's a nice sort of sad. Its things that I want but so often I'm afraid to ask. Because he wouldn't have time for that.*

Therapist*: So say it again, just for here, I long for more of me to come out.*

Ruth*: I just feel so isolated, and it's too much now. When mam died, I lost so much, because she would have been there (to keep me company).*

Therapist: *Can you bring your sister here and tell her how you feel?*

Therapist invites Ruth to nominated an imagined other who would support her. Ruth nominates her sister and Ruth's sister brought into imaginary chair dialogue):

Ruth (speaking to sister in imaginary dialogue): *I feel so lonely...but I don't want to burden you because these are not nice things.*

Therapist: *Can you tell her how you are holding it in? What's that like?*

Ruth*: It's stressful and upsetting and takes a lot of energy---sometimes then I can't do anything…it's a lot of hard work.*

(Ruth changes chairs and therapist asks for a response from the imagined sister)

Therapist*: So as your sister, what do you say to Ruth?*

Ruth [enacting her sister]*: I want you to know I'm always here for you and I love you.*

Features of avoidance and unbearable emotional arousal changed over the sessions as Ruth was gradually able to integrate compassionate, kind words and name her sense of worth, "*I'm a really good mother, my children have turned out to be great and that is because of me*". Ruth's contact with her vulnerable experience of feeling unloved, humiliation within the marriage, and aloneness with her illness generated transformative compassion that helped her to bear core painful emotions. Sources of compassionate presence across sessions included her mother, her sister and herself.

Together, with the coaching of the therapist, Ruth was able to discover the healthy part of herself that needs to feel protected and loved and connect to her experience of herself as worthwhile. In terms of her maladaptive emotion scheme, core sadness was transformed by increased tolerance and compassion without secondary shame interrupting her ability to express unmet needs.

With repeated dialogues across sessions, Ruth was able to hold her husband accountable for mistreatment as well let go of some of the secondary shame and anger at herself that obscured primary pain, sadness and loneliness. Towards later sessions, Ruth was able to convey a sense of respect and forgiveness towards herself with adaptive compassion; "*you are not to blame…you deserve better. I deserve better"* and acknowledge a sense of being lovable and worthy of love, "*I know my children love me."* Nearing the end of her therapy, Ruth felt relief (*"a weight had been lifted"*) and that the newfound sense of empowerment she carried was *"a huge reassurance, it helps me to tap into what I know is the truth about things,"* suggesting inner resilience. For Ruth, her expression of compassion was fused with self-directed forgiveness (no longer blaming herself for her difficult life conditions), and the transformation of shame gave her a sense of hope that she possessed the capacity to support herself outside of therapy.

Ruth developed an increasing capacity to experience and express compassion towards her primary core pain, which, was promoted through contact with her sister and her children, following which Ruth was able to develop and express towards herself. Across dialogues Ruth also spoke about her cancer experience, increasingly expressing primary sadness and grief, which was significant as Ruth had previously been unable to name cancer without collapsing into panic and fear. Greater connection to herself as agentic and compassionate in the aftermath of her recent

illness meant that Ruth's sense of fear and powerlessness decreased, and she increasingly felt able to live with her illness and capable of managing her physical and emotional recovery. While Ruth remained within a difficult marital dynamic, her experience of adaptive emotional responses gave rise to a sense of herself as valid and deserving of love that buffered the potential for future adversity.

3.2.3 Measures

3.2.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Ruth's scores are presented for pre-, mid-, and post-therapy and at her 6 month follow up assessment in Table 3.2.1.

Table 3.2.1

Ruth's Pre-Post Outcome Scores

Scale	**Caseness**	***RCI***	**Pre-Treatment**	**Mid-Treatment**	**End of Treatment**	**6 Month Post**
HADS	11	3	29	25	11	11
Anxiety			19	16	7	8
Depression			10	9	4	3
FACT-G	78	17	75	57	86	82
SCL-90-R GSI	0.8	0.19	1.08	1.08	0.43	0.88
DERS	78	16	95	102	63	60

Note: Caseness= the cut off for determining whether the client is clinically distressed. HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

On the HADS, Ruth's initial pre-therapy score of 29 indicated severe clinical symptoms of anxiety and depression. Her mid-point assessment score of 25 remained in the severe range for CAD, however her score reduced to the mild clinical range of 11 by the end of therapy. Her end of therapy score suggests that reliable change but not clinically significant change (Jacobson & Truax, 1991) had taken place which was maintained at 6 month follow up post therapy.

On the FACT-G measure, scores of 78 or below are taken as the cut-off scores for poor Quality of Life. At the beginning of therapy, Ruth's score on the FACT-G was 75, which indicates that she was experienced a low quality of life based on changes since her breast cancer treatment. By the mid-point of therapy, Ruth's score had reduced to 57, which suggests there was deterioration (negative reliable change) in terms of her perceived life quality. Ruth's post treatment assessment demonstrates a marked improvement in a pre-post differential of 11, but suggests there was no reliable change on this measure.

Ruth's scores on the SCL-90 show that pre-therapy, her GSI score of 1.08, which placed her in the clinical range and indicated significant distress. By mid-therapy, her score was sustained at 1.08, suggesting that she continued to experience ongoing symptomatic distress, however by the end of therapy this was reduced significantly to 0.43, indicating clinically significant and reliable change (Jacobson & Truax, 1991) that Ruth can be considered to be recovered on this instrument. Ruth's distress did increase above clinical cut off at her six month follow up and placed her in the mild range of CAD symptomatology, indicating deterioration and negative reliable change on this instrument.

On the DERS, Ruth's pre-therapy assessment scored of 95 suggested emotion regulation strategies that were maladaptive and likely contributing to distress. By

mid-treatment, her score of 102 indicates that she was experiencing greater difficulties with emotional regulation, which is corroborated by her higher ratings on the HADS and SCL-90, reflecting a heightened awareness around emotional experience and reporting it accordingly across these measures. As therapy progressed, her end of therapy score on the DERS of 63 indicates improvement in her capacity for emotion regulation strategies, and satisfied the criteria for reliable change (Jacobson & Truax, 1991). Her six month follow up score of 60 shows a further decrease in difficulty with emotional experience (i.e. lesser emotional dysregulation), and thus she can be considered to be recovered on this instrument.

Target Complaints

At her first session, and in each subsequent therapy session, Ruth was asked to fill out a target complaints form, detailing the issues which were currently causing her the greatest distress and to rate how much they bother her on a scale ranging from 1= not at all, to 13= it couldn't be worse (See Table 3.2.3).

Table 3.2.2

Data from Ruth' Target Complaint Forms

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post Therapy**
Wanting to Change Things	13	13	13
My Home Life	13	13	13
Marital Relationship	13	13	13
Uncertain how to Progress	13	13	13

On the first day of psychological therapy, Ruth was asked to fill out a TC form, detailing the issues which were causing her the greatest distress and to rate how

much they bothered her on a scale ranging from 0=1 not at all, to 13= it couldn't be worse. It is striking given Ruth's GAD presentation that she stayed away from naming worries, however in keeping with her responses on her quality of life measure (FACT-G) and the SCL-90 as part of her pre-post outcome measures (see section 3.2.3.1), Ruth avoided responding to questions on these measures that pertained to fears and worries such as thoughts of death and dying, which is perhaps reflective of her avoidance processes. Ruth's avoidance of these items continued in the measure after therapy was completed, which perhaps highlights the limits of therapy in terms of resolving all trauma based avoidance Seldom explicit, Ruth chose to name her target complaints quite broadly, and perhaps her final target complaint (uncertain how to progress), combined with her maintaining high scores across all her target complaints for the duration of therapy demonstrates the complexity of her safely navigating a controlling marriage, and her continued need to represent some of her dilemmas/stressors as an ongoing concern, despite her reporting attitudinal and psychological shifts on the basis of therapy in her HAT forms and the mid-therapy and end-therapy Client Change Interview Schedule.

3.2.3.2 Analysis of Process Measures

Helpful Aspects of Therapy

Like the other participants in the study, Ruth was asked to fill out a Helpful Aspects of Therapy form, the data from which are presented in Table 3.2.3.

Table 3.2.3

Data from Ruth's Post Therapy Helpful Aspects of Therapy Forms

Session	How Helpful?	Helpful Event	What made it helpful?	When in session?	How long did it last?
1	9	Chair work: when I leave this leave this session today what I have acted out by changing seat will be of great help to me, later today and over the next few days.	My day got off to a bad start and I got to talk about it to the therapist. Got to realise I'm not the problem all the time.	Near End.	10 minutes
2	9	I'm so surprised at the way things have gone today because I have learned a new thing about myself. I don't have to be so hard on myself.	The chair change over. Everything applied to me and made so much sense. I had to face the other side of myself that is not always understanding to the needs of me.	Near End.	5-10 minutes
3	9	Being kind to myself and acting out "chairs" was honestly the way I feel about myself.	Saying over and over again to myself things I know are true already and reminding myself of them. Seeing and speaking on behalf of the other side of myself.	Near End.	20-30 seconds
4	9	Today we talked about my childhood and it brought up some memories I had parked and had chosen to forget.	Just being able to speak freely and not having to be afraid I have said too much or said the wrong thing.	Near End.	15 minutes
5	9	Saying "I know her so well"- it was a wake up call.	Being able to talk through it and mostly being able to do it with the therapist while it was happening.	Near End.	10 minutes

6		9	Talking honestly to the therapist and being able to say what I wanted to say there and then. The therapist seems to be able to bring out the best in me because I can talk to her and not worry about it later.	Saying what was on my mind so I could clear it up and be honest to those feelings.	Whole session	50 minutes
7		9	Getting to have a chance to just say what I feel and knowing it is okay.	Not having to worry about my words and knowing "I don't pay later"	Mid-way	30-35 minutes
8	no form		no form	no form	no form	no form
9		9	I was given the chance today to talk and be listened to.	Being able to speak out and talk about what's really happening in my life right now.	Whole session	50 minutes
10		9	Knowing and acknowledging the way I feel about myself and that its not a wrong feeling.	Being able to talk openly and honestly and say things as they are.	Mid-way	30-35 minutes
11		9	I got to talk to the therapist about my operation I had a couple of years ago and say things I haven't told anyone else.	Just saying the words and talking the whole time about how I feel.	Quarter into session	45 minutes
12		9	Sometimes when I'm talking with the therapist I get upset and cry but I can't always get back to my happy place with her because the therapist gives me the chance to talk.	The therapist being who she is, and working her magic. Just talking helps me so much.	5 minutes into session	50 minutes
13		9	Just working through things and talking with the therapist makes it very plain for me to see things as they are.	Being given the time to talk and I think this is very helpful and the best thing for me. Sometimes the therapist know what I'm going to say before I even speak.	10 minutes into session	40 minutes

14	9	I was given the chance to be totally honest and speak freely not having to worry over what I said.	Just being able to talk openly and get things off my chest, and I get to park them here. I tell the therapist things I wouldn't tell anyone else.	Whole session	50 minutes
15	9	I had a difficult few days at home and I got to talk today about it.	Just being given the time to speak about it.	Whole session	50 minutes
16	9	Sometimes the therapist will say something that's very obvious but I don't think too long before I realise it also applies to me and it takes me a while.	Its very important for me to be able to take in what's been said because I am given the chance to talk freely and when I'm alone and have time to myself I will follow through.	Whole session	50 minutes
17	8	I got very upset today in my session and was crying a lot.	Being able to talk to the therapist knowing she won't judge or think badly of me. I was afraid to acknowledge feelings to myself- I'm always afraid of getting upset.	10 minutes into session	40 minutes
18	9	I got the chance today to talk through what has been so upsetting to me this morning.	Being given the opportunity to express my feelings and working my way around my way of coping with them.	Whole session	50 minutes
19	9	The therapist gave me the chance today to speak openly, honestly and didn't judge me.	I feel the better for talking and it's very important for me to express myself through talking. I got brave and got things off my chest. I felt honest about what I was saying.	10 minutes into session	40 minutes
20	9	I got the chance to talk about the morning I had and how it has impacted on me.	It is always good to talk, because sometimes I doubt myself.	Quarter into session	50 minutes

21	9	Being given the chance by the therapist to be in my sister's shoes because I always know she is there for me, I just need to remind myself more.	Talking it through and then feeling comfortable with myself afterwards.	20 minutes into session	50 minutes

Initially Ruth expressed a sense of relief (Session 1) about the space and expression therapy afforded her, as well as an acceptance that her feelings of upset were legitimate, "*I got to realise I'm not the problem all the time."* Sessions 2, 3, and 4 also shared the sense of appreciation in the benefits of expressing herself, as well as an awareness of her own self-treatment, including being hard on herself, "*I had to face the other side of myself that is not always understanding to the needs of me."* Ruth's tendency to hold her feelings and experiences away from others in everyday life is contrasted by her openness in therapy, where *"talking helps so much"* and "*makes it very plain for me to see things as they are*." Ruth continues to identify the most beneficial aspect of therapy as being the place where she doesn't need to censor her feelings, alluding to her problematic marital relationship, "*not having to worry about my words and knowing I don't pay later."* Her experience of being empathically understood is also strengthening for Ruth where she felt she could connect to the *"best in me."*

The majority of sessions for Ruth re-phrased the experience of being understood, feeling validated, less burdened by her emotions, a sense of relief from expressing her feelings, and sharing difficult memories, including that of her breast surgery in session 11, which was the sole identified helpful event that was explicitly related to her breast cancer. Her sense of safety in therapy translates into increased clarity in terms of her emotional needs, in that Ruth feels better able to then tackle

"*working my way of coping with them [feelings].*" An increased ease with naming her feelings contributes to Ruth feeling able to accepting her emotional experience.

Session 17 was identified as a particularly powerful session, where Ruth felt particularly upset and identified *"crying a lot"* as a part of a breakthrough where her past fears of being overwhelmed by her emotional experience was recognised as part of her self-interruptive process, "*I was afraid to acknowledge feelings to myself- I'm always afraid of getting upset."* In fact, in Session 20 and 21, she is seemingly able to move past these fears, aware that she has a tendency to *"doubt myself"* and that talking helps her feel more *"comfortable with myself afterwards."* Ruth did not elaborate on the items she listed in her target complaints in the HAT forms in therapy, but rather focussed on the benefits of therapeutic support and reassurance, and demonstrated a continued explicit gratitude to her therapist for the space and receptivity offered across sessions.

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

In her post therapy client change interview, Ruth identified a number of beneficial changes in herself since the start of therapy, which she described as gradual initially, but which led to *"change the way I think about things entirely."* These shifts in perspective were also witnessed by her sister, who saw Ruth as *"stronger in myself"* whereas her husband framed her newfound confidence in less positive terms, suggesting she had become *"too independent because I think more for myself."* Finding therapy *"intense",* while Ruth didn't identify anything as changing for the worse since commencing therapy, she did find EFT chair work to be emotionally confrontative, "*the chairs…wouldn't be my favourite…I used to dread seeing the*

therapist' body language when she was going to ask me." Ultimately, however, Ruth felt that *"the chair thing…even though I didn't like it, it was the best thing for me."*

There were numerous changes Ruth felt had taken place as a result of therapy, including not being as hard on herself and greater flexibility in her self-treatment. Through talking weekly in therapy, Ruth realised the high standards she set for herself and how her anxiety drove her to avoid her feelings, "*I started to realised I actually don't think about my feelings all that often"* but through her therapy sessions, Ruth felt more agentic in choosing how to take care of herself emotionally, "*I felt sorry for myself whereas I wouldn't have before. I found it very in your face, because it's real and it's happening."* The starkness of coming into contact with avoided feelings allowed her to acknowledge them and to continue to process her time in therapy as the week went on, "*I would go home and then go over how things had happened."* Pushed out of her comfort zone and simultaneously made to feel safe and accepted, Ruth was able to re-evaluate her self-worth, "*I got to see myself that it's not all bad and even though I'm used to being told you are doing wrong, or that's wrong…I had to accept myself that I'm really not a bad person. I realised that just because someone else is saying it and not happy doesn't mean that what I'm doing isn't good."* Seemingly, Ruth began to evaluate herself by her own standards, rather than those dictated within a difficult relationship.

Similarly, Ruth reported a changed perspective on the changes she felt in her body since her treatment for breast cancer, "*when you get sick…and everything goes wrong for you…it's hard to get back on track. But when you do, I've learned to accept, okay even though I can't do everything now, I can do some things. I'd rather be positive about the things I can do."* Powerfully, Ruth linked her adjustment to being given the space to grieve; "*I had the space to adjust, and I grew out of that and*

started to rebuild a sense of myself." Her determination to surmount the negative verbal dynamics within her marital relationship is palpable when she describes her feelings of increased resilience, "*Stronger…words are just words…they can hurt you but I'm just stronger and I can see the bigger picture."*

Ruth felt that being diagnosed with breast cancer was like *"having all the walls tumbling in"* and that her therapist took the role of *"pick[ing] all the rubble off me and showing me how to re-build the wall but do it in a way that its secure around me…picking it all up and building in again, but the way you want it, not the way someone else has built it for you."* Identifying that she was *"so unhappy"* was paradoxically *"the best thing ever, because I got to get to figure out what was making me so unhappy."* Ruth felt this process of discovery and self-understanding was thorough, and there was not anything missing, attributing the comprehensiveness to her therapist's skilfulness; "*the therapist covered so much."*

When asked whether she believed if it might have been possible to bring about changes without therapy, Ruth felt she "*couldn't have managed without it,"* in part because her confidence prior to therapy, had been *"on the floor…it was almost gone."* Her increased awareness of her choices in relation to self-care allowed her to step back and *"stop pushing myself so hard."* Giving herself more time to be in her own company seemed to connect Ruth back to a sense of self-sufficiency and self-worth, "*I'm just happier in myself, in my own skin, just with me."* Ruth identified this as the hardest part of therapy, stating *"that took a bit of work."*

Asked whether there were any particular attributes which she felt may have assisted her in the process of therapy, Ruth implicitly named a perseverance, repeatedly stating that a number of changes in herself through therapy took *"a lot of*

work," and was an ongoing development in learning to sustain herself that would continue beyond therapy; "*I'm not fully there yet but I have it to work on."*

While reporting there was nothing unhelpful or disappointing about the therapy, Ruth again highlighted the challenging nature of the EFT chair work, joking that she sometimes *"wanted to hide the (extra) chairs or move them out of the room!"* Finally, when asked about the whether she would change anything about therapy, Ruth felt she would change nothing, stating how she felt the approach allowed for options and felt like *"being empowered back again."* Similarly, Ruth felt there were no needed changes in relation to the research aspect of her therapy experience.

3.3 Case Study 3, Sophie

3.3.1 Introduction

Sophie is a 54 year old Caucasian female, who was referred to the Psycho-Oncology department by her Radiation Oncologist. Her treatment for Grade III breast cancer included surgery (lumpectomy), chemotherapy, radiation therapy and hormone treatment. The stated reason for referral on her referral form was low mood, for which she was attending her GP.

Initial intake in the department suggested she was presenting with high distress as a result of a longstanding but undiagnosed history of depression and current stressors in relation to her breast cancer treatment. Her anxiety was contributing to her current worries about side effects stemming from her chemotherapy and hormone treatment (e.g. hair loss, neuropathy, weight changes). Consequently she was asked if she would be interested in participating in the study.

Sophie had been diagnosed with Stage II hormone positive breast cancer that required surgery, chemotherapy, radiotherapy and hormone treatment. She was also

attending physiotherapy for post-surgical pain and was receiving medication for the neuropathic pain she was experiencing as a side effect of chemotherapy.

Her family has a history of prostate cancer but she had no other outstanding medical history. For a long time prior to engaging in therapy, Sophie had been experiencing anxiety and depression. Sophie is married and the mother of three children, two of whom are adults. At the time of engaging in therapy she was on sick leave from her work in education. Sophie participated in 19 sessions of psychological therapy with the Principal Psychologist of the Department, who was an experienced EFT therapist.

Prior to commencing therapy, Sophie completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current Major Depressive Disorder and Panic Disorder. Sophie also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Avoidant, Obsessive Compulsive and Depressive personality disorder.

3.3.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective: General Impressions

The therapist felt the therapy went well with Sophie albeit found it to be challenging therapeutic work. The beginning of the therapeutic sessions were dominated by frequent episodes of global distress characterised by a sense of hopelessness and despair. Sophie found it difficult to tolerate emotional vulnerability and this was particularly seen when she would collapse into global distress when

enacting ‘the other’ in imaginary chair dialogues, whether it was her daughter, mother or husband. The therapist described having to work hard to keep connected with Sophie, as she presented with minimal verbal elaboration and had particular difficulty naming her emotional experience. The therapist took the approach of actively trying to differentiate emotions, coaching and encouraging emotional expression and made sure to provide ongoing opportunities to verify she was capturing the emotional experience and impact, however this was demanding to sustain. Sophie described the sense that she was speaking about her inner experience for the first time in her life, conveying how much she felt there was intimacy being established. The therapist’s experience was pronouncedly different; and often felt palpable distance and emotional disconnectedness. This difficulty with connecting in a shared way for therapist and client perhaps demonstrates aspects of Sophie’s sense of chronic lifelong loneliness and one that was further accentuated by her cancer diagnosis.

As the sessions continued Sophie showed an evolving capacity to tolerate emotion, in particular self-compassion. The therapist found her to be less self-deprecating, gentler and more forgiving with herself. This allowed her to practically plan a future of better emotional self-management in terms of articulating her emotional needs with her husband as well as incorporating self-care activities into her life. During the course of the therapy, a friend of Sophie’s died from cancer. Naturally, this evoked feelings of grief for her friend as well as distress and fear around her own cancer experience.

In exploring her emotions of loneliness, shame and fear around her cancer diagnosis Sophie demonstrated an increased capacity to tolerate painful emotions including a sense of loneliness connected to being overwhelmed and shame that may

not have been possible before engaging in therapy. Overall the therapist felt that relative to the beginning of therapy Sophie demonstrated emotional transformation, even though there were times Sophie fell into global distress and rejecting anger.

Case Formulation

The analysis of Sophie's case formulation was based on the reflections of the therapist.

Triggers of Emotional Pain

Sophie had a longstanding history of depression and anxiety for which she had never sought psychological support. Sophie's recent and historical triggers beyond her breast cancer stemmed largely from her upbringing. Her childhood experience included a speech impediment that ostracised her in school, but was overshadowed by a more severe impediment her sibling had, leaving her feeling lonely and that there was no room for her concerns to be attended to. The parenting she received as a child was disciplinarian and authoritative, and involved scarce emotional nurturance. Her parents ran a business that was demanding and relentless, and her memories were of very little pleasure, with an emphasis on labour that left her father often frustrated, angry and tense, and her mother frazzled and prone to episodes of burnout. Their commitment to serve the community ahead of the family left Sophie feeling unimportant and unwanted. Bullied in school, Sophie felt targeted and rejected by her peers and consequently did not experience a sense of safety necessary to loosen her sense of play or engage her in peer based connection. Sophie's need for validation was never realised, which was further undercut in her own career where she struggled to feel effective and experienced chronic and debilitating (scanning, double checking, difficulty completing tasks) self-doubt.

Since her diagnosis, she struggled with the associated feelings of vulnerability relating to feeling physically weakened from medical treatment, particularly in relation to hair loss, weight gain that contributed to feelings of lethargy, and hot flushes and nights sweats stemming from hormone therapy as part of her breast cancer treatment. Her breast cancer diagnosis highlighted a lifelong sense of loneliness and feelings of shame stemming from emotion schematic memories of humiliation and failure and an overall sense of powerlessness.

Global Distress

Throughout therapy but particularly across early sessions, Sophie presented with minimal verbal elaboration of her inner experience. Her descriptions were often vague but highly characteristic of depression, including a *"blackness"* and a sense of being weighed down. Her memories of childhood were summarized as a form of apprehensive anxiety; "*constantly afraid, on tender hooks. Afraid of everything and nothing. Afraid of everything falling down around me."* Largely characterised as uncontrollable and unsafe, Sophie's fear prevented her from being able to stay with painful, upsetting feelings.

Chronically feeling deprived, Sophie couldn't recall a time in her life where she felt content or at ease. Her primary experience was of global distress; *"I'm just so tired and carrying around all this baggage."* Interactions with her therapist across the sessions were marked by hopelessness, capturing a tension between her longing to feel connected and her primary experience of maladaptive sadness where she was often resigned and sparse in her verbal expression.

Irritability, sleep disturbance, panic attacks, hot flushes and night sweats associated with hormone induced menopause (as part of her breast cancer treatment)

further contributed to her difficulties recovering after her medical treatment, and this compounded her feelings of helplessness and heightened anxiety that she was "*damaged*." Often collapsing into generalised hopelessness and helplessness, Sophie felt frightened and overwhelmed after her diagnosis; "*I don't know who I am."*

Similarly, her daughter's adolescence and its associated boundary testing behaviour activated an insecure sense of self as fragile, powerless and lacking in capacity for interpersonal relatedness. Her angry outbursts also scared her, "*I've no control and it makes me feel that I don't know how to handle things."* Judging herself as ill-equipped only exacerbated her fear, triggered by memories of depressive episodes in the past, "*It was horrible, I was constantly crying and wishing I was dead. I couldn't cope."* In the aftermath of her treatment, her physical experience of vulnerability (e.g. hair loss, fatigue, pain), generated further terror, "*I could just fall apart.*" Under the weight of her diagnosis, Sophie felt *"haunted"* and *"victimised",* stating that living with breast cancer *"drags me down, into despair."* She found her hormone therapy side effects (hot flushes, night sweats) particularly distressing, as a physical symptom that reminded her *"something is wrong with me"* which mirrored her maladaptive emotion scheme as defective and inferior. To the therapist, Sophie's difficulties were linked and perpetuated by not knowing how to soothe or take care of herself. Her breast cancer diagnosis also cut to the core of her anxiety on an existential scale, whereby she was terrified *"I could die."* Cancer related fears, including an intolerable awareness of her mortality triggered painful feelings of being alone and unsupported, which heightened her global, diffuse distress.

Negative Self-Treatment

Sophie experienced significant secondary fear and avoidance that blocked more primary emotions of assertive anger, sadness and vulnerability. Injunctions

against feelings included the sense of her anger being dangerous *"you will be too frightening, powerful, controlling [if you get angry]"* and her sadness as an intolerable sign of weakness for which she criticised herself, "*I'm a wimp…I need to cop on."* When she did express herself, an inner-critic dominated Sophie's self-view as defective and alienated from the world where she witnessed others enjoying themselves and her own experience as one of doleful struggle. Breast cancer unbearably felt like a confirmation of her shame based sense of being abnormal and corrupt; "*you are a bad person."* Her complex secondary emotional reactions created a vague sense of enduring bad feeling in her life, with which she was self-critical and dismissive; "*you just see the blackness in everything*." Often highly cognitive, Sophie felt she *"live[s] in my head a lot,"* to the point where she felt she could not sustain herself, "*sometimes I want to get a head transplant."*

Stemming from an atmosphere of dread and insecurity in her upbringing, she perceived feelings of vulnerability to be fodder for self-recrimination, "*you are too sad to be around."* Too much to bear, she rejected and disavowed the part of herself that felt sad and lonely, "*I'm ridiculous...stupid to feel like this."* Self-criticism, shame and inadequacy form part of her maladaptive emotion scheme triggered by the emotional toll of living with breast cancer, alongside longer standing perceived sense of failure in relation to her working life and role as a mother, "*I feel faulty*."

Sophie was particularly harsh around her relationship with her daughter, "*I'm a failure as a mother"* which was accompanied by despair and primary maladaptive fear/anxiety; "*it's just the most important thing and I don't want to mess it up."* Sophie's difficulty in showing herself compassion created a cycle where her self-admonishment resulted in her feeling chronically inept and struggling to meet standards.

Anticipatory Anxiety, Emotional and Behavioural Avoidance

Sophie demonstrated an awareness that sadness, grief, loneliness, and anger were all inside her but was avoidant and afraid to further process these feelings, fearing that she would be unable to tolerate these painful affects. Traumatic impingements in childhood inhibited emotional connectedness, and Sophie avoided loneliness and longing for intimacy primarily by evacuating and interrupting the connection to her core primary emotions within her emotion schemas, resulting in a paralysis of affective liveliness. Such alexithymic insulation was likely necessary for survival in childhood, however it also represents a secondary maladaptive shame process that saddles her with an intense dread of encountering unbearable and overwhelming affect.

Sophie developed a coping pattern of avoiding painful emotions by focusing external demands, constantly putting hours and hours into preparing coursework as a lecturer prior to her diagnosis and post diagnosis, ruminating how she would cope with returning to work. Her diagnosis activated a shame-based core pain that she was inherently damaged, and damaging to others in times of distress. Sophie's mitigation of these threats seemed to be a) behavioural, in that she was generally withdrawn in order to avoid criticism and ridden with social and performance anxiety, re-inspecting any tasks to the point of exhaustion and b) emotional in that she was constantly apprehensive and overwhelmed by panic attacks. Sophie's secondary interruption of emotions also included fear and shame; often laughing nervously when she became angry or contemptuous of herself in therapy, and she described that she found it *"strange"* and *"unfamiliar"* to express any form of compassion towards herself, which made it difficult for her to stay with her primary core emotions.

Core Emotional Pain

Sophie's emotional pain related to feeling unloved and inferior. With a shame based inability to feel compassion towards her wounded self, her difficulties were accompanied by a sense of loneliness. Sophie felt she needed more nurturance and support, but her defective sense of self, filled with shame, was dejected and hopeless about her own capacity as a *"weak person."* Sophie's core painful emotion scheme was dominated by *loneliness,* known from early attachment relationships, and affected by the lack of interpersonal connectedness in her adult life. Feelings of *shame/trauma* related to her experience of a speech impediment and bullying during childhood, and were re-activated by her breast cancer diagnosis which she experienced as a further indicator that she was damaged, and finally, *loss,* of a healthy and familiar body (i.e. post treatment weight changes, change in shape) and loss of a sense of womanhood that reinforced her defective sense of self.

Unmet Needs

Sophie's core unmet needs were for comfort, nurturance and validation from her mother and father, and she craved closeness, security and acceptance from significant others. Sophie also needed to feel validated and acknowledged both in her own family and in her family of origin as well as from the self. With regards to her feelings of fear/terror relating to her breast cancer, Sophie needed safety and protection as well as the strength within herself to face living with the illness into survivorship.

Transformation of Emotional Pain

The reflection of emotional transformation in the course of therapy is based on the therapist's reflections. Dominant in Sophie's presentation was an overarching sense of loneliness, which her inner critic deemed to be an intolerable sign of weakness. Often becoming angry and judgemental about her tearfulness when speaking about her breast cancer in initial sessions, her secondary anger protected her from staying with the needs associated with her primary grief in relation to cancer related losses. Consistent with other cases, Sophie often collapsed and submitted to harsh attack in chair dialogue. However, gradually she was able to both loosen her inner critic's contempt and hatred, with a more assuring recognition of her admirable *"hard work"* in her family and working life as being good enough. In turn, her vulnerable experiencing self was able to shift from submissive responding to more flexible self-assertive claims, which also facilitated her to express authentic needs for support and soothing in times of difficulty. Increasingly able to attend to her internal experience, Sophie's early experiences of herself as shameful, anxious and afraid as a child shared many parallels with her emotional landscape in the aftermath of her breast cancer. Her difficulty with self-soothing around these emotions largely stemmed from her harsh inner critic, and during her seventh session an imaginary chair dialogue with her mother was enacted to help restructure her sense of shame, however her experience of compassion and protective anger came in the context of unresolved unfinished business:

Therapist*: I want you to be your mother. So how do you feel towards her? The young Sophie. There's a lot there. Let those tears come…and how do you feel towards her? She's so frightened and desperate. And just feeling so unsafe.*

Sophie (enacting mother in imaginary chair dialogue)*: I wouldn't have wanted that for her.*

Therapist: *So I didn't want this for you. And it upsets me to hear, to see how you are.*

Sophie: *Because I loved you.*

Therapist: *Because I love you. And I didn't want this for you. I don't want this for you. And I'm so upset to see how this was for you.*

Sophie*: Yeah I've had done something about it.*

Therapist: *It's like it hurts me to see you like this. Because I love you so much. Can you say that? It's just so painful.*

Sophie: *I hate seeing you like this. Because I love you so much.*

Therapist*: Does that fit?*

Sophie: *Yeah.*

Therapist: *Can you come over here? So what's it like to get that? To hear that as a young girl.*

Sophie: *Eh. Yeah. I know it. I know you love me. And she was a great mother.*

Therapist: *So really look into her eyes and say yeah I know you love me.*

Sophie: *I know you love me. You're a great mother.*

Therapist: *But there's something else there?*

Sophie*: Yeah it's just that there was…(but you should have)…yeah [protective anger appearing here].*

Therapist: *Yeah it's like I know you love me but you should have noticed.*

Sophie: *Yeah it was. Yeah you were always there for everything else. But for just the one huge thing.*

Therapist: *You weren't there for me. If you weren't so busy with work…*

Sophie: *Yeah probably.*

Therapist: *You would have noticed me. So can you really look into her eyes and say you should have noticed what was going on.*

Sophie: *you should have noticed what was going on with me.*

Therapist: *So I hear that you love me, but I was struggling. It wasn't enough. You should have been there.*

Sophie: *Yeah.*

Therapist*: I was just so small. It's like…*

Sophie*: I suppose…you let me down.*

Therapist: *Can you tell her again.*

Sophie: *You let me down.*

Therapist: *What does it feel like to say that? Does it fit?*

Sophie*: Yeah. I deserved better, especially when I was so young.*

Therapist: *I should have been protected. And no it's just even so hard saying what I needed. I needed to be protected. I needed you to protect me. Can you tell her that?*

Sophie: *I needed you to protect me and keep me safe.*

Therapist: *You slipped up.*

Sophie: *Yeah you did with that.*

Therapist: *Can you come over here? Now as the mother in your head, what's it like to hear that? I needed you to protect me.*

Sophie: *It's killing me.*

Therapist: *It hurts like…*

Sophie: *Because I would have done anything for them…for you.*

Therapist: *I should have done it for you. I was just so busy…and consumed with work.*

Sophie: *I don't know how I missed it.*

Therapist: *But I just did. I'm sorry…*

Sophie: *(tearful) Yeah, I'm sorry.*

Therapist: *Can you say that to her again.*

Sophie: *I'm sorry I missed it. I'm sorry you went through all those years (crying) [experiencing and expressing compassion].*

Therapist: *I'm sorry for the impact this had on you.*

Sophie: *yeah I'm sorry you were affected.*

Therapist: *What's it like to say that? Does it fit?*

Sophie: *Yeah. She would have been very distressed if she knew.*

Therapist: *[speaking as if mother]. I'm sorry these things happened. But it's not your fault. Everything you went through. Can you say it's not your fault?*

Sophie: *It's not your fault. You were so young. I should have been there. I should have protected you.*

Therapist*: And I'm so sorry*

Sophie*: I'm sorry I didn't do that.*

Therapist: *Can you come over here? (client changes chairs). What's it like to hear those words inside you.*

Sophie: *I suppose…yeah…(sighs)…it's nice I suppose. Yeah.*

Therapist: *Can you take those words in?[encouraging Sophie to let in compassion]*.

Sophie: *I think so yeah. It doesn't turn back time though does it? [Sophie still touching on hopelessness]*.

Therapist: *Can you tell her that? It's good to hear those words but it doesn't turn back time. [the therapist respects the hopelessness]*.

Sophie: *It doesn't stop the years of pain I went through.*

Therapist: *Tell her what you need now.*

Sophie: *Umm…*

Therapist: *Is it helpful to hear those words it's not your fault?*

Sophie*: Yeah.*

Therapist: *It's good to take in those words but it's still so hard thinking about what happened.*

Sophie: *All those horrible feelings. [grieving the past pain]*.

Therapist: *Can you come over here. (*client changes chairs*). As your mother, how do you respond?*

Sophie: *You are not inferior. You are not worthless. You never were (*tearful) [more compassion coming from the enacted imagined mother*]*.

Therapist: *It hurts me to see you in pain. And that's why I missed out on it because you were so strong.*

Sophie: *Yeah*

Therapist: *It was nearly hidden. That's how strong you were.*

Sophie: *Yeah. Yeah.*

Therapist: *And that tells me how strong you were. So tell her how strong she is.*

Sophie: *Yeah you were strong, yeah. I always felt you were strong. [*as imagined mother validating the self*]*.

Therapist: *And maybe that's why I missed out, because you were so strong.*

Sophie: *You were so strong and capable.*

Therapist: *You must have been strong to get through it alone. It's like I'm so proud of you. Does that fit?*

Sophie: *Yeah.*

Therapist: *Can you tell her that? I'm so proud of you for taking all of this on your shoulders?*

Sophie: *I'm so proud of you. You did a lot. And I missed a lot.*

Therapist*: I missed out, but I also wish you shared it with me. You aren't at fault. But you took on so much yourself.*

Sophie: *Yeah (*crying*). Yeah you did. You did well.*

Therapist*: You did so well. But I'd like you to really reach out in future. Reach out.*

Sophie: *Yeah don't be hiding stuff because it doesn't help.*

Therapist: *So try not to tuck away all that pain.*

Sophie: *Yeah, it's better to share it.*

Therapist: *Can you tell her, you are not alone.*

Sophie: *You are not alone. [*more compassion coming*]*.

Therapist: *And I'm so proud of you.*

Sophie: *Yeah.*

Therapist: *Is it hard to say those words? Can you come over here?* (client changes chairs*). What's it like to hear those words? I'm so proud of you? What does it feel like to take that in?*

Sophie: *It feels good yeah.* [letting the compassion in].

Therapist*: So tell her…*

Sophie: *It's good to hear that.*

Therapist*: What's happening inside you now?*

Sophie: *I wish you could have told me sooner (*sobbing).

Therapist: *These are the words I needed to hear. And it's just so sad. What I missed out on. Can you tell her, I longed for these words?*

Sophie*: I wanted to hear them so much.*

Therapist*: I deserved to hear those words.*

Sophie*: I deserved to hear those words. You should have…what's the point in thinking those words if you didn't say them.*

While there was an emerging sense of assertive/protective anger and an ability to articulating needs for recognition and acceptance, Sophie's assertive anger often reverted to rejecting anger. Anger was fleeting in its expression across multiple dialogues as assertive and self-protective, largely not tolerated for long enough to be transformed. More often than not, she would express herself primarily by rejecting anger with close others who offered compassion or made gestures towards requesting forgiveness in the chair (imaginary) dialogues. Expressing her feelings of entitlement with healthy anger seemed difficult for Sophie, and appears to stem in this instance from a fear that overt anger would carry her to situations where she would lose control over herself or act in a way that might be hurtful. Consequently, letting go of passed unmet needs were only partially savoured. For example, during her 15th

session of therapy, Sophie expressed compassion towards her experiencing self, however she also exhibited features of avoidance, partially distancing herself or laughing after self-soothing statements:

Therapist (addressing the experiencer self from the point of view of the inner critic): *So how do you feel towards her when she's saying she has suffered for so long?*

Sophie (speaking from the inner critic): *I know, I can see that yeah. (critic softens)*

Therapist: *I can see you have been suffering.*

Sophie: *I can see that, being with you all the time. I've seen you struggle.*

Therapist: *How do you feel towards her? With how she has struggled and how she is struggling now.*

Sophie: *I suppose I feel sympathy and I wish it was different.*

Therapist: *So I want things to be different for you. Can you tell her that?*

Sophie: *I want things to be different and for things to change for you.*

Therapist: *I want the best for you.*

Sophie: *I want the best for you and I want you to be happy.*

Therapist: *And I want to help.*

Sophie: *And I want to help. I want to help you change and get better.*

Therapist: *I care for you.*

Sophie: *I care for you.*

Therapist: *What's it like to say that, I care for you?*

Sophie: *Hah it's strange.* (deflecting compassion)

Therapist: *Strange to say I care for another part? Just say it. Say it again. I care for you.*

Sophie: *I can for you. Its weird.* (Distancing from caring feelings)

Therapist: *Can you come over here? (Sophie changes chairs). What's it like to get those words from that part of you? What's it like to hear those words?* (Therapist probing for compassion being let in).

Sophie: *Yeah it's nice.*

Therapist: *Can you take them in? Can you allow them in? Just allow them to stay and really kind of sit with them. Can you tell her, it feels nice.*

Sophie: *It feels good, it's nice to hear them. I haven't really heard them before.*

Therapist: *And it's nice to hear them from you.*

Sophie: *It's comforting.*

Therapist: *Tell her it's comforting, it's good.*

Sophie: *It's comforting, it's good to hear them.* (Acknowledging some soothing stemming from compassion).

Therapist: *So it's like I really want to take it in.*

Sophie: *There is a bit of hope there I suppose.*

Therapist: *So it makes me even more hopeful. Tell her that.*

Sophie: *It makes me hopeful that you'll support me and not be fighting against me. It's good to hear you care.*

Therapist: *What's it like to say those words?*

Sophie: *Hah. It's nice.*

Across the sessions but particularly towards the end of therapy, a more soothing relationship to herself began to be accessed, and she could demonstrate self-directed

compassion, stating in her 17th session, "*"I care that you are hurting."* The therapist validated Sophie across dialogues and sessions when she recognised and acknowledged a sense of entitlement to have her needs met, in particular with her sense of having been wronged by exclusion and rejection as a child, *"I suppose it's okay to be upset. Nobody said that to me back then. I've carried it all along."*

Increasingly, Sophie was able to acknowledge her own deprivation and pain and disclose her vulnerability to her husband in the imaginary dialogues, who responded with compassion, facilitating her to attend to her need for contact and comfort in her current life. His ability to provide reassurance and soothing helped ease the fear she felt associated with her cancer, and reduced her distress. Unmet needs relating to her upbringing continued to be expressed across unfinished business dialogues in session; *"I needed a lot more hugs. I needed to be told I was loved. That I mattered,"* with the acknowledgement *"you are important."*

Sophie's harsh internal critic was more difficult to transform. While she could take in compassion from her husband towards the latter therapy sessions, her fear of *"exposing"* her own perceived defectiveness remained a source of self-directed judgement and invalidation, *"you can't hide...but if you expose yourself, bad things will happen. It's all bad."* Sophie was able to stand up to her critic in brief moments of the imaginary chair dialogues (*"you aren't helping, you are ridiculous to say that to me"),* but continued to collapse into hopelessness and global distress *"this is such a burden"*, more in contact with rejecting anger *"you are nonsense, full of rubbish"* but unable to connect with the protective anger and consequent agentic self that would inoculate against feelings of self-deprecation, and lead to a sustained sense of empowerment. Nonetheless the therapist offered protective anger and validation as well as significant others in unfinished business dialogues, and Sophie's increased

resilience and sense of self-assertiveness was reflected in her expressed entitlement that an apology was owed and deserved in her family of origin. Partially stemming from her experience of primary sadness over painful events in childhood and letting in newfound compassionate self-soothing, she was increasingly able to loosen her harsh inner criticism with regards to her own parenting. Ensuing imaginary chair dialogues with her daughter facilitated her to access further self-assertiveness (buffering her inner critic) and build the resiliency needed to acknowledge her strengths as a parent, make amends for herself, and vow to become a better parent as she developed self-reassurance and more compassionate understanding of her experiences in times of difficulty.

Sophie did capitalise on repeated dialogues where she accessed compassion from significant others and herself, which helped her soothe her core painful emotions of feeling worthless and defective, and experience adaptive responses including being protected, cared for and loved. With a newfound sense of security, Sophie's self-doubt decreased significantly, and she was able to *"see hope for the first time"*, particularly as she began to share more of her emotional experience with her husband and she was responded to with acceptance and love. Towards the end of therapy Sophie continued to collapse into global distress, but she was better able to allow space for the possibility that she was deserving of love and support and became more adept at pursuing meeting of her own needs in terms of her communication with others and self-care. Perhaps illustrative of her gains through therapy, towards her final sessions Sophie reported a major shift in her life whereby she described for the first time sensing hope and 'light' for the future with an inner confidence that she would continue on the journey towards more adaptive and flexible emotional well-being.

3.3.3 Measures

3.3.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Sophie's scores are presented for pre-, mid-, post-therapy and at six month follow up in Table 3.3.1.

Table 3.3.1

Sophie's Pre-Post Outcome Scores

Scale	**Caseness**	***RCI***	**Pre-Treatment**	**Mid-Treatment**	**End of Treatment**	**6 Month Post**
HADS	11	3	24	26	4	11
Anxiety			14	13	2	7
Depression			10	13	2	4
FACT-G	78	17	66	51	86	74
SCL-90-R GSI	0.8	0.19	1.11	1.05	0.43	0.47
DERS	78	16	110	102	59	57

Note: Caseness= the cut off for determining whether the client is clinically distressed. FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; HADS= Hospital Anxiety and Depression Scale; DERS= Difficulties in Emotional Regulation Scale.

At the beginning of therapy, Sophie's score on the HADS was 24, indicating that she was in the clinical range for CAD. By the mid-point of therapy her score increased marginally to 26, indicating she was experiencing slightly more distress and greater symptomatology of depression and anxiety. By the end of therapy, her score had dropped to a score of 4, with a pre-post differential of 20 indicating clinically significant and reliable change (Jacobson & Truax, 1991). Her six month follow up

score of 11 indicates that her score on this measure had slipped back to 11, which would place her again in the clinical range for CAD on this measure, indicating deterioration and negative reliable change post therapy.

During her pre-therapy assessment on the FACT-G, Sophie's score of 66 suggests that she rated her quality of life as poor. By mid therapy her score of 51, consistent perhaps with her greater indication of distress on other measures, continued to decline, indicating a worsening of subjectively perceived quality of life. By the end of therapy she scored her quality of life at 88, demonstrating improvement and reliable and clinically significant change (recovery) (Jacobson & Truax, 1991) had occured. At six month follow up, her score of 74 shows that she maintained improvement and reliable change from her original score.

Sophie's pre-therapy score on the SCL-90 of 1.11 placed her in the clinical range of clinical distress and symptomatology on the global severity index. By mid-treatment Sophie's score had reduced to 1.05, which suggests improvement, although she remained in the clinical range on this measure. By the end of therapy Sophie's score had dropped significantly to 0.32, which indicates reliable and clinically significant change (recovery) (Jacobson & Truax, 1991) on this measure. The dramatic fall was mostly maintained at six month follow up post therapy, with a score of 0.47 indicating that she remained below the clinical range, which differed from her clinical score on the HADS by comparison.

Sophie's score on the DERS at the beginning of therapy was 110, suggesting that she struggled with emotional awareness and regulation. Her score dropped to 102 by mid-therapy, and continued to demonstrate she had improved on the measure by the end of therapy with a score of 59 that demonstrated reliable and clinically significant change (recovery) (Jacobson & Truax, 1991). At six months follow up her

score of 57 suggested she maintained an improved sense of quality of life in relation to her cancer.

Target Complaints (TC)

Prior to each therapy session, Sophie completed a Target Complaints form. The information provided by this measure is presented in Table 3.3.2.

Table 3.3.2

Sophie's Target Complaints Data

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post-Therapy**
Tiredness and Lack of Energy	10	4	4
Making Life Changes/Need Change	8	7	3
Relationship with Daughter	10	7	5
Relationship with Husband	8	6	4
Sadness	8	6	4

It is notable that Sophie's primary target complaints are reflective of the sense of stuckness with which Sophie enters therapy, and the identified target of "*making life changes/needed change*" also suggests a wish to utilise her cancer experience is some way to harness desired growth. Sophie's scores drop considerably from pre- to mid-therapy, and again at the end of therapy. What is observable is that Sophie's scores in relation to her target complaints of her interpersonal relationships with her husband and daughter decrease the least across the course of therapy, staying in the mid-range, suggesting this complaint was still quite problematic for her by the time therapy concluded. Post therapy, Sophie scored her compaints are broadly improved but remained relevant and important to her.

3.2.3.2 Analysis of Process Measures

Helpful Aspects of Therapy (HAT)

In common with other participants, Sophie was asked to fill out a Helpful Aspect of Therapy form, the data from which are presented in Table 3.3.3).

Table 3.3.3

Sophie's Helpful Aspects of Therapy form Data

Session	Helpful Event	What made it helpful	When in session?	How long did it last?
1	Talking about loneliness	I realised I deal with a lot of issues on my own.	Towards End	5 minutes
2	Everything	That I must stop giving out to myself and be kinder.	Whole session	50 minutes
3	Talking about the changes cancer has brought about.	I've been reading a lot about diets and anti-cancer measures and trying to do a lot of changes. I must slow down and make gradual changes.	Midway	30 minutes
4	When I realised that I never felt I mattered when I was younger.	I realise I have to be my own support, that I do matter.	Whole session	50 minutes
5	When I was specific with what I need.	If I'm specific with the details then maybe results will follow.	No data	No data
6	Saying unhelpful things to myself does not make anything better.	That I have to have me on my side, I have to care about myself	No data	No data
7	I must support myself to get stronger.	I have to be kinder and more gentle with myself	No data	No data

8	I need to remind myself that I am doing a good job as a mother, that I have a good relationship with my daughter.	Because I always seem to focus on what is going wrong and not what is going right.	Whole session	50 minutes
9	Talking to my mother.	That I didn't share my thoughts with her in case I'd be a burden.	Most of session	Most of session
10	Talking to the young girl that I was.	I told her what she needed to hear at the time, and I need to remind myself of that.	Midway	30 minutes
11	The conversation about my behaviour when Carol was growing up.	It’s something I've been thinking about on and off for years. I have to chat to her about it.	Most of session	Most of session
12	Talking about making decisions.	I don't make decisions lightly, so I have to trust and believe that they are right and not doubt myself.	Midway	30 minutes
13	Talking to and seeing things from my daughter's point of view.	My daughter's words don't necessarily imply that things are my fault. I need to focus on what she is feeling at the time. I realised I'm tired of dealing with problems, sometimes I need a break.	Whole session	50 minutes
14	When we discussed how I deal with a lot of stuff on my own.	Support and help doesn't have to be physical or involve action, understanding and words of encouragement can help.	Whole session	50 minutes
15	Talking to my "burden", how it affects me.	I need to talk about me more often to my husband, to help him understand what is going on.	Midway	30 minutes

16	Dealing with my sense of worthlessness. Talking through emotions with my mother.	My sense of worth and inadequacy has been ongoing and goes back a long time.	Most of session	50 minutes
17	To remind myself of my value and worth when situations become tough.	When I begin to feel overwhelmed with emotions, I need to hang onto something to keep me solid.	Whole session	50 minutes
18	Teasing out the conflict inside with my husband.	There is no right or wrong way to feel, if I need support or reassurance, then I must talk and ask for it. Talking about my feelings and how to deal with them.	Midway	30 minutes
19	We recalled a lot of what I learned over the sessions. They were all important.	A reminder of things I must continue to do.	Whole session	50 minutes

In Sophie's HAT initial session forms she identified the process of talking and self-expression as helpful, becoming aware of isolation with difficult issues prior to entering therapy, and the degree to which her inner critic impacts her. This awareness was followed in subsequent sessions 3-7 with acknowledgement *"I do matter"* and came with increasing self-directed compassion; *"I have to be on my side"* and that it mattered to *"to be gentler with myself."*

In Sessions 8-10, Sophie's engagement with imaginary dialogues for unfinished business involved speaking about difficult childhood experiences that included helpfully asserting her needs and validating her right to speak about issues with significant others. In Session 12, Sophie focused on her feelings of worth and its impact on her decision making, recognising the value in *"trust[ing]"* that her abilities extended beyond her capacity to doubt herself. The realisation that she *"need to give*

myself a break" and that support and encouragement from others would help her to further establish her emerging confidence were commented upon in Sessions 13-15.

Acknowledging the depth and long standing nature of her painful emotions was identified as helpful in Session 16-20 in so far as it helped Sophie to begin to address ways to look after herself in times of overwhelming emotion, including seeking support and reassurance. In her final session, reflection over the entirety of her learning within therapy was seen as a helpful way to finish.

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

At her end of therapy interview, Sophie felt that she found therapy of benefit, and identified a significant change as *"my self-talk; because of really how important it is, how powerful it can be."* She described the shift as a kind of felt sense, integrated into her experience of herself, the difference, she felt, between "*knowing about it versus knowing it."* Sophie attributed the change in her self-talk to the chair work in therapy, as it fit for her experience of her self-treatment, *"I always seem to be fighting with myself but you can always work it out when you have the chairs. It's more tangible."* Through the repeated dialogues, there was an increased experience of clarity over her feelings as well as a recognition of the power of words to evoke feeling.

When asked about personal strengths which may have contributed to her ability to engage in therapy, Sophie felt that her hard working, obliging, conscientious character was part of what supported her to undertake therapy, and she emphasised that these qualities were helpful in her approach to her difficult relationship with anger, and its impact on her close interpersonal relationships, specifically with her daughter. At this point, Sophie was pragmatic about her increasing emotional

awareness, cautious to overstate it beyond an emerging capacity to tolerate strong emotion, "*I still get tearful a lot, and I still have [angry] outbursts but I'm working on it. It's still an emotional reaction but now when the emotion comes I can think about it. And it doesn't last as long."* With an increased capacity to experience strong emotion, Sophie can regulate her own arousal and describes a meta-awareness that is strengthening in her estimation.

The weekly sessions were also described as being a vital part of increasing her self-reflectiveness, a change she felt would never have taken place without therapy. Sophie described how she experienced a newfound inquisitiveness in relation to her life experience, feelings and responses, suggesting an overall increase in self-awareness; "*I'm putting a lot of thought into thinking about stuff I never would have really."* This was also identified as an unfamiliar experience that she was developing her skillset around, highlighting the role of the therapist in helping he label her emotions, "*I think she puts a lot of work into finding the words for me. And I think that's because I've never done it before and nobody's ever asked me. So I'm learning. I'm getting to know myself, which is strange saying that at this stage."* There is a sense of painful regret with how she treated herself in the past, "*I never tuned into myself…I've always just put it to one side and carried on. I don't think I really knew who I was (tearful)."* Sophie's sense of grief filled compassion extends to and shapes her perceptions about the life she was leading pre-diagnosis, partially attributing self-blame but also articulating sadness about her self-treatment in the past "*I think my immune system couldn't cope being constantly under stress and I gave myself cancer so I had to change."* She cites her *"anger and negativity as a work in progress*", however equally noted that she has made significant changes in terms of what she is

doing outside of therapy based on her experience of increased capacity for self-care, *"I'm doing things that are a time out for myself. I'm trying to do stuff for me."*

When asked if there was anything she found difficult in therapy but possibly helpful in the long run, Sophie described finding the sessions exhaustive; "*it's draining, you get a bit wrecked…but it gets me thinking."* Seemingly, the benefits of the work outweighs the impact on her energy levels. Asked if there was anything she felt was missing from therapy, Sophie demurred, *"I don't think so because I don't know any better."* Perhaps indirectly, she did highlight her own tendency to question her own answers, offering that amongst her therapists' most helpful interventions was to offer a space for a more exploratory approach to understanding, less concrete but also more empowering as a result; "*I felt I'd been looking for answers all my life and she said well maybe there are no answers and that helped me a lot. I was looking for a set of instructions, a, b, and c, and it's not as simple…it's hearing things like that as well that's also helped."* She did elaborate that she felt the gains from therapy were motivating, and that taking courses on self-care and reading self-help books were part of her further plans to develop a deeper understanding of how to sustain her own emotional well-being.

3.4 Case Study 4, Laura

3.4.1 *Introduction*

Laura is a 50 year old female Caucasian who was referred to the Psycho-Oncology department by her radiation oncologist. The stated reason for referral by the medical team was documented as feeling overwhelmed, emotional and fearful about the future. Initial intake indicated that Laura was demonstrating symptoms of depression and anxiety in relation to managing home related stress, returning to work

post treatment and her long term prognosis. Consequently, she was invited to participate in the study. Laura engaged in 15 sessions of psychological therapy with the Principal Investigator of the research study, who was experienced using an emotion focused therapy approach

Laura is married and the mother of two children, one of whom has a learning disability, the other of whom was being assessed for learning difficulties and was being seen by local services for low mood nearing the end of Laura's therapy. Laura was on medical sick leave at the time of participating in the study as a result of her breast cancer from her employment in healthcare. Her treatment for Stage II/III breast cancer with metastatic deposits in her lymph nodes included breast conserving surgery (lumpectomy), alongside systemic treatment of chemotherapy, radiation therapy, and hormone therapy. Her family of origin had a history of cancer but no history of breast cancer specifically. Laura had a history of major post natal depression after the birth of each of her children and she had taken periods of stress leave from her work in recent years. Laura had taken an anti-depressant after the birth of her second child, which she discontinued. At the time of participating in the study, she had a prescription for an antidepressant from her GP but decided against taking it for the stated reason that she wanted to avoid becoming "reliant."

Prior to commencing therapy, Laura completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Major Depressive Disorder with Anxiety Disorder NOS, including symptoms of sub threshold General Anxiety Disorder and subthreshold Panic Disorder. Her score on the Hospital Anxiety and Depression scale was 26. Laura also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met

the diagnostic criteria for Depressive Personality Disorder and met the subthreshold criteria for Obsessive Compulsive Personality Disorder.

3.4.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective: General Impressions

The therapist believes that the therapy progressed consistently well in this particular case. Initially, Laura presented with a great deal of anxiety, often holding significant muscular tension and describing recurring migraines and sleeplessness. Her fear that significant episodes of high stress in her life had contributed to her developing breast cancer in part motivated her reason for attending therapy, and these attributions (implicitly self-indicting) were addressed in the context of EFT as part of a harsh process of directing blame upon herself. While Laura outwardly presented herself as capable and adept at handling challenges, her decision to enter therapy was one she privately felt was overdue in the context of her adult life history. Across the sessions, Laura was reflective and showed herself to be a thoughtful and caring woman who had often put the needs of others first, but her capacity to make the most of her sessions in therapy established her growth psychologically during her cancer journey as she put her own needs forward.

Interpersonally, Laura was somewhat reserved and the stress associated with her emotions was more familiar to her than her direct primary emotions. Broadly, Laura characterised feelings of isolation and secondary frustration by a perceived lack of support within the nuclear family as a central issue for her. The therapist felt there was a good alliance fostered by the acknowledgement that Laura used few words to

capture her feelings, and there was a lot going on inside beneath the surface that others often missed which may have been contributing to her feelings of being alone. The therapist had the sense that Laura's cultural upbringing may have contributed to her reserved presentation, an understanding which was corroborated by Laura towards the end of therapy when she reflected on her country of origin, its social value on emotional restraint and influence on her interpersonal style. This exchange between therapist and patient seemed important in terms of acknowledging and valuing the disclosures Laura did make in the context of her breast cancer with the therapist, particularly in terms of sensitive topics such as the changes in her body and lack of intimacy in the marriage as contributing factors to her feelings of isolation prior to and after her diagnosis and treatment.

Increasing humour and engagement with resuming social activities and making a graduated return to work as the therapy came to a close demonstrated the gains Laura had made through attending therapy as part of the research study. By the end of therapy Laura reported improvements in her capacity for assertiveness, which benefitted her interpersonal relationships and gave her a greater sense of self-efficacy and agency in navigating future stresses.

Case Formulation

Triggers of Emotional Pain

The analysis of Laura's case formulation is based on the reflections of the therapist. At the initial intake, Laura described feeling over-burdened and overwhelmed by daily life since the time of her breast cancer diagnosis. Initially, Laura experienced secondary maladaptive fear in relation to feeling stressed, blaming herself for her breast cancer and ascribing prolonged periods of high stress as a

working mother of two adolescent children and a number of traumatic family events since their birth as contributing factors.

Laura spoke of triggers that were both recent and related to her upbringing in her family of origin. In terms of Laura's core pain, her childhood experience was of failing to meet the standards set by her siblings who excelled academically. Missing out on the praise and attention she saw given to her brothers and sisters left Laura feeling devalued and alone. Her father's loss of employment prompted Laura to become "*an adult too early,*" wherein she learned to portray herself as stoic to avoid burdening others with her pain, and felt the pressure to keep appearances and depict pride in the face of the family's loss of status and security.

Triggering events in Laura's adult life included post-natal depression following both childbirths, the life threatening acute sickness of her newborn second child, and a close friend of the family criminally convicted of CSA. Often left to cope on her own, Laura experienced a sense of abandonment from her husband. Her husband was unable during difficulties to apprehend Laura's distress and was often intimidating and dismissive. She described never feeling fully accepted with her family in law, and characterised a critical and rejecting mother in law, leaving her ostracised from two families and with a strong theme of being disproved of. Without that emotional support, Laura experienced these events as sources of painful disconnection that left her feeling insecure, alone and defective.

More recently, Laura had been working in a high stress and fast paced health setting, and prior to her diagnosis she was demoted from a management position that had shaken her confidence and left her doubting her competence. She attributed the development of her breast cancer to high stress and her failure to cope. To Laura, her cancer signified an internal threat, different to the past external threats that would

have overwhelmed her. Her sense that her body was unsafe within her environment and inwardly contributed as a trigger that evoked feelings of terror and shame.

Global Distress

Laura's hopelessness and helplessness was expressed in emotional numbing and avoidance of the extent of her difficulties. Across the initial sessions, Laura spoke of how her cancer treatment left her feeling isolated, fearful and angry. Laura's low expectations modulated some of her upset most of the time, however in times of need, she would react to rejected bids for attention with outbursts of secondary anger that were sudden "*like a volcano*" and would destabilise the entire household, leaving others walking on eggshells. Rather than garner a response, Laura's outbursts rendered her less effective at establishing a more equitable parity of labour around chores to do with the household, and further distanced others from relating to her.

The marriage was described as distant and tense; "*we are worlds apart."* Laura characterised her marriage as strained since the birth of their children, and hopelessness also defined her sense of the relationship's capacity to be different, which she coped with by minimising her needs for intimacy and closeness. Hurt feelings after losing her belief that her husband could be depended on for emotional comfort were internalised at a high cost; "*rather than risk you really knowing me when I'm hurting or sad or scared- I will sacrifice myself."* Laura's presentation demonstrated how shame inhibits the feeling of being loved, however these more primary feelings of core pain were out of awareness. A maladaptive coping strategy of collapsing into hopelessness meant Laura's needs went unexpressed; "*I'm scared I'd just get annihilated inside if I got rejected one more time so I stop myself from even trying.*" Instead Laura focused on attending to the needs of others, completing all

of the household chores, managing finances and doing all the family organising on top of her working role. Laura offered a visual image of her self-interruption and avoidance of core pain, *"a pressure cooker, you [I] have no option, just secure the lid…"*

Negative Self-Treatment

In terms of her relationship with herself, Laura was self-critical and subsequently collapsed into feeling helpless, with a tendency to comfort eat when upset. Perceiving herself from a young age as unable to match her siblings' accomplishments and as a result, unworthy of the same love, acceptance and attention, Laura was self-critical and dismissive of her own needs. Her cancer highlighted the family's reliance on her as the nurturer, disciplinarian and organiser within the family, and she conceded to appearing invulnerable and stalwart. Expectations Laura placed on herself involved a tremendous amount of responsibility for others; "*I didn't want the children to be aware of how low I was, because they wouldn't be able to cope, and my husband wouldn't cope- he would probably fall apart. So I had to stay together….stay together. Because it was like being the lynch pin. The flag pole. I was always the flag pole."*

Inwardly, Laura held *"a fear of falling apart,"* and this vulnerability *("others see me losing it")*, saddled Laura with the sense that she was to blame for her children's current ongoing behavioural and learning difficulties in school, creating a sense of guilt and further evidence for self-directed recrimination. Laura also blamed herself for her breast cancer, attributing it to years of high stress, which brought urgency to longstanding feelings of strain, resentment of close others and a feeling of being unprotected.

Anticipatory Anxiety, Emotional and Behavioural Avoidance

In the early stages of therapy Laura experienced anxiety and worry about incurring additional stress and responsibility, which stemmed from her belief that stress caused and would increase her likelihood of recurrence. Laura's over-exertion in order to meet the demands of running the family household as well as adjusting to her own cancer diagnosis and the recovery post treatment meant that she was in a chronic state of worry that she was putting her body in danger. Irritable and exhausted, Laura would pursue other family members to contribute to household chores, and the pursuit cycle around practical matters (avoidance) meant that primary, emotionally based concerns remained unacknowledged in the family.

Scanning behaviour for tasks that needed to be completed in the family home would often make others defensive. Their defensiveness in response to her anxiety would increase Laura's anxiety even more, escalating her need to be reassured (around the impact/danger she perceived around stress). Her anxiety would trigger secondary anger, and Laura expressed her worry with secondary anger. The vicious cycle was paralysing for Laura; "*I think it will do damage."* Her husband and children reacted by withdrawing even more from practical and emotional support.

Coping by withdrawing and emotional distancing historically, Laura had avoided more core painful emotions of abandonment, rejection, loneliness and shame and was primarily in a state of hopelessness that felt unfulfilling and empty. Her strained relationship with her in-laws, where she perceived herself to be devalued and demeaned similarly left with a sense of ineptitude. Feeling judged and criticised for her behaviour, Laura felt she had to put on a façade to hide her shame, which over time, left her brittle and prone to outbursts of maladaptive anger or silent withdrawal

and collapse into hopelessness. Laura described how she often found painful emotion to be *"more than I could face"* enduring by *"swallowing it and getting on with things"* which left emotional ruptures unresolved and a wake of distrust and unacknowledged resentment.

The experience of suppressing her feelings was described as "*a lead weight in my chest"* and was linked to traumatic events where she felt abandoned, alone and unsupported within her marriage and as a mother. Maladaptive avoidance meant Laura often faced chronic feelings of hopelessness and despair that "*nothing would ever change*." These emotions were compounded since her diagnosis, where her existential fear and awareness of her own mortality added to her sense of vulnerability and heightened her need for response and acknowledgement of her more primary feelings of being unloved, lonely, fearful and ashamed.

Terrified of strong emotions, which she associated with losing control, Laura avoided her primary emotions which were experienced as intolerable and associated with a deep rooted fear of psychological collapse. As stated in her target complaints form Laura was overwhelmed by the threat posed by her illness, and constant apprehension created bodily tension and exhaustion that added to the challenge of recovery post radiotherapy.

Core Emotional Pain

Underlying core pain across her childhood and adulthood was the sense that no matter how hard she tried, she was not good enough and would never measure up. Her breast cancer diagnosis served as further evidence for her harsh inner critic that she was defective and would never be worthy of the same celebration and pride given to her siblings in her family of origin. The core painful emotions underlying her depression and anxiety were feelings of invalidation and abandonment. Laura's core

emotion scheme was described as being dominated by the sadness of *loneliness,* connected to putting on a brave face for others, feeling ostracised and dismissed in her family of origin, with her in-laws and in her own family, *shame and trauma,* related to perceived abandonment and invalidation in her marriage during acute crises that left her feeling unloved, her experiences of stress leave during her career and subsequently step down from the leadership role, and the perception that she had brought her breast cancer on herself. *Loss* added to her core emotion scheme in the aftermath of her breast cancer, including loss of bodily parts, bodily scarring and her sexual self.

Unmet Needs

Laura's unmet needs included the need to be recognised, loved and appreciated. Her core emotional pain of shame, loneliness, trauma and loss, previously unprocessed, left her feeling disconnected and hopeless regarding the future, with fears of further breast cancer recurrence. Expressing her feelings of emptiness and loneliness within chair (imaginary) dialogues across therapy sessions spoke to the depth of her sadness and her unmet needs for closeness and support within her marriage, in her own family and her wider family by marriage. Within her marriage, her experience of fear related to verbal attacks and withholding behaviour evoked needs for safety and predictability, and the shame incurred from this dynamic also called for respect and validation of her own right to boundaries and self-assertion.

Emotion Transformation

The account of emotion transformation is based on the therapist' report. While Laura's dominant presentation of global distress was characterised by a sense of burden, and a fear of stress and anxiety, Laura's underlying core pain was of feeling unloved, and involved a longing for connection beneath the shame of (self-perceived) inferiority. Emotionally evocative reflections and empathic responses from the therapist served to encourage Laura to communicate her internal feelings. Underlying her awareness of stress stemming from the household dynamic and her accompanied fear that a return to work subsequent to medical treatment completion for breast cancer would result in a similar sense of being over-burdened and under-recognised/valued and increase her likelihood of cancer recurrence were profound feelings of loss. Laura grieved the loss of a healthy body and of her sexual self.

Initially, Laura's distress made it difficult for her to elaborate on her emotional experience, and the therapist' identification and permission to disclose and explore her emotions was modelled in relation to her sense of being unsupported and the associated feelings of sadness, loneliness and disconnection. As therapy progressed, Laura developed reflective awareness of the responsibility she took on in caring for others, and that tension created across her relationships was perpetuated by the constant pressuring of a harsh inner critic that viewed her own needs or vulnerability during difficulty as "*silly."* Laura gained flexibility in responding to her inner critic through imaginary chair dialogues where she was able to recognise the negative impact of such criticism and in kind, stand up to that criticism and assert that her feelings were connected to valid needs and important limits. Core feelings of pain from her experiencing self stemmed largely from betrayal, whereby Laura's experience of relying on others had resulted in traumatic betrayal or abandonment

(e.g. family friend accused of CSA, husband prioritizing work during life threatening hospitalisations of the family, family's minimisation of her breast cancer diagnosis). Her subsequent chronic experiential avoidance (bodily constriction, self-disparagement, going numb) was the cost of controlling her feelings of worthlessness stemming from these traumatic events.

In order to facilitate emotion transformation, imaginary chair dialogues were employed across the therapy sessions. Specifically, using chair dialogues for unfinished business with her imagined husband in the empty chair during the fifth session, Laura connected with the sadness of feeling forsaken during her breast cancer treatment: "*it felt as if I wasn't there and I didn't matter. It just felt so shrinking. And you know, I felt so insignificant. Not there*." Laura's core primary sadness was of feeling invalidated in time of need, and consequently unloved. Accrued over years and experienced again at the time of her diagnosis and as she went through her breast cancer treatment, attending all her appointments on her own, Laura's maladaptive avoidance was a self-protective method of avoiding experiencing further rejection, "*I couldn't bear that you could walk away from me again."* In chair tasks, Laura was coached by the therapist to assert, "*I've needed so much from you (her husband). I tried not to put pressure on you but I've needed it*." As her communication in the home was primarily focused on chores/tasks to be done, her connection based core feelings of fear, aloneness and loneliness were previously unarticulated but captured in dialogue; "*the tiny things you just ignore but they snowball….it and it just causes me so much pain."* Laura's articulation of her pain as valid was an important step away from her tendency to dismiss or undervalue herself, and essential to the therapeutic model where her emotional experience is valued as mobilising and motivating.

At times collapsing into hopelessness about getting her needs met, Laura's core pain was also linked to experiences of abandonment/rejection within the marriage that complicated her need for connection. While Laura had a profound need to feel worthy of love, her experience of hurt and sadness over abandonment was unprocessed and lead to frequent collapse into helplessness "*I couldn't actually bear that you could walk away from me again."* Her sense of herself shrunk when she felt discredited or rejected; "*It's like a cloak I want to put over myself…an invisibility cloak to hide under*." The poignancy of these statements can be examined through their reflection of her negative view of self (e.g. as unworthy and undesirable) and others (e.g. as threatening, harsh, powerful and hostile that may criticise, reject, exclude, harm or persecute her). Through repeated chair (imaginary) dialogues, Laura was increasingly able to stay with the feelings of core pain and loss of connection and fully acknowledge the sense of loneliness, shame and sadness she had inhibited. Transformation came through harnessing protective anger where she held her husband responsible and expressed previously unprocessed feelings of anger. Her protective anger ("*felt at the diaphragm level, like a band across*") was conveyed assertively towards her imagined husband in the dialogue "*I refuse to be made to feel small about this.*" Further expression was uncensored and spoke to the depth of her pain and anger; "*I loathe the fact that I've been treated this way. At times I hated you (speaking to husband).*" Imaginal confrontation in chair dialogues facilitated Laura to hold her husband accountable and articulate her sense of violation and devastation, and access her worth, "*I do matter*" Experiences of bullying and dismissive behaviour from her husband in the chair dialogues elicited attachment based needs for security; "*I just want to be protected from you actually. I feel I need protection from you when you talk like that*." Laura, over time, was able to recognise and take ownership of her

adaptive need for "*recognition*" with a sense of empowerment. As Laura felt stronger in herself, her sense of threat in relation to her husband and his extended family decreased, and she was able to hold a sense of herself as deservedly part of the extended family, and with a sense of belonging, began to call on support from available others (and shift expectations of non-supportive others) in a way that was direct, clear and no longer plagued by self-directed criticism and its associated sense of shame.

An additionally important contribution towards Laura's increasing sense of self as valid and worthy was a dialogue with her critical and harsh self, whereby she looked back on her experience in employment and periods of stress level and self-chosen job demotion, and was able to contextually, compassionately acknowledge the circumstances that contributed to her feeling burnt out and depleted. Consistent with self-critical dialogues, Laura's initial responses were to recriminate and shame her experiencing self for "*weakness*" and *"failure*", however the division of voices within the self in the form of a dialogue facilitated a different point of view to emerge, where Laura responded to criticism with protective anger towards the high and self-limiting standards she held for herself, and reorganise around more positive and assertive emotions of pride and protective anger (e.g. being unwilling to sacrifice herself emotionally for the sake of her job). Gradually softening towards a more compassionate understanding of her stepping down in her career as a decision that demonstrated she valued herself too much to permit work to take more of her than was reasonable, Laura reconciled her career choices with pride and a greater sense of entitlement to protect her limits in a high stress demanding work environment. Her sense of resolve helped transform fears around stress, in that she validated herself for having adaptive needs and goals. These gains helped build resilience against harsh

self-criticism as her wants and desires for a healthier perspective around working life were recognised as important.

Throughout her therapy, Laura identified her stressful outbursts as part of her target complaints form. Underneath the secondary maladaptive "volcano" of anger, the therapist perceived, was core sadness and loneliness, which Laura connected to as her emotional experiencing was focused and deepened; "*the loneliness is very very barren. It's like being out here on the rocks just miles from anybody*" Laura's loneliness, accentuated since her breast cancer, was partially attached to emotion schemes established by attachment injuries over the course of her marriage. In imaginary chair dialogues for unfinished business, Laura was encouraged to articulate the unmet needs as part of transforming her core pain of loneliness and abandonment, and in her 11th session of therapy she stated; "*I needed you there more than you realised. I needed to know you care to make me feel safe and comfortable when I was going through so much."* At times, her (imagined) husband responded with empathy and validation, whereby he compassionately responded to the hurt and sense of abandonment Laura felt during her cancer treatment. At other times, her (imagined) husband was unable to convey empathic understanding, and these responses were also important in generating increased understanding on Laura's behalf of her partners' limitations, and facilitated a letting go where her compassion and acceptance towards his shortcomings was part of her emerging emotional capacity. Additionally, as her empathic awareness increased of both her longstanding unmet needs and processing of traumatic events were unfolded in therapy, Laura expressed forgiveness (towards her husband, towards her mother in law, towards her father and mother) in imaginary chair dialogues, reflecting transformation of previously burdensome and unprocessed emotions.

Towards the end of therapy, Laura began to feel calmer in herself, and went through several circumstances where she was able to see change in herself, and her capacity for assertiveness was connected to feeling worthwhile and deserving of care and support from others. Laura could now connect with feeling empowered to get her needs met, which brought an increased sense of security and self-assurance that buffered anxiety about future stressors, "*now if things were falling apart I would say it to my husband rather than pussyfooting around it. And there are other people I would talk to too, and say 'keep an eye on this, I'm concerned or worried.'"* In one of her final chair dialogues, Laura spoke to the part of her that still felt burdened and frightened by the future:

Therapist: *What do you want to say to that part of you that has the capacity to just put a lid on it.*

Laura: *Don't put a lid on it, leave a crack open. You need to let it out. You can't suppress it. You need to allow me to be who I am.*

Therapist: *Right, I need to express…*

Laura*: This is a far healthier way of living, for now and for the future.*

Therapist: *Can you come back over here? (Changes chairs). Does the pressure cooker part of you let that in?*

Laura: *Yes, but there still a pressure cooker there. I hadn't realised that.*

Therapist: *Can you speak as that part?*

Laura: *I will keep trying and I know with practice it will become easier to not totally suppress where I am.*

Therapist: *And what would that part of you need? Does that part of you need anything?*

Laura*: You just need to tell me it's okay. It's perfectly normal that I don't suppress it.*

Therapist*: So I'll do my best to give you permission to feel things, but sometimes I might sort of be there. How do you feel towards the part of Laura that still feels a bit raw about things?*

Laura: *Still a bit raw, but less raw. I'm actually pleased with her. She hasn't done a bad job this year or last year.*

Therapist*: Can you say that to her directly? I'm proud of you.*

Laura: *I'm proud of you. I'm proud of you Laura and you did rise to it. And it's okay to feel the way you felt, but let's just do it a bit more healthily and normally.*

Therapist: *And it brings tears to your eyes to say all of you is welcome. Even the tears, it's human.*

Laura: *Yes, it's normal, everyone has fear sometimes.*

Therapist*: And it's like it feels good to tell you that?*

Laura*: It's quite cathartic to say it.*

(Changes chairs)

Therapist: *What's it like to take it in?*

Laura: *Nice. Yeah. Loved.*

Therapist: *Right. Closeness. Like I have a lot to be proud of for the year that's passed. And it feels a bit tender too?*

Laura: *Yeah, it's good, and as time goes on that is going to become less sensitive or tender. But definitely not forgotten. It's the habit of lifetime. And it's hard to do away with nearly fifty years of doing*

things a particular way. It's like re-programming your brain to think and feel in a different way.

Therapist: *But the idea of letting it go…that it can ease up, soften?*

Laura: *That feels so good.*

Identifying wants and needs strengthened Laura to assert boundaries and seek out support and nurturing- either internally, in the form of compassion and self-soothing, or interpersonally, from therapist or others. Having pride in herself was a significant and transformative emotional shift in Laura that illustrates her burgeoning capacity to self-soothe, and undoes fear of negative evaluation from others. Working through unfinished business in her family of origin also contributed to her emotional transformation from unbearable core pain, shame and loneliness to one where there was the establishment of a feeling of being worthwhile of compassion, love and protection. Laura continued to feel a "*deep sadness*" about her breast cancer, however towards the end of therapy she was able to experience this primary sadness and tolerate it, which was facilitated by her recognition of herself as worthy of love, care and respect, and her capacity to communicate this to close others in relationship. As her confidence improved around how to cope with strong or difficult emotions, Laura's perception of daily life as stressful reduced and she carried these gains into her re-entry into working life, reporting that she also began making more time for enjoyable hobbies she had previously sacrificed. Resuming swimming and other forms of gentle exercise demonstrated how Laura now placed herself as a priority alongside her family, and formed a helpful complement to her physical and psychological recovery post treatment for breast cancer.

3.4.3 Measures

3.4.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Laura' scores are presented for pre-, mid-, and post-therapy and at her 6 month follow-up assessment in Table 3.4.1.

Table 3.4.1.

Laura's Pre-Post Outcome Scores

Scale	**Caseness**	***RCI***	**Pre-Treatment**	**Mid-Treatment**	**End of Treatment**	**6 Month Post**
HADS	11	3	26	9	6	4
Anxiety			16	8	5	3
Depression			10	1	1	1
FACT-G	78	17	64	84	123	125
SCL-90-R GSI	0.8	0.19	1.07	0.86	0.31	0.31
DERS	78	16	104	78	50	44

Note: Caseness= the cut off for determining whether the client is clinically distressed. HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

At the beginning of therapy, Laura's score on the HADS was 26, which indicated she was in the clinical range for CAD. By the mid-point of therapy, her score had reduced to 9, placing her in the non-clinical range, which further reduced post therapy to 6, suggesting she recovered on HADS (using Jacobson & Truax [1991] criteria for reliable and clinically significant change). Laura's scores from mid treatment to 6 month follow up indicates her recovery in terms of CAD symptoms. .

On the FACT-G, Laura's initial score was 64, which indicated that she rated her Quality of Life as moderate. By the mid-point of therapy her total score was 84, which suggested an improved sense of quality of life. By the end of therapy and at six months follow up, her respective scores of 123 and 125 indicate reliable and clinically significant change (recovery) (Jacobson & Truax, 1991) and that she perceived significant improvement in overall Quality of Life.

Laura's pre-therapy assessment score of 1.07 on the SCL-90 placed her in the clinical range. At mid-treatment, her score of 0.86 indicated that the overall intensity of her distress remained somewhat elevated but demonstrated a reduced level of overall distress. At the end of therapy, her score of 0.31 showed a significant decrease in clinical distress, and satisfied the criteria for clinically significant and reliable change (Jacobson & Truax, 1991) had taken place, which was maintained at 6 months post therapy.

On the DERS, Laura's score of 104 pre-therapy indicated that her ability to emotionally regulate in terms of arousal, awareness, understanding and acceptance of emotions were maladaptive and likely contributing to distress. Mid-way through therapy, her score improved by dropping to 78, and further improved at the end of therapy (50) indicating reliable and clinically significant change (Jacobson & Truax, 1991). Laura's six months follow up with a score of 44 suggests she continued to improve in terms of emotional regulation on this measure and indicates her recovery in the use of adaptive emotion regulation strategies was stable.

Target Complaints (TC)

Prior to each therapy session, Laura completed a Target Complaints form. The information provided by this measure is presented in Table 3.4.2

Table 3.4.2

Laura's Target Complaints Data

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post-Therapy**
Dealing with a Cancer Diagnosis	12	7	3
Preventing Recurrence (caused by stress)	12	8	3
Managing Day to Day	11	7	2
Working on my Relationship/Communication	10	7	2

As can be seen from Table 3.4.2, all of Laura's target complaints are related to her CAD diagnosis in the context of also living with a recent cancer diagnosis. In addition to difficulty adapting to the diagnosis, Laura is worrying about the possibility of cancer recurrence, general coping and also feels her communication in her marital relationship has been suffering. At the beginning of therapy, all of Laura's reported scores on the Target Complaints are very high. By the midpoint of therapy, the score for all her target complaints have been halved. At the end of therapy, all of the Target Complaints listed by Laura have reduced to the low range, with significant pre-post differences (8-9) across all targets.

3.4.2 Analysis of Process Measures

Helpful Aspects of Therapy (HAT)

At the end of each session Laura was asked to fill out a Helpful Aspect of Therapy form, the data from which are presented in Table 3.4.3. Laura's forms tended to identify specific events in therapy as helpful, as her responses in the section "how long did it last" was commonly identified as 5 or 10 minutes duration. Her quantitative rating of helpful events routinely scored the helpful aspects of therapy as between 8 and 8.5, indicating she found the events between greatly and extremely helpful.

Table 3.4.3

Laura's Helpful Aspects of Therapy form Data

Session	How Helpful?	Helpful Event	What made it helpful?	When in session?	How long did it last?
1	8.5	The chair task- it was difficult to do but it had a small positive outcome- loosening the clenched fear.	Giving me the opportunity to talk to myself, and not be overly hard and negative.	Towards End	5 minutes
2	8	By the therapist acknowledging the facts that I'm angry and frustrated.	It validated that I do matter, and that in time, I need to be open with my partner about how I feel.	All through session	Most of session
3	8.5	Realising that I am multitasking to an unrealistic and unsustainable level.	Knowing and realising can be very different so it was like a "grounding" that what has been happening can't continue.	Towards End	5 minutes
4	8.5	By being able to loosen the lid on how I feel about not being high on the ladder of importance.	It has begun to make me realise that I have to face up to and tell my husband about how I feel. The whole session was helpful as it focused on a difficult area of my life.	All through session	Most of session

5	8	Talking to my daughter and my daughter responding in the chair.	Seeing her try to vocalise what she is thinking or worried about. Being able to describe how upsetting a particular episode was.	Towards End	5-10 minutes
6	8.5	Being able to identify that I need to have the "difficult" conversation about how isolated I feel.	Acknowledging openly issues which have been covered up for so long. Being able to see clearly the importance of opening up parts of my life which I tend to ignore or skirt away.	Towards End	5 minutes
7	8.5	Realising how difficult it is to be open about the pain I feel deep down.	It demonstrated that I am suppressing my emotions at times.	Whole session	Most of session
8	8.5	Being open about my feelings of loss when my grandfather died. Talking in the chair.	It reassured me that it is okay to feel the loss, but also that he is still there.	Towards End	10 minutes
9	8	At the end of the chair task being able to talk to my husband about what I need from him in relation to his mother.	It was being able to acknowledge that he will support me in this area. The chair role play (with mother in law) helped me feel stronger.	At End	5 minutes
10	8.5	Allowing myself to say I'm proud of how I've dealt with the last year.	Being able to see that I've accomplished a lot last year but also how I'm a different person. Less suppressing of my needs/emotions. Recognising that to suppress my emotions is not required to survive. That I need not be like a pressure cooker!	Towards End	5 minutes

11	8	Talking to my husband in the chair about how I feel and that I do matter.	It raised how to talk in a potentially difficult manner about important things. And that it may be difficult but at least it will give me a voice about what matters.	Towards End	4-5 minutes
12	8	Talking about how to manage my return to work in relation to being absent for 15 months	Talking about this to someone not directly involved, and being able to discuss how not to be over emotional with coworkers about this. I think that to say I've taken last year as time out is a good solution.	Early in session	5-10 minutes
13	7.5	Talking about communication issues in my early to mid-teenage years	Realising that I need to keep open channels of communication with my own daughter.	3/4 into the session	15 minutes
14	8	Realising how long the emotional shut down has been going on.	This has been going on for longer than I ever realised. I realised the importance of confronting my husband about how his behaviour affects me.	Midway	10 minutes
15	8	That I appear to be content and able to manage potentially difficult situations relatively easily.	Its acknowledging the time and effort put into these sessions	All through session	Whole session

Initially Laura found the chair task *"difficult"* but found a somatic and experiential change that *"loosened the clenched fear."* She was also able to see a renegotiation happening in her relationship to herself, *"talking to myself, to not be overly hard and negative."* Session 3 was helpful in validating emotions that had been out of awareness, namely anger and frustration within her marital relationship. Laura was

able to increasingly apprehend these feelings in Sessions 4 and 5, whereby she was able to assert her needs around traditionally over-extending herself "*it was like a 'grounding' that what has been happening can't continue."*

Sessions 6 and 7 opened Laura up to her feelings of isolation and the vulnerability she felt expressing herself emotionally, *"realising how difficult it is to be open about the pain I feel deep down…it demonstrated that I am suppressing my emotions at times."* Session 8 allowed Laura to experience some relief stemming from the expression of painful emotions in her dialogue with her grandfather, "*It reassured me that it is okay to feel the loss, but also that he is still there."* The following sessions 9-11 involved expressing needs connected to core pain, such as *"talking to my husband about how I feel and that I do matter,"* which Laura found helpful to strengthen her understanding that *"to suppress my emotions is not required to survive. That I need not be like a pressure cooker"* provided relief.

Equal to increasing her capacity for sharing her feelings in intimate relationships, Laura found it helpful to have support around protecting herself emotionally where appropriate; for example in the case of returning to work which was identified as helpful in Session 12. A developing ease with self-expression and the identification of needs for recognition and support was central to Laura being able to take responsibility for how she approached relating to others, included her daughter in Session 13. With session 14, Laura reported realising *"how long the emotional shut down has been going on,"* reflecting both an increased awareness of her own emotional processes with painful emotions and how to translate them into communication that would facilitate change and support; "*I realised the importance of confronting my husband about how his behaviour affects me."* The emerging agency and emotional flexibility enables Laura to validate herself in the final session (15),

"*I'm able to manage potentially difficult situations relatively easy"* which she relates to the *"time and effort put into these sessions."* Across the sessions, Laura identifies improved self-awareness, insight and self-acceptance as valuable, and identified the support and emerging ability to recognise her own ability to express needs as key to the amelioration of past interpersonal injuries and restore a self-belief to handle challenges in the future.

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

Stating "*I'm not having the sleepless nights where my mind is buzzing and buzzing and buzzing"* and remarking that her children had noticed *"I'm not the weepy wreck I was, and I'm no longer volatile."* Her improved restraint of impulsive expression of negative affect coincided with an ability to confront problems directly, "*I'm happier, but I'm also more assertive."* She reported that exploring painful parts of her own history was helpful in discovering her emotional self-efficacy. Laura likened the process of therapy to that of climbing a mountain, where exploring the *"steep and stoney area"* at the very top of the mountain had been a challenge, but as with any challenging journey, it also *"felt like a huge sense of achievement."* She elaborated:

> *I wouldn't use the word inner peace. But I do think there is a lot more calmness within. Things that would have upset me and bugged me in the past, I'm now saying, it's only whatever, and it's not a major issue any longer. I don't feel the stress.*

When asked about what specifically had helped in therapy to bring these changes about, she cited the "*chair talking"* as "*phenomenal…difficult but very powerful."*

Laura also identified concrete behavioural changes based on her more compassionate relationship to herself, observing that she now made time for regular exercise and prioritised *"living life over work.*" These changes were also recognised in the family. Laura's husband remarked on the link between her shifts in prioritisation of life purpose and how that affected her assertive capacity around work demands. Whereas in the past, she would have "*normally not said no to people*," Laura emphatically stated, "*I do now*." This ability to put a greater emphasis on herself and look after herself physically and mentally gave her a sense of self-efficacy and hopefulness: "*I'm looking forward to the next thirty or forty years. I'm far more positive about the future than I would have been."*

Besides a restored sense of optimism about living life, Laura felt there was an increased sense of inner resilience to cope with life's challenges, and the challenges close others faced as well. Using another analogy, Laura described her increased awareness of emotional boundaries: "*Before I used to feel I had to be there for everybody but now there is a layer of cling film just separating it."* The experience of feeling "*incredibly safe"* facilitated Laura to confront difficult problems, for example longstanding friction with her mother in law, and to feel an increased sense of *"being able to step back"* and feeling the historical frustrations were now *"shifted and it's so much water under the bridge now. It's one stressor I can step back from."*

Across the identified changes brought about, when Laura was asked if she believed they might have been possible without therapy, she was resolute, "*it would have been extremely unlikely. And it was all very important."* Laura came to therapy expecting that both her need to *come to terms with the cancer diagnosis* and her *fear of recurrence* would be addressed and she felt she benefitted from the sessions correspondingly. However Laura described herself as "*very surprised"* with the

additional changes of improving her relationship with her husband, her improved and increased closeness in relationships with her friends, her acceptance of difficult relationships, and her increased capacity to assert herself and place a priority on her own needs; *"I've come a long way, and I think it shows that as time has gone on priorities have been changing and this is where I am now."* She noted that her relationship with her husband has been tenuous prior to therapy *"my closest friends thought I was going to walk, or that I'd kick him out,"* however increased understanding resulted from Laura being able to voice her feelings about their respective coping during her cancer treatment: "*being able to say I felt very alone and he now acknowledges he was probably not the easiest…I think he really understood what I was saying to him."* Being able to express her feelings of isolation and vulnerability exposed Laura to emotional expression that was non-threatening and felt helpful, further enabling her to develop the confidence to share with others her needs, "*Through talking with my therapist I've been able now to talk generally about how I felt and my emotions about things. Which is a good thing*."

3.5 Case Study 5, Kate

3.5.1 Introduction

Kate is a 46 year old Caucasian female who was referred to the psycho-oncology department by her radiation oncologist. Since her diagnosis of grade II invasive ductal carcinoma, Kate has been experiencing high levels of distress punctuated by symptoms of anxiety and depression.

Kate is married with children and a history of one miscarriage. At the time of participating in the research study and after her diagnosis Kate had taken voluntary

redundancy from her previous employment. Kate's husband was unemployed and separate to the research study, was also seen by a psychologist in the Psycho-Oncology department for four sessions to support his adjustment and coping in relation to Kate's diagnosis. One of their children was attending community psychology services in relation to his history of low mood.

Kate's treatment for breast cancer involved surgery (mastectomy), and her adjuvant treatment included chemotherapy, radiation therapy and hormone therapy. Her maternal and paternal sides of the family had an extensive history of breast cancer, including her mother and sister. Her father had died from terminal cancer. There was a significant psychiatric history in the family as well as chronic alcoholism. Kate had experienced mild depression in the past after the birth of her third child but did not meet the criteria for post natal depression based on retrospective account. She engaged in 12 sessions of psychological therapy with the Principal Investigator of the research study, who was experienced in using an emotion focused therapy approach

Prior to commencing therapy, Kate completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-patient edition: Research Version: SCID-I-NP-R. Her results indicated she met the criteria for Major Depressive Disorder with Generalised Anxiety Disorder and Panic Disorder. Kate also completed the SCID-II for assessing DSM-TR- Axis II personality disorders, which indicated she met the criteria for Depressive Personality Disorder. Kate had also been seen at another hospital by liaison psychiatry who had prescribed her Escitalopram two months previous to beginning therapy (Lexapro; a selective serotonin reuptake inhibitor (SSRI) class antidepressant), and Xanax to take when needed for anxiety and acute symptoms of panic.

3.5.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective: General Impressions

The therapist found work with this client quite delicate as it progressed and correspondingly difficult. In the initial session it was noted that Kate was extremely emotionally fragile and distressed. Kate had attended psychiatric services in an adjacent hospital for assessment and prescription medication during her chemotherapy, and had experience of psychiatric support during an episode of postnatal depression. Kate presented with alternating avoidance and collapse, contrasting the enervated vulnerability she was overwhelmed by since her diagnosis by speaking of her pre-cancer self with brashness and bravado. During her time in therapy, Kate contacted the therapist by telephone in between sessions reporting periods of acute distress and subsequent exhaustion, fearful she could not endure emotionally and requiring reassurance, soothing and care strategies.

Emotionally Kate was experiencing a level of vulnerability that had been warded off through a lifestyle that, pre-cancer, demanded too much (full time work and a successful career, alongside motherhood of three boys and financial stress as the sole earner in the household). She also sought input around her family's coping with her breast cancer, reporting early in therapy that one of her children was expressing suicidal ideation (resulting in referral to community services) and that her husband also sought psychological services during this time. During the telephone calls Kate needed containment from the therapist that the family was being supported.

Despite this, the therapist felt that therapy progressed well, taking into account that the number of sessions was considerably shorter than would be typical for a presentation with this level of anguish and psychosocial complexity in the wider

family system. Towards the end of therapy, Kate remained prone to episodes of high distress in and out of therapy, however she was able to express compassion towards herself and an increased security that she was regaining her confidence. While Kate was encouraged to continue attending therapy, her preference to finish with twelve sessions was respectfully abided. By the end of therapy, Kate had resumed some social activities with close friends and began getting involved in community events, which she reported feeling good about. During her final session Kate described an increased sense of positivity about the future, however she continued with medication and monitoring to keep abreast of her stability.

Case Formulation

Kate's case formulation presented here is based on the therapist's report.

Triggers of Emotional Pain

Kate's early history involved a father who was a high functioning alcoholic. Family secrets of incest and child sexual abuse were embedded in her narrative, which she herself reported she had not experienced. Prior to Kate's diagnosis a sibling disclosed to the family being sexually abused by their father after years of psychiatric episodes that required hospitalization for lengthy periods. Kate's memories of her childhood were largely pastoral, however she described an acute awareness of receiving different treatment from her older siblings, ("*mum and dad used to do everything for me*"), which was accompanied by a tremendous sense of guilt. Her later memories of her parents were coloured by her mother's coldness towards her father in the aftermath of the reports of CSA, and Kate opted to be his main carer when he was terminally ill with cancer and subsequently died, which left her feeling alienated from the family, and as though *"I had chosen an allegiance*."

Painful life events contributed to Kate's important core maladaptive emotion schemes. Grief linked to illness related losses and mental health difficulties in her family of origin were difficult to process within a low conflict and avoidant family system, and these historic feelings of loss, harm and estrangement had been activated by her own subsequent breast cancer diagnosis. Hair loss and weight loss further were daily triggers that she was negatively changed by her illness. The physical threat of her illness as well as her loss of good health ruptured Kate's sense of stability, and her inner resources were overwhelmed by the danger she felt in relation to a cancer diagnosis.

Global Distress

Kate presented with high distress and anxiety that her emotional state was indicative of emotional collapse from which she found it difficult to foresee recovery. Frequently tearful, Kate felt her strength and resilience had been lost. These perceptions generated further anxiety and sadness surrounding her breast cancer, and added overwhelming exhaustion. Her chronic exhaustion (as well as fatigue stemming from recent courses of chemotherapy and radiation treatment) contributed to mood instability and secondary sadness during brighter moments due to an overarching sense of helplessness and trauma in the wake of her breast cancer diagnosis and her own subsequent, limited coping. Irritability and frustration were also features of the initial characterisation of her feelings. On a similar vein, reactive anger formed part of Kate's global distress in response to her breast cancer, particularly towards her husband whom it seemed she perceived as too vulnerable emotionally to be the source of strength she needed. His helplessness evoked guilt for Kate that she was letting the family down. Guilt fuelled her hopelessness and finding these emotions unbearable,

she escalated her worry in relation to her own and others ability to cope. Feeling trapped and powerless dominated Kate's narrative; "*I feel so responsible as a parent but I'm exhausted….I'm falling apart."* Her partner's emotional unavailability to the children not only created catastrophic worry, it bore more primary relationship to her own unresolved primary core pain of sadness at (perceived) abandonment and grief in relation to her parents respective illnesses during her young adulthood. Kate experienced her own sadness as unsurvivable, and she was prone to collapse into hopelessness, "*I just don't know how to carry on…I just want to lie down, just stay in bed*." Conflict and ambivalence were features of the marital partnership as both had respective histories of depression, and the ensuing difficulty maintaining a satisfying romantic relationship contributed to feelings of hopelessness/helplessness.

Negative Self-Treatment

In the aftermath of her breast cancer diagnosis Kate's self-treatment seemed changed as it was primarily dominated by recrimination and a perception of herself as fundamentally flawed. Judging her feelings of vulnerability as *"weak,"* Kate's inner critic consistently dominated and demeaned her, leaving her feeling unprotected and unequipped to contend with the demands of breast cancer, family stressors and thoughts of her subsequent future. Fears around loneliness stemming from earlier experiences of ostracism in her family of origin appeared to contribute to her harsh internal standards that pushed her to provide and please others at the cost of herself under the weight of exacting high standards. Her husband's authoritarian stance to parenting reinforced Kate's fears that her temporary absence from the emotional day to day with her children was dangerous, evoking further fears of catastrophe and

comprising her worry dynamic and high personal expectations; ""*I have to be there for everyone*."

Anticipatory Anxiety, Emotional and Behavioural Avoidance

Kate presented with a lot of fear and pervasive worry. She was scared of being harmed or damaged by the amount of distress she felt, and feared that her loved ones (her husband, her children) might also be damaged as a result of witnessing the psychological effects breast cancer had on her. Kate made such efforts to take the advice of others and engage in day to day tasks (perhaps again reflecting a high level of perfectionism in her approach to recovery) despite her profound feelings of pain and loss that she exhausted herself. Her subsequent exhaustion resulted in attempts to protect herself by shutting off or withdrawing to her bedroom during the daytime. This cycle of avoided emotional experiencing denied her need to be loved and accepted and left her feeling traumatically helpless and hopeless about ever recover emotionally from her diagnosis.

The therapist also found that Kate was prone to interrupting her emotional experience by making self-deprecating jokes, demonstrating her discomfort with expressing primary feelings of sadness or anger and familiarity with minimizing/concealing her more primary feelings in front of others.

Core Emotional Pain

The core painful emotions underlying her depression and anxiety were of sadness and loneliness from missing emotional connection in her marriage, and feelings of abandonment. The primary fear aspect of Kate's core pain related to schematic memories witnessing the suffering of close others, including when her

father went through cancer, and her sister's periodic episodes of profound psychological disturbance, both sources of pain which Kate herself now (over) identified with. Kate's experience of shame was related to the feeling of not adequately protecting her own children from her current upset and anguish. Combined with an extensive history of trauma, abandonment, and shame within her family of origin, Kate's core emotional pain was dominated by *loneliness*, composed of feelings of loss and disconnection following the disclosure of sexual abuse in the family; which left her feeling unsupported and unloved; *shame and trauma*, related to the abuse, as well as her breast cancer which she perceived as a failure and which triggered a frightening confrontation of "toxic" feelings; further injury to her belief in herself as worthy of love and connection. Lastly, *loss* contributed to her core emotional pain, including loss of bodily parts, health and sexual self.

Unmet Needs

Kate had poignant and intensely moving dialogues across therapy with her imagined husband, mother, father, sister, to voice unmet needs for validation of feeling hurt and betrayal stemming by her father's transgression of social mores and unprocessed grief from his death. Kate also had unmet needs for safety and protection in the face of overwhelming fear of her breast cancer, and a yearning for acceptance in her family of origin and from her own nuclear family that was linked to her experience of loneliness and ostracism in the wake of traumatic events (e.g. the revelation of CSA in the family or origin and currently, her own breast cancer diagnosis). Needing to be reached out to, cared for and connected to formed part of the loneliness based unmet needs Kate harboured, as well as having the need for protection, safety and control to assuage her loss and cancer related fears.

Emotion Transformation

Kate perceived herself to have been stable and successful in her life prior to diagnosis, conflicting somewhat with her accounts of financial difficulties related to impulsive spending and a history of binge drinking, which hinted at unarticulated needs that may have gone unmet within her working and home life. Recognition that she felt terrified was focused through evocative unfolding in relation to her husband's irritability and outbursts, which left Kate feeling further isolated with her illness and scared of the future. Rather than attend to her maladaptive response (e.g. wishing she could withdraw, lie down, and shut herself away from family in her bedroom *"just give up")*, the therapist evoked and amplified Kate's sense of missing the strength drawn from an available and emotionally present significant other, which also triggered historical core pain in relation to her father's cancer and the lack of support she received in relation to his care. With unmet needs for reassurance and soothing around her loneliness and fear, a chair dialogue with an imagined supportive sibling offered courage and protective anger, "*I'm not going to let you fall apart…I'm here for you every step of the way [in your cancer treatment]."*

With repeated chair dialogues and across therapy sessions, Kate was able to connect to more primary feelings of sadness, loneliness, and shame, and with empathic validation from her therapist, recognise that her painful emotions could be processed in a way that provided her relief and a helpful avenue for change. Kate's particular methods of avoiding dreaded emotions placed her in a bind whereby needing love in times of difficulty made her vulnerable to hurt and pain, yet interrupting her needs (e.g. negative self-treatment) had left her isolated and lonely.

Chair dialogues highlighting how she interrupted her emotional experiencing spurred Kate to move forward in elaborating and unpacking her emotions in therapy. Kate held deep sadness for how long she had harboured such painful feelings "*I was so lonely with all of it (family trauma), never knowing how to honestly talk about it*." Some grief for the burden she had carried seemed to be a positive step towards self-directed compassion, and her statement also indicates she identified having censored her feelings in the past in a ways that were unhelpful (outlined in self-treatment), an awareness that helped motivate Kate to bear the intensity of processing emotions attached to her traumatic experiences.

Somewhat bolstered by the recognition of some of the triggers that were activating her current distress, Kate's core pain in part stemmed from hurt, betrayal and boundary violations relating to the disclosure of incest in the family, as well as the distancing she experienced from her siblings as a result of her maintaining a close relationship with her father after the disclosure. Kate's feelings towards her father were multi-layered and complex, and required unpacking across multiple imaginary chair dialogues for unfinished business. In one particular dialogue during her 9th therapy session Kate expressed her sense of burden with vehement fury and hatred (of his actions); *"yeah, I'm angry I had to carry this for fifty f*&!ing years…I've been saddled with this poison for years, it just ate away at me."* Initially, brief bursts of rejecting anger such as this quickly gave way to global distress. Anger during this dialogue was connected to feelings of *"disgust,"* conveying how violating it felt for her to carry the knowledge of her father's transgression. Seen in the context of complex trauma, her disgust and contempt towards her late father's reported sexual abuse of her sibling can be viewed as an example of a blend of rejecting *and* protective anger. Invited to assert a need from her anger, Kate pronounced; "*I need*

you to admit the shame and responsibility you feel for committing a terrible act against my sister."

In the following dialogue for unfinished business, Kate continued articulating her anger with her imagined father in the empty chair that also unfolds the underlying hurt and loss. She then responds with compassion towards her own hurt:

Kate (speaking to her imagined father): *I want you to be honest with me and tell me what happened. I just want us to always have been honest with each other.*

Therapist: *Tell him what you missed out knowing from him*

Kate: *Was there a reason you did that [*to my sister*]? Is that why you drank so much? To dampen down those feelings? We could have gotten over it as a family. I needed you to take responsibility for what you did. And not brush it under the mat or keep it secret. There was something hugely wrong.*

Therapist: *And I'm angry that I was left with all these unanswered questions.*

Kate: *Yeah, I really am. And I nearly feel guilty that I was the only one that got the positive side of a close relationship. It felt good to me but I also felt guilty that I was hiding it from my siblings (*sobbing*).*

Therapist: *Yeah. Why was I the exception…and it's like, I feel the burden of that.*

Kate: *I felt that and it nearly stopped me from getting close to my other sisters. I felt I missed out on that--- it's like I had an alliance to you.*

[she touches on sadness for the loss here.]

Therapist: *Either way I was going to be betraying somebody.*

Kate: *Yeah exactly.*

Therapist: *It must have kind of torn you apart.*

Kate: *It did*.

Therapist: *Try saying that to your father: I'm angry because it made me feel so alienated from my brothers and sisters.*

Kate: *I'm angry at you. Even after you died it took a long while…and I'm angry at you because we all lost her (*sister*) when she moved away…my mother missed her so terribly…she really did (*sobbing*) because she was so close and she missed helping her raise her children.*

Therapist: *I'm angry at the hurt you caused everybody. And how that hurt split the family…people moving away.*

Kate: *It felt like everything kind of fell apart.*

Therapist: *And I felt so alone after that.*

Kate*: I felt so so alone.* [again touching on sadness]/

Therapist: *And what do you feel right now?*

Kate: *I just feel sadness.*

Therapist: *It was never the same. I really missed that sense of things being repaired in some ways.*

Kate: *Absolutely, yeah*

Therapist: *And I really felt that as a father it was up to you to do that.*

Kate*: I really felt it was up to you to try and knit everybody back together. And you didn't even try. And even when you got sick I really felt you didn't try to beat it you just let it overcome you. Because you were afraid of what life was going to be like if you did live on*

*(*sobbing*). I know you didn't fight it and I know that because I've had it and I did and I'm angry at you because of that (*crying harder*).*

Therapist: *Yeah, yeah, this is what hurts so much. Just breathe. Can you come over here? As your father, what does he say to that?*

(Kate moves to the empty chair to speak as her imagined father).

Kate (speaking as her father): *I'm sorry I didn't want you to feel like that. (*tearful*). I really wish I could have made it better.*

Therapist: *I'm sorry you carried this pain for so long.*

Kate (speaking as her father)*: I'm sorry I didn't fight it like you fought.*

Therapist: *It's like, I wish I could be here to help you.*

Kate (speaking as her father): *Because I love you so much.*

Therapist*: Because I love you so much and it pains me. I see your pain.*

Kate (speaking as her father): *I do see your pain. I wish I could take it all.*

Therapist: *What do you feel as you say that to her?*

Kate*: It feels good, it feels really good to say that.*

Therapist: *Can you come over here?* (Kate moves from her imagined father's chair to her own chair). Therapist asks Kate: *What happens inside when you get that?*

Kate (speaking as herself)*: It takes a weight off my shoulders.* [letting in compassion].

Therapist: *It's like a balm that this matters.*

Kate: *I wish (*giggles*) that you could have done all this*

Therapist: *What's the feeling?*

Kate: *It's just really…healthy.*

By expressing her primary feelings of anger, betrayal (hurt) and sadness, Kate was able to hold her father accountable for the injustice and articulate the compromise it had placed on her within the wider family. Furthermore she was able to express that it had undermined her ability to trust and depend on others, with a shame based fear of being tainted or stained by the taboo of his actions. Seemingly, this unfinished business had previously been minimised/avoided until her breast cancer diagnosis, which may have triggered a heightened awareness of her vulnerability and underlying unmet needs for care and protection.

Her unmet needs for love and connectedness in relation to her father was also linked to forgiveness and letting go, "*I'm so sorry I never gave you the answers you needed. If I could go back 20 years and have this conversation in person I am your dad and I will make it alright" (voice breaking).* Kate was also facilitated to express her unmet needs towards herself "*I need space and to look after myself*" which was expressed with a sense of relief as well as grief of the years spent focused on others at the cost of her own emotional well-being. The softening of her self-critical stance was demonstrated as therapy progressed, where Kate was able to process and reflect on her emotional needs at a greater depth, "*I want to give myself an easier time, and accept the limits I have*." Kate's emerging compassion with herself suggests a change in self-perception as she felt more empowered and worthy. Holding her father accountable (as well as her mother, and husband for other experiences where she felt they were unresponsive to her in times of vulnerability) was an important step in transforming her feelings of shame, loneliness and fear. Looking back at herself as a woman frightened by her diagnosis, Kate was soothing and compassionate, "*I'd give her constant reassurance, and I'd tell her she could get through it*."

Across chair dialogues, Kate transformed feelings of unworthiness, shame and failure to adaptive primary emotions of assertive anger and self-directed compassion, deeming her emotional needs as worthy of being cared for, "*I deserve to feel protected and loved.*" In imaginary chair dialogues with her husband she conveyed her feelings about her breast cancer that had previously been too difficult to articulate without collapse into global distress, *"the cancer always feels like it's there in the background, scaring me. And needing you scares me because I don't know if you can handle it."* As her imagined husband in a structured chair dialogue she received the soothing and protecting presence that bathed her with acceptance; which she was able to let it; "*I need that, to feel safe and protected, to hear its okay I'll be there for you no matter what*." Kate's increased flexibility in terms of receiving support helped her to open up to the bodily changes (e.g. hair loss, scarring, skin irritation from treatment) as a result of her cancer as temporary with increased acceptance, reflective perhaps of the inward security felt from self and other soothing.

Kate reported some sense of relief, hope and confidence developing as therapy progressed, but she also continued to experience high levels of arousal within therapy sessions and reported significant upset in between sessions. While Kate could clearly access self-compassion and protective anger in session, her appraisals of personal vulnerability suggested that some of her core pain remained unprocessed and that some issues for her remained unresolved. She was encouraged to continue attending therapy as part or separate to the research, however Kate decided to finish her therapy sessions and began attending community events and started volunteer work as part of her recovery, which she was successfully able to engage in.

3.5.3 Measures

3.5.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Kate's scores are presented for pre-, mid-, and post-therapy and at her 6 month follow-up assessment in Table 3.5.1.

Table 3.5.1

Kate's Pre-Post Outcome Scores

Scale	Caseness	*RCI*	Pre-Treatment	Mid-Treatment	End of Treatment	6 Month Post
HADS Anxiety Depression	11	3	12 6 6	14 6 8	8 4 4	7 4 3
FACT-G	78	17	59	44	82	86
SCL-90-R GSI	0.8	0.19	0.98	1.14	0.70	0.66
DERS	78	16	77	100	68	64

Note: Caseness= the cut off for determining whether the client is clinically distressed. HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

At the beginning of therapy, Kate's score of 12 on the HADS indicated that she was in the clinical range for symptoms of anxiety and depression. By the mid-point of therapy, her score had increased to 14, suggesting heightened symptoms of anxiety and depression on this measure. Her score reduced to 8 at the end of therapy, which demonstrates reliable and clinically significant change (recovery) (Jacobson & Truax, 1991) on the HADS. At six month follow up, her score 7 indicated that she

was still subclinical for symptoms of anxiety and depression on this measure and indicates recovery on this instrument.

On the FACT-G, Kate's pre-treatment score of 59 placed her in the range of caseness for low quality of life. Her mid-point assessment score of 44 indicated that she continued to decline in her self-assessed quality of life on this instrument, however her post therapy score of 82 indicates that she satisfied the criteria for clinically significant and reliable change (Jacobson & Truax, 1991) and thus she can be considered to be recovered. At six month follow up she continued to improve in her score for overall quality of life on this instrument.

At her pre-therapy assessment, Kate scored 0.98 on the SCL-90-R which placed her in the clinical range. By mid-therapy this had increased to 1.14. By the end of therapy her score had reduced to 0.70 suggesting that she was no longer in the clinical range and that reliable and clinically significant change (recovery) (Jacobson & Truax, 1991) had occurred. Kate's post therapy score of 0.66 indicates recovery on this instrument.

Kate scored 77 on the DERS at her pre-therapy assessment, which placed her one point below the caseness for difficulties in emotional regulation. At mid therapy her score of 100 indicated that difficulties in emotional regulation had increased. By the end of therapy Kate scored 69, indicating that with her pre-post differential of 10 that no reliable change had taken place on this instrument. Of note, Kate added notes in the margin of her DERS assessment forms to elaborate on positive changes she observed to her emotional regulation since her cancer journey, as she felt the changes had been so meaningful to her. This is somewhat at odds with her pre-post outcome scores on other measures that would suggest she did not objectively change to the extent she subjectively reported. The pre-post scores in her DERS forms indicate that

in the past she felt more in control and certain of her emotions but more *shameful/intolerant* of them when they arose. At the time of her post therapy assessment, she indicated that *she had become more acceptant* of the importance of her emotions.

Target Complaints (TC)

Prior to each therapy session, Kate completed a Target Complaints form. The information provided by this measure is presented in Table 3.5.2

Table 3.5.2

Kate's Target Complaints Data

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post-Therapy**
Emotional Fragility	10	7	5
Move forward without Fear	9	8	4
Understand how Cancer has Affected my Physical and Mental Well-Being	9	5	2
Dealing with Stress	9	4	3
Honesty/Communication with Family and Friends without Hurt	8	6	2

As can be seen from Table 3.5.2, all of Kate's target complaints are related to her CAD diagnosis and in the context of the demands placed on her by her breast cancer. In addition to being fearful and worry of having been harmed, she is also worried about dealing with stress going forward, and is conscious of how she relates to close others in terms of communicating needs and wants. At the beginning of therapy, Kate

scored all of her Target Complaints the high range (8-10 scores), however by the mid-therapy, half of her target complaints had reduced, while the remaining half was still in the high range. By the end of therapy all of her target complaints had deteriorated, however her *emotional fragility* was still experienced in the mid-range (5).

3.5.2 Analysis of Process Measures

Helpful Aspects of Therapy (HAT)

At the end of each session Kate was asked to fill out a Helpful Aspects of Therapy form, the data from which is presented in Table 3.5.3.

Table 3.5.3

Kate's Helpful Aspects of Therapy form Data

Session	How Helpful?	Helpful Event	What made it helpful?	When in session?	How long did it last?
1		no form	no form	no form	no form
2		no form	no form	no form	no form
3		no form	no form	no form	no form
4	8	I really felt the exercise of talking to myself in the opposite chair unlocked those feelings of negativity and blame that were hidden.	I feel lighter and happier inside! These negative feelings really took the energy out of me on a fairly regular basis. I've now realised I can learn from allowing my emotions out and using these experiences positively/	Second half of session	20 minutes

5	8	Addressing ongoing emotional issues with my husband.	I worked through how to tell my husband what I need him to do and why. I spoke the words out loud for the first time and it physically felt like a breath of fresh air in my body.	Quarter into session	Until the end
6	9	When I let out my emotions and sobbed for some time. It really made me aware how deeply hurt and angry I am.	I now know I must confront my husband with this hurt and anger. Tell him the current way of dealing with difficult emotional and family issues must change.	Midway	5 minutes
7	9	Tapping into how I felt about losing my dad.	I realise I need someone to be 100% accepting of me.	Midway	40 minutes
8	7	Opening up about my lack of sexual desire. Also discussing how much I missed work and who I was to those people.	I haven't thought too much about sex and haven't discussed it much with my husband. Maybe I need to have another chat. Recognising my sadness and accepting it regarding work.	Throughout session.	Whole session
9	9	Chair work in relation to my dad.	Let go (or started the process of letting go) of the anger and guilt I have towards my dad.	10 minutes into session until end	Whole session
10	8	Talking about my husband's family and their dynamics and communication.	I could open up about them and why I don't like the way they keep their feelings hidden about certain subjects.	Midway	30 minutes

11	8	Working with myself and how to separate yourself from your emotions in order to deal with them effectively.	Beginning to understand how to process emotions in a way that helps me.	Midway	30 minutes
12	9	Identifying the feeling of dying- after the past years' treatments- allowing myself to leave that fear behind.	Brought out very clearly to me what further work I need to do with Allison to enable myself to be stronger emotionally.	Later quarter of the session	20 minutes

From sessions 1-3 there is no data available as Kate completed forms for these sessions at home at her request, however, the forms were not returned to the researcher. From the 4th session of therapy, Kate identified the value of accessing parts of her emotional experience that were previous out of her awareness; "*talking…unlocked those feelings of negativity and blame that were hidden."* Her reflections on what made that process helpful seemed to present a new possibility for Kate, that "*I can learn from allowing my emotions out"* suggesting she apprehended their adaptive value. Her appreciation of the relief and insight stemming from experiencing emotion continued in her 4th session where she somatically felt a shift "*like a breath of fresh air in my body."* Kate's feedback on the fifth and six sessions demonstrated how giving herself permission to let out her emotions was an ongoing process, but when she did, she became aware of *"really how deeply hurt and angry I am."* She was able to translate these feelings into articulated needs to communicate with her husband and voice the need for changes in their relationship. Her recognition of her need for support in adulthood was expressed as a result of a chair dialogue in relation to her father's death from cancer in session 7, where "*tapping into*" her grief prompted her realisation "*I need someone to be 100% accepting of me,"* highlighting

an inner experience of loneliness and its corresponding need for connection and valuing.

Session 8 underlined her feelings of loss around stopping work since her diagnosis, and that by recognising and acknowledging the high value she placed on her work identity and the sense of connection and purpose she experienced in her career, she could in part work towards *"accepting"* feelings of sadness as important and valid. The 9th session addressed complex emotions regarding her father, specifically of anger and guilt, and that a process of letting go of these feelings came through their expression. Across sessions Kate cited a feeling of opening up and realisation that stemmed from connecting with her emotional experience, suggesting she was overcoming her avoidant tendencies. Correspondingly, Kate began to expect others in turn to open up to her, asserting in session 10 that not keeping feelings hidden was important for her. Her focus turned inwards in session 11 with what she felt was an increasing understanding of *"how to process emotions in a way that helps me."* Evidently feeling relief, Kate observed that in her final session she could name the feelings around mortality that she had confronted since her cancer diagnosis and *"allowing myself to leave that fear behind.*" Seemingly, her final session illustrated how Kate could access, acknowledge and experience her more difficult emotions, and learn from her emotional experience without fear. Kate's decision to finish therapy at this point suggests that her final insight about what further work to do in terms of her emotions was going to be done without therapeutic input.

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

Unfortunately there was no data for Kate's end of therapy interview, as it was her preference not to arrange another interview at the end of therapy, so in order to

capture some of her experience of therapy the following summary of her mid-point of therapy is presented.

Mid-point of therapy interview

In her mid-point of therapy interview after session 7, Kate began by stating that she had been feeling physically fatigued from an infection and as a result low in mood all week. Having been weaned off strong painkillers in the days previous and coming off a course of antibiotics, she observed *"feeling good since the start of therapy"* but there were *"really really low periods*" in the past week that had her so physically unwell she "*has lost the handle on things. When I feel weak, and tired, and annoyed I get sick of myself. That's how I'm feeling now."* An initial consultation with her reconstructive surgeon had also furthered doubts and fears in Kate, *"it turns out it won't be straightforward at all, so I'm going to have to put myself through more pain. It's all been so severe and has had such an impact on my life."* The interview proceeded with this context in mind, perhaps reflecting the physical demands of her illness during the particular week the interview took place and the influence it may have had on her perceptions of her progress in therapy. In coming to therapy Kate felt she had come to see the value in acknowledging her feelings "*Before*, *I might not have told anyone how much I've gone through or how it's been and now I would say it."* This increased ability to communicate her own feelings also translated into how she interacted in close relationships, notably that "*I would listen to people more and take their views into account before assuming I'm always right because I have a knack for doing that. Particularly at home."* Trusting others more allowed her to approach longstanding tensions in her marital relationship, which included discussing their respective families of origin, parenting styles including "*how we raise the kids,*

separately and together and we are really honest with each other now, it's changed us massively in a very very positive way…we have been able to be a lot more open with each other."

Perhaps telling, Kate alluded at the start of the interview to the high level of performance and achievement she expected from herself historically, and perhaps relatedly, she interspersed her commentary about the process of therapy with statements reflecting how profound her treatment fatigue was "*right now even lifting my arms feels like such an effort."* Her ability to push herself, even to attend her appointment for the interview itself, may reflect that her expectations for herself over-extend her need for self-care, and have an impact on how she relates to others caring for her. Kate shared an illuminating anecdote about the relational bind her high expectations create; "*I went to sleep yesterday afternoon and when I woke up I had to ring my husband to bring up soup- I got kind of annoyed- like I'm lying here for hours and no one has come to see how I am."* While Kate could see she would have good days and bad days in the process of recovery, her wish for a full recovery dominated portions of the interview. She described finding therapy quite challenging, including fears of whether she could access her emotional experience without becoming completely overwhelmed by it, "*it's the low periods coming back when I feel so physically sick when it's hard to see that I will ever feel better again."* It would seem that at the mid-point of therapy Kate felt a considerable amount of fear in approaching the emotional impact of past experiences and in addressing current fears related to the impact of her breast cancer. It is notable that throughout the interview Kate seemed to vacillate between recognising the ways that therapy had been of benefit and expressing doubt about sustained improvement, which is perhaps reflective of the labile quality of Kate's emotional expression her therapist observed across therapy

sessions in the first half of therapy, as well as the high level of support Kate needed to draw on to sustain her through her challenges.

When asked to comment on what she felt to be the major areas of change since starting therapy, she reported *"stepping back and allowing others to take an action or solve a problem another way than how I would have done it."* Letting go of feelings of over-responsibility was "*huge"* because of the relief that came with knowing "*I don't have to be the one to be everything to everyone all of the time."*

Kate also elaborated on the value of exploring her place in her family or origin and processing how she had reacted to losing her father from cancer a decade previous. Kate felt she connected to unprocessed emotions: *"I had three small children at the time, and working full-time I was up to my tonsils, so I didn't really have time."* "*Facing that kind of thing has been good*" and Kate felt there were beneficial ramifications in her apprehending an increased ability to come to terms with her own diagnosis, acknowledge that those dialogues had also enables her in terms of *"facing the fear of dying"* and "*dying from cancer.*" She felt these changes were very unexpected and unlikely without therapy, "*When I came to therapy I had no idea how it would go and I've come through it feeling more equipped to deal with issues as they come up in life, and will even through the next year or two."*

Becoming tearful as she described the comfort taken from the attentiveness therapy provided; "*having someone just to completely focus on how I'm feeling,"* highlighting perhaps an increasing awareness of a latent loneliness that she had been carrying emotionally. This sustained attunement facilitated Kate to be more *"vulnerable- it was coming out of me voluntarily but those deep emotional traumas that came out early in therapy were surprising to me and they came out of me at such a deep heart felt level. It surprised me but it was also very helpful and a cathartic*

kind of thing." In particular, Kate identified the chair tasks as catalysing the greatest changes; "*it was very helpful using the chairs, moving from one chair to another as a method because verbalising it out loud really brings it out into reality and makes it easier, and also makes it seem real rather than when you just talk about it."* Kate also attributed the space and approach in therapy as helpful in overcoming some of her historical avoidance that had been a primary part of her coping from a young ago, "*The therapist knows the right questions to get me to explore my feelings and attitudes that I don't think I would have taken the time to do, or really even know how to do on my own."*

3.6. Case Study 6, Emily

3.6.1 Introduction

Emily is a 41 year old Caucasian female who was referred to the Psycho-Oncology service after she completed her radiotherapy treatment. Her documented reason for referral was stated as distress and upset in relation to fertility problems and hormone therapy side effects. Initial intake confirmed that Emily was highly anxious and distressed around the long term side effects of her treatment and was struggling with medical decision making, including whether to continue taking hormone therapy as a consequence. At the time of referral Emily had also made the decision to resign from her place of work, and the family pet had died suddenly, of metastatic cancer, three months before she was referred to Psycho-Oncology services. Emily had one child with her partner, whom she described as generally as supportive over the course of her breast cancer treatment and who took time off work to accompany her to all her medical appointments. A total of 25 sessions of psychological therapy was completed

as part of the research study an experienced EFT therapist who is the Principal Investigator of the research study.

Emily's treatment for Grade I breast cancer involved breast conserving surgery (lumpectomy), and her adjuvant treatment included radiation therapy and hormone therapy. Emily had a medical history of anxiety and depression (post-partum onset), which she did not receive psychological therapy or psychiatric medication to treat. There was no specific family history of cancer.

Prior to commencing therapy, Emily completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP/R/. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Major Depression and Generalised Anxiety Disorder and Panic Disorder. Her score on the Hospital and Anxiety Scale was 22. Emily also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Depressive Personality Disorder.

3.6.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

The therapist believed that therapy went well in this case, although it was not always apparent that therapeutic progress would translate into a good outcome in that her historical experiences of invalidation had been internalised so absolutely that overcoming her avoidance of core pain was challenging. Early on in therapy, Emily could not identify a figure in her life who had given her a sense of security, comfort, or who she could rely on emotionally for support and encouragement, which was reflected in her scepticism around receiving verbal soothing and support from the

therapist. Interpersonally, Emily needed a lot of encouragement to verbalise her concerns for therapy, and often reported difficulty labelling her emotions. The therapist often had a sense of "digging" for specific autobiographical memories to access affect. At the same time, it was clear Emily felt there was a value in attending and used feedback extremely well, as she completed post therapy forms with thoroughness and a fluency that reflected her need to reflect privately before she could articulate what had been captured for her in session.

Emily often presented with overwhelming fear alongside helplessness. Challenges within the therapy included the delicacy of establishing a good therapeutic alliance where there was a trauma (interpersonal rejection and humiliation) based avoidance of engaging in novel tasks such as those which are central to EFT as an experiential therapy. In her life generally Emily worked extremely hard to ensure that no criticism could fall on her. She also felt a generalised sense of failure for being so held back based on her worries and fears, sensing that she was missing out on her own full potential. A lot of encouragement to not worry about the "right answers" was needed for her to engage in the chair dialogues and that on relational terms the therapy was non-judgemental. Overall, the therapist believes that good progress was made and Emily was able to access her core pain of loneliness, fear and shame through chair dialogues with herself and significant others. Reflecting back on the case, the therapist was aware of having to go extra lengths to show due consideration to Emily's feelings of loss associated with the death of her pet, and to maintain the empathic recognition of her pet as a beloved companion. The seriousness of the bereavement for her as a loss as equivocal to the loss of a significant family member or spouse was a trigger for her core pain and one where Emily herself was conflicted by self-criticism and invalidation over the depth of her anguish. Providing

encouragement to mourn the loss seemed further complicated by the wider limited social/cultural sanctioning of mourning pet losses where pet/human relationships are commonly considered less important. Maintaining the validity of the loss and its particularly frightening aspect for Emily as it stemmed from cancer as part of the case formulation was central to helping to differentiate her core pain and to further develop her capacity for self-compassion

The relational aspect of the work felt particularly significant as Emily seemed to benefit from the therapist modelling a certain candidness, and the humour shared fortified the alliance and carried the therapeutic work through to its ending, where she felt a greater sense of confidence, visibly reflected in her increased expressiveness in her clothing and style through personal grooming, and describing a flourishing community based involvement in fundraising and other cancer awareness events.

Case Formulation

The analysis of Emily's case formulation is based on the reflections of the therapist.

Triggers of Emotional Pain

In keeping with the EFT model of case formulation, there were several triggers both past and present that triggered emotional pain in Emily. Early experiences were shaped by paternal authoritarianism that was punitive and extremely limited in emotional nurturance. Her mother's mental health was fragile throughout her childhood, which rendered her "*distant…she never knew us really*." Her mother's intermittent psychiatric hospitalisation for postnatal depression across subsequent pregnancies while Emily was a child was never discussed or explained in the family.

Recalling periods where her mother would be taken into hospital, her relationship with her father was very difficult, as she described always "*being on alert*" to his "*moods*", noting he had a temper and that the children were primarily seen in terms of their capacity to take care of housework, particularly herself and her sisters. Witness to her father's contempt towards her mother and her mother's fear of her husband's recriminations, Emily's early experience was that vulnerable emotions were unacceptable and a sign of weakness that would result in treatment as invalidated and inferior. The disapproval towards her mother was also shown by her older siblings' verbal put downs and disdain, which pained Emily as she recollected feeling vicariously diminished. Emily had few memories of laughter in the household, and rather recalled being made to do chores with efforts made to be seen as little as possible to avoid bullying by her older siblings. Gendered power imbalances also shaped Emily's early experience, as she remembered the women of the household getting cheaper cuts of meat and food. With fleeting validation, affection or mirroring, Emily felt she was a failure. Often feeling unloved and inferior, her worth rested in what she could accomplish with tasks at home or in her career, with hopelessness about this ever changing.

Other historical triggers involved her older siblings physically intruding on her privacy, producing shame around the time of her sexual development. Her father openly would express critical contempt and verbal abuse towards Emily's mother, which her siblings also directed at her mother, furthering her distress. The frequent threat of violence left Emily with the feeling that she was "*walking on eggshells*", and recalled often tightening her body, holding her breath, and trying not to be seen or heard in order to avoid punishment or condemnation.

A current life stressor related to her breast cancer that was painful for Emily at the start of therapy was the impact of hormone therapy on her fertility, which complicated and diminished any likelihood that she would be able to conceive the second child she had always wished to have. Hope for another child was also linked to past hardship/trauma, whereby her pregnancy during adolescence was perceived as a source of shame on her religious and traditionally valued family of origin. Too cloaked by shame to celebrate the birth of her firstborn meant that she had always longed for a different pregnancy experience, which was compromised by her hormone positive breast cancer diagnosis and its associated treatment (i.e. inducing early menopause).

The second life stressor that contributed to her feeling overwhelmed and distraught was the death of her pet dog to metastatic cancer months after her own treatment for cancer. Challenged by her own survival (and contrasted with the bereavement), Emily felt a dominating, frightening pressure to change her lifestyle to a way that was more closely connected to values she had previously minimised, including a sense of meaningfulness in her life purpose and career, and supportive relationships, however the mortality based threat breast cancer represented triggered an urgency that prevented her from moving forward, rendering her panicky and overwhelmed.

Emily was also traumatised midway through psychological therapy from an episode of intimate partner violence (IPV), and historically had experienced physical abuse from older siblings and witnessed physical intimidation by her father towards her mother. The ruptured sense of safety in the marital relationship, which had been free of violence for years (but had initially been reportedly violent), triggered

significant heightened distress and exacerbated her symptoms of anxiety and depression.

Global Distress

In session, Emily often talked about her fears in relation to mortality that were triggered by the loss of her pet and her own breast cancer diagnosis. She found thoughts of loved ones dying unbearable and overwhelmingly frightening, collapsing into global distress. Emily's feelings during this time were of annihilation and unbearable devastation. Sessions during the period after her partner attacked her felt even more fragile to the therapist as Emily's experience of painful shame was so strong that she would become frightened, cutting them off. This traumatic experience further triggered Emily's underlying pain and her self-contempt that made it more difficult for her to stay with feelings of not being loved as she would have wished, and she collapsed into helplessness and hopelessness (global distress) under the weight of her own self-blame.

Her death anxiety included fears of bodily pain, bodily failure, separation from loved ones and loss of control and power when she thought about loved ones dying that led to collapse into helplessness, "*we should be able to stop it (death)…it's just got to be so painful, and there's nothing that can be done."* Her worries were highly evocative and distressing in that each thought of envisioned death involved pain, suffering and a sense of failure. Unbearably catastrophic, Emily would feel overwhelmed and collapse into upset and a sense of helplessness.

Negative Self-Treatment

Emily described her working life as a significant stressor for years prior to diagnosis. Long hours were exhausting and filled with performance anxiety that she characterised as chronic "*self-doubt*" and "*poor self-belief.*" Beyond her fear and anxiety surrounding the idea of further loss or death of loved ones was secondary hurt from her own self-critical invalidation (the internalised voice of her father and husband) that often judged her to be incompetent. Even as an adult, Emily perceived her father's expressions as capable of reducing her to feelings of failure, inferiority and inadequacy.

Triggers for the possibility of further losses or pain was followed by self-blame and chastisement that her emotional vulnerability was "*stupid,"* deepening her sense of inadequacy. Emily struggled with a sense of not belonging and a lack of self-competence, and perhaps consistent with her high score on SCID II for avoidant personality disorder, Emily described herself as extremely sensitive to negative evaluation. She viewed herself as inept and devalued her skills and capacity.

In relation to her loss of fertility and the loss of the family pet, her grief was compounded by self-blame *"obviously I didn't help her [family pet]. I failed…the tumour was inside her and so I didn't…I should have acted sooner."* Emily's helplessness in relation to mortality would render her childlike and terrified, and subsequently self-admonishing and contemptuous about her own feelings of painful vulnerability, *"It's all my fault that I didn't save her."* Her pet's death raised feelings of terror in relation to the possibility of losing others in her life, which Emily felt was unbearable, but her inability to cope with loss also brought up profound feelings of inadequacy and failure "you *didn't do good enough"* that came with self-condemnation, "*I am so stupid."* Emily found her sadness unbearable, and her self-

reproach was relentless; "*it's easier to be mad at you than feel sad."* Her intolerance of emotion compounded her contempt; "*if you get emotional, it's your problem. You need to get yourself together."*

Prior to her diagnosis, Emily treated her work as her life, however post diagnosis she reflected on how she coped with painful feelings by working herself *"to the point where I was just a machine, all auto-pilot*." High standards dictated her rigid self-treatment; "*do everything perfectly or it's not worth doing at all.*" Emily's perfectionistic "*soldier*" self (mobilising achievement as well as self-critical and ridiculing) was contributing to her high levels of shame around emotional experiencing, leaving her with a resulting difficulty tolerating and processing the feelings of pain and loss relating to her experience with cancer.

Anticipatory Anxiety, Emotional and Behavioural Avoidance

Emily found it hard to trust herself as a consequence of a childhood that was structured by "*tasks to be done*", and had learned to suppress tears or other outward signs of distress, which left her alone and small, and largely avoiding outward self-expression. As an adult she carried her fear of authority and was terrified of being unable to withstand criticism, leading to chronic anticipatory anxiety and an underlying sense of inadequacy. Invariably these secondary feelings prevented her from connecting with others, in so far as her anxiety perpetuated anticipation that social interactions would to lead to personal ridicule, humiliation, rejection or dislike from others. She recalled her childhood as "*watchful"* and having internalised the admonishment she experienced as a child, Emily avoided anything that might lead to

another bit of (self-directed) contempt. Highly sensitive interpersonally, Emily regulated interpersonal pain by withdrawing from and avoiding closeness.

Often avoiding new situations, Emily consequently felt empty and unfulfilled. Tellingly, Emily often presented as highly rational. By focusing on rationalism as a way of coping she consequently avoided accessing more primary based feelings. Early on in therapy Emily described great difficulty with decision making around whether to discontinue her hormone treatment. Stopping her hormone treatment would affect her probability of cancer recurrence, however the cost of continuing involved facing the profound loss associated with infertility. Her tendency to rely on her intellect and process of rational thought was exhausting as it was tied up with self-criticism, in so far as if she ended up in a disaster (e.g. an outcome she dreaded) she would blame herself, believing it was her fault. Her own self-recrimination was a source of fear for Emily, as she experienced it to be paradoxically deserved and persecutory.

In the context of past triggers and current stressors and losses, Emily did not verbalise or experience her emotional life with much detail. Often over controlled, she inhibited feelings in a number of ways, through 'deactivating feelings', and situational avoidance. Avoiding acknowledgement of her need for love was achieved by a tendency to minimise the maltreatment she had received as a child, "*I didn't deserve any better."* Emily would often flee internal experience by narrowing attentional focus, becoming highly cognitive and/or shutting down. As a consequence of so many avenues for avoiding feeling, she was in exile from reflecting on or experiencing her deepest values, wishes and needs. What was accessible was a profound self-contempt, and she often called herself "*stupid*" and "*crazy*", particularly if she became outwardly emotional. Constantly apprehensive of triggers that would bring painful

emotions, she was afraid of feedback from others that would put her down, and she also dreaded feelings of loneliness that were triggered by any reminders of death or dying. In session she often demonstrated avoidance by emphasizing her wish to "*move forward*" and achieve unclear goals, again demonstrating her cognitive emphasis while also indicating how unbearable her core feelings of shame, sadness and loneliness were to tolerate.

Core Emotional Pain

Overwhelming grief after the death of her pet and the loss of her fertility after her breast cancer treatment had activated Emily's core feelings of unresolved sadness and shame. Her completion of her treatment for breast cancer and her good prognosis highlighted Emily's impression of being hidden and half alive, which she felt at odds with in the face of the added responsibility for *"really living"* her survivorship presented.

From the perspective of CAD symptomatology, Emily's core pain is dominated by *loneliness,* related to low self-competence (shame), and for others to see what she could do. The sense of *loss* contributed to her core emotion scheme, including loss of the unconditional love she experienced from her pet, loss of bodily parts, reproductive capacity and loss of potential to re-experience pregnancy and motherhood.

Her underlying pain further contained *shame and trauma* (sense of worthlessness) stemming from invalidation and attacks/rejection—currently from her partner, and potentially triggering situations where she might be criticised (in work, or in her exercise training), and the threat to her mortality that her cancer presented, in terms of herself and others.

Unmet Needs

Historical sources of interpersonal pain includes experiences of being shamed and humiliated, which leave unmet needs for affection and support, and to feel adequate and valid. Interpersonally, her unmet needs are to be valued and acknowledged, and for a sense of safety and protection where she feels connected and loved by others.

Unmet emotional requirements from childhood for unconditional love, safety, reassurance and basic mirroring and interest in her character development left core feelings of not being good enough and a need for nurturing, which was heightened in the context of distress related to her cancer. Her associated existential distress was a closely connected adaptive need to feel loved and protected.

Emotion Transformation

Emily's initial distress involved a constant apprehension of painful emotion and fear of any further sudden trauma or loss. With regard to her experiences of loneliness and shame, Emily needed to hear that she was worthy of nurturance and love. In (imaginary) chair dialogues with her father in sessions 1, 3, 5 and 17, Emily experienced the core pain of loneliness of having missed out on being recognised and accepted by her father; "*I missed out trying to be invisible all the time…you [father] didn't get to know me, I'd be afraid to talk to you, properly (voice breaking in pain and sadness)".* Emily's core pain from childhood was exacerbated around the time of her adolescent pregnancy, "*I knew you were going to judge me so I had to hold this pregnancy for five months. I had to keep a secret because I knew and felt then that*

you definitely wouldn't love me." Emily expressed the heart-break of her loneliness and shame, and how she needed her father's support and acceptance, *"I needed to hear you were there for me no matter what."*

Emily's core pain of not feeling loved was closely linked to being dismissed/rejected, shame, and to the accompanying feeling that she deserved such treatment. Emily's self-directed contempt was pervasive across early sessions, particularly in relation to the self-blame she felt about her pet's death; "*I couldn't save her, I let her down."* Emily further criticised herself for still being upset *"I should just get over it. I know other people would think it's just a dog."* In early self-dialogues, Emily would frequently express a lot of hopelessness and direct harsh admonishment towards herself for having feelings of pain or hurt, "*The time is gone. It's gone."* In a structured imaginary chair work for unfinished business where Emily dialogued with her pet, her core pain of sadness at loss and loneliness was poignant, "*When my partner and my son are away it feels like the house is an empty vessel. I wouldn't have noticed if I didn't get cancer….we would have a baby. I would have another life in a baby carrier…she (the family pet) was company…you and I were companions for each other."* Emily's grief was also for the part of her that enjoyed looking after others and nurturing. Having learned not to show affection meant that providing compassion or soothing towards herself felt unfamiliar. Chair dialogues where her experiencing self was able to speak up to her harsh inner critic and proclaim a right to *"not be a soldier all the time"* helped loosen the rigidity around what feelings were acceptable as it fostered a sense of protective entitlement. With repeated validation to stay with her feelings of sadness as a valid expressions and through dialogues with significant others (e.g. mother, partner) where she articulated unmet needs for validation, mirroring and connection, her imagined ideal mother

responded with the words in one dialogue that *"it's okay to feel that way",* reflecting an adaptive emotional response to her need for love and acceptance in the face of profound sadness. Emily was able to connect and experience the pain of loss associated with the death of her pet, and immerse herself in the feeling of unconditional love and safety she had received within that relationship. Needing love made her vulnerable to hurt and pain, however beyond her grieving she was able to feel the relief that came with feeling supported, letting go of some of the primary sadness she had been avoiding.

Primarily making good in session progress, her feelings relapsed with an episode of intimate partner violence. With such a profoundly disrupted sense of safety and degradation, accessing core painful feelings was too evocative in the aftermath of the trauma. Emily was offered support to access information about resources, including legal and other community services that might be helpful, as well as made aware of the option to report the incident to appropriate authorities, which she declined. Safety issues were also discussed. In therapy, self-soothing work helped Emily develop self-support and feel strong enough to "withstand" strong, painful emotions, and restore enough empowerment to mobilise the need for allowing her feelings and their expression. Emily was only able to access minimal self-compassion in the wake of the attack for several sessions, as she felt unworthy of soothing or support from herself or another, including the therapist. Experientially, Emily blamed herself and felt subsequently eroded in herself.

As Emily was increasingly able to take in some soothing and compassion in imaginary chair dialogues, lessening her distress, sense of trauma and self-blame, imaginary chair dialogues for unfinished business with her husband were employed in the therapy sessions. This work was done tentatively and with close attention to

helping Emily feel more in control of her life by articulating her own feelings of anger about the violation of her safety. The imaginary chair dialogues were not about re-living the abuse, but rather about accessing a sense of empowerment from adaptive anger that could be safely expressed within therapy. Able to stand up for the self in the imaginary dialogues with him, Emily demonstrated emotional transformation from primary core shame to protective anger that generated a sense of empowerment and transformed her insecurity to self-regard; "*I am strong and proud of myself*," acknowledging the event *"was not my fault"* and assertively holding her partner accountable for wrongdoing. The therapist gave due consideration to the delicacy of ensuring Emily engaged in the dialogues with the understanding that experiencing herself as strong and agentic was important, and at the same time that these dialogues were separate to her relationship with her partner where she had to consider their interactions in the context of her own perception of risk of further violence. Outside of therapy, the couple came to an acceptable resolution around the event for Emily, where her partner did take responsibility and agreement was made around limiting alcohol intake.

While these dialogues helped generate a sense that she could gather strength and persevere, imaginary chair dialogues were also utilised for dialogues with her mother and father respectively. Core pain included sadness and loneliness stemming from historical emotional abandonment and neglect, "*I felt a lot of pressure, a huge sense of responsibility at a young age…to always be working and never being allowed to play much…never able to let my guard down in case mam got too frazzled or dad came home with drink on him and got angry"* Never getting the reinforcement of a sense of acceptance and security from her parents and partner, Emily connected to the core pain of loneliness, sadness and shame that accompanied her feelings of being

scrutinised and yet emotionally abandonment and lonely. Asked to name what she needed in the context of that primary pain, Emily asserted, "*I needed more love and affection and care"* because *"I felt I wasn't safe."* With coaching from the therapist and validation of her core painful feelings, Emily could assert *"I needed to feel good about myself. And I'm angry that you didn't instil any confidence in me."* When she enacted her imagined father she (as him) was able to acknowledge her hurt *"I'm sad that you had those feelings"* stating *"I love you."* Emily found these words alien (thus invalidating reception of them), although they also came with a sense of *"comfort."*

Strong emotional avoidance presented limitations as to what could be achieved across the therapy sessions, however a great deal was achieved in therapy. Emily was able to access her core pain of feeling lonely, shame around her experiences of loss, invalidation and rejection, and her fear of facing frightening things (i.e. her breast cancer, mortality of loved ones) and new situations that were unfamiliar. She was able to be compassionate towards the vulnerable part of herself (often through enacting her pet dog caring for her in the imaginary dialogues). Compassion also brought more grieving over her own losses, but this developed a "letting go" quality that was experienced as cathartic and was tolerated as meaningful and important, rather than as a source of shame and self-directed contempt. Chair work around early experiences with parents provided a way to process past injuries as well as putting into contextual meaning into a new and developing sense of self. A lingering sense of being able to progress post treatment was addressed in terms of a dialogue with her inner critic:

> Therapist (Speaking to critic): *How do you make Emily feel panicky? This is your relationship with you right. So what do you say to her?*
>
> Emily (as her inner critic): *Well what are you doing now? And that's not being done right.*

Therapist: *And what's the message?*

Emily: *Make sure you do it right or don't bother doing it at all*.

Therapist: *Because what would happen. What's the fear?*

Emily*: Well nothing will happen but it won't be done right. And I'll make you feel like crap. Because why couldn't you get it right the first time.*

Therapist: *And can you come over here? (*Invites Emily to switch to experiencing chair*)When you get that, it's familiar but what do you feel*

Emily: *You make me feel afraid to do things that I haven't done before or perfected.*

Therapist: *What's the impact of hearing if you can't do it right don't do it at all.*

Emily: *It makes me feel bad.*

Therapist*: Tell her. You are cheated me of…*

Emily*: Of the ability to try and to try new things and so what if there are mistakes or two it's not the end of the world.*

Therapist: *Because I want what? (*Encouraging articulation of unmet need*).*

Emily: *I want the freedom to be able to explore little things and not to feel anxious if something isn't gone right. So I want, yeah, I want that anxiety unleashed, not given power but broken.*

Therapist: *So are you someone who makes mistake after mistake?*

Emily: *No.*

Therapist*: But this part of you has been telling you that for years. So tell her. (*Promoting protective anger*).*

Emily: *Well okay, I'm not the sort person who makes mistake after mistake. I listen as carefully as I can. And I do that to show respect and also because I am interested.*

Therapist: *So tell her what you think of the fear of doing new things.*

Emily: *I have a right to be creative, and to explore, I need to have that freedom and if it doesn't look right who says there is a right way?*

Therapist: *What does it feel like when you say those words, I'm not a person who makes mistake after mistake?*

Emily: *It's like a recognition admitting that I'm not that person. It's like speaking out.*

Therapist*: And you feel something, it sounds like it registers some truth. I'm not inept.*

Emily: *No I'm not, I do try my best.*

Therapist*: And what do you believe about you?*

Emily*: I believe I'm actually okay. And I'm listening to people now, and looking at other people now more, and I notice now that I'm not a bad person. I am actually good, and I am good and what I do.*

Therapist: *Yes.*

Emily: *And so it's not just that I'm going along…and faking it.*

Therapist: *Right! So tell her, I don't even need your approval because I know I am good enough.*

Emily: *I don't even need your approval because I'm good as I am and I'm good at a lot of things.*

Therapist: *And when you say that what do you feel?*

Emily: *It's beginning to resonate with me. Yeah. Yeah.*

Therapist: *Right, can you come over here?*

(Emily changes chairs from critic to experiencer self).

And do you hear that statement Emily has just said that I don't need your approval anymore.

Emily: *Yeah I do.*

Therapist: *And what happens in you when you hear that. Because it's like first of all I'm so angry and fed up with you that I could shoot you, but secondly actually I don't even need you anymore.*

Emily*: Yeah. Well it feels like you are rising to my level.*

Therapist: *And that does what to you?*

Emily*: It makes me feel like maybe the little person inside her isn't such a piece of shit.*

Therapist: *Tell her.*

Emily: *Yeah maybe the person inside you that's trying to grow and develop and try new things is to be respected. You know maybe you aren't a piece of crap.*

Therapist: *So what do you think, if she isn't a piece of crap, what is she? What do you feel towards her….is it like I respect you?*

Emily: *Yeah, I'm beginning to have respect for you, yeah. Because you are a different part of me, but you are also interesting. So you have my attention.*

Therapist*: Right.*

Emily: *Yeah, because I do really think that part of me is interesting. The bit that is getting growing.*

Therapist: *Right, and the feeling towards her being interesting? It's not only you are not a piece of shit it's like I care or something.*

Emily*: Yeah, and I enjoy that. And I enjoy seeing you like that.*

Therapist: *Good. Can you come over here? What do you feel when you hear that? It's like a real relationship.*

Emily: *I'm thinking the more we get to know each other, I do honestly believe that maybe we can work together*.

Therapist: *Yeah that this high standard can be a part of you but it doesn't need to break your ability to know that the process is okay, and that there's room for things needing to be adjusted along the way without that being painful or stressful.*

Once Emily could feel herself to be worthy of experiencing life without having a constant pressure that missteps would be unforgiven, she was able to explore her own desire and wish to try new things with decreased defeating self-judgement and without the plague of anticipatory failure that was also hindering her ability to live more fully.

Towards the end of therapy, Emily began to change what she was doing, taking on new projects, demonstrating a restored sense of motivation and purpose alongside expanding her social circle and supports. Emily's transformation was apparent in her increased acceptance and agency, which was seen in her recounting of the sadness she tolerated and shared when speaking to support group about her loss of fertility. Free of the elements that contributed to previous upset and able to accept

herself and her situation, Emily could express healthy grief and maintain her sense of herself as worthwhile, with the support around her to endure the vulnerability associated with sadness. Across the sessions, the transformation of her fear of mortality was built by naming unmet needs for security and accessing compassion for her primary sadness alongside a need for motivating protective anger that charged her with the volition; "*I can build a meaningful life*."

Emily's increased self-confidence was also apparent in her ventures post therapy, which involved an adventure trip abroad for a worthwhile cause and sharply contrasted with her past avoidance of risk taking and novel behaviour. Interacting with the public during her fundraising events meant that she was telling her story and describing the meaning she apprehended as part of her recovery. The dominant emotion was of feeling "overwhelmed" and "moved" by the reactions of others in their feedback to her. Their positive evaluations were being internalised in a way that would have been difficult for her previous to therapy.

3.6.3 Measures

3.6.3.1 Analysis of Quantitative Pre-Post Outcome Measures

Emily' scores are presented for pre-, mid-, and post-therapy and at her 6 month follow-up assessment in Table 3.6.1.

Table 3.6.1

Emily's Pre-Post Outcome Scores

Scale	Caseness	*RCI*	Pre-Treatment	Mid-Treatment	End of Treatment	6 Month Post
HADS Anxiety Depression	11	3	26 14 8	6 6 0	5 4 1	5 4 1
FACT-G	78	17	91	89.5	95	98
SCL-90-R GSI	0.8	0.13	1.41	0.81	0.33	0.31
DERS	78	16	85	69	38	32

Note: Caseness= the cut off for determining whether the client is clinically distressed. HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

At the beginning of therapy, Emily's score on the HADS of 26 indicated severe clinical symptoms of anxiety and depression. By the mid-point of therapy, her score had dropped significantly and placed her below the clinical range. She kept her (5) score by the end of therapy, and maintaining a subclinical score with a pre post differential of 21 indicates that she recovered on HADS (using Jacobson & Truax [1991] criteria for reliable and clinically significant change). Her maintained score of 5 on the measure suggested she remained free of comorbid anxiety and depressive symptoms at her six month follow up.

On the FACT-G, Emily's score of 91 prior to therapy indicated that her quality of life was perceived to above what is considered caseness. The increase in her

score mid-therapy suggests she was beginning to see improvement in her quality of life, which continued up to the end of therapy with a score of 95. Emily's pre-post differential of 4 did not meet the criteria for reliable change (Jacobson & Truax, 1991), thus her score on this measure needs to be considered as unchanged.

Emily's pre-therapy score on the SCL-90 of 1.41 placed her in the clinical range. By mid-therapy, her score had reduced by nearly half to 0.81, which remained in the clinical range but demonstrated a reliable reduced level of overall distress. Her score continued to decline to 0.33 at the end of therapy and satisfied the criteria for clinically significant and reliable change (Jacobson & Truax, 1991) and thus can be considered to be recovered on this instrument. This subclinical score was maintained at follow up six months later, suggesting she remained subclinical.

Emily's DERS score at the start of therapy was 85, indicates she used emotion regulation strategies that were maladaptive and likely contributing to distress. By the mid-point of therapy, her score of 89.5 indicates that she was having greater difficulty with her emotions, or perhaps that she had a heightened awareness of the number of ways she had difficulties across the dimensions of the scale. By the end of therapy, her score of 38 demonstrates reliable and clinically significant change (recovery) in capacity to modulate emotional arousal and employ more flexible strategies and responses in relation to emotions. Her final score 32 six months after completion of therapy indicates her recovery and that in the use of adaptive emotion regulation strategies she was stable.

Target Complaints (TC)

Prior to each therapy session, Emily completed a Target Complaints form. The information provided by this measure is presented in Table 3.6.2

Table 3.6.2

Emily's Target Complaints Data

Complaint	**Pre-Therapy**	**Mid-Therapy**	**Post Therapy**
Afraid to Progress	10	6	3
Sadness/Overwhelmed	9	6	2
Self-Conscious/Self-Doubt	9	7	2.5
Fear of Future and Concerned I need to Embrace It/Live Fully	9	6	3

As can be seen from Table 3.6.2, all of Emily's target complaints are related to her CAD diagnosis. In addition to her fear of the future and felt need to fully live, she also reported fears about making progress and moving forward, as well as feeling emotionally overwhelmed, sadness reflecting her low mood and self-doubt. At the beginning of therapy, Emily rated all of her Target Complaints in the same upper range (9-10), however by the mid-point of therapy they appear to be somewhat diminished at par (6-7), and by the end of therapy her scores had settled in the lower range (2-3).

3.6.3.2 Analysis of Process Measures

Helpful Aspects of Therapy (HAT)

At the end of each session Emily was asked to fill out a Helpful Aspect of Therapy form, the data from which is presented in Table 3.6.3.

Table 3.6.3

Emily's Helpful Aspects of Therapy form Data

Session	How Helpful?	Helpful Event	What made it helpful?	When in session?	How long did it last?
1	6	Realising that my dad still has an impact on my feelings and the way I behave today	Recognising that my dad might not have been aware of how he was making me feel	Towards end	10-15 mins
2	8	Realising that the feeling that "I didn't do a good job" were instilled in me from childhood. And that I took this interpretation from my dad's behaviour	I felt good coming away from the session. I realised how my dad has impacted my feelings, even now	Mid-way	30 mins
3	8.5	When I heard my dad saying that he is proud of me.	I recognised that I have an overwhelming need to hear my dad saying that he is "proud" of me. I see how as a child I needed that	Mid-way	20 mins
4	7.5	Recognising that my pet's passing has been so painful and the feelings that me and her shared	My pet's diagnosis of cancer and mine; that we were on a journey together. But it was cut short and I feel it was abrupt. Using my pet to tell me to remember the good years will help me	Near end	20 mins

5	7.5	Picturing myself as a little girl, I had to feel how she felt: de-valued, unsure, not noticed, not recognised. I realised that this little person was achieving everything she could, trying to be the best at anything she did (because she wanted to be recognised).	I realised how much potential that little girl had and that she had so much to be proud of but she had not experienced enough feelings of praise, celebration, and recognition for who she was and her capabilities. I realised I need to build on this	Mid-way	30 mins
6	7.5	I had to be the part of me that needed nurturing, encouragement and self belief	I realised there is a potential creative side of me, a part that dreams a lot of positive possibilities. This side is kept "in check" by the other part that's stronger. I think I've realised this part of me needs to grow, it needs to develop and have equal space as the strong part	Mid-way	30 mins
7	7.5	When I put my partner in the chair. Also putting my pet in the chair.	I realised how deflating my partner can make me feel and how much I depend on him. I realised how warm my pet's words are and how I need to hear them	from start	50 mins
8	7	When I had a dialogue with my husband. And I had to explain to him how I feel.	I realised that his words can be restricting in times of conflict. So I need certain things from him. I felt a feeling of slight determination	quarter in	40 mins

9	7	Using my pet to draw comfort from	A lot of emotion is attached to thoughts of my pet being there for me. And I think there's so much pain because of her feeling for me and that I miss her for what she was	quarter in	40 mins
10	7.5	Putting my partner in the chair	It made me recall positive comments as a person and my personality	quarter in	40 mins
11	7.5	Discussing my relationship with my sister. Discussing my fertility challenges	I realised how important maintaining close connections that I have in times of struggle. I've realised I'm revisiting my options	Mid-way	55 mins
12	7.5	Re-visiting the part of me that constricts myself	By exploring and understanding this part of myself. I can lay down new patterns of behaviour	quarter in	40 mins
13	7.5	When the therapist asked me to talk about death	I realised I need to explore feelings of fear that are attached to death	quarter in	40 mins
14	7.5	Recognising the importance of the emotional role my mam took	I've realised how her behaviours and her attitude within the family have impacted me	quarter in	40 mins
15	7.5	When the therapist made me aware that I need someone (friends or relative) in my life that connects with my adventurous side. Or that it's important to have someone who allows you to celebrate experiences	I realised that's why I gravitate towards certain people. And that I need more of this in my life	Near end	15 mins

16	7.5	When the therapist spoke of the need for my emotions to be given some space, comfort and reassurance	I've recognised that my emotions are important to me and that I need the people close to me to reflect that also (and show me reassurances)	quarter in	40 mins
17	7.5	Realising that my progress towards obtaining objects that offer me enjoyment is ok. It's more than ok. It symbolises a lot in my life.	These discussions have allowed me to improve my mindset. And to be more positive and look forward to the future	near start	50 mins
18	7.5	When I discussed with the therapist why I feel I can't be more outgoing	I'm hindering myself with my own thoughts that are instilled in me. These thoughts lead me to believe "I'm just a girl so don't really count"	quarter in	40 mins
19	7.5	When we put my brother in the chair and explored the possibility that feelings of inferiority have been projected by him towards me	I realised that he had a lot of power when we were younger and the ability to make the girls feel like shit	near start	50 mins
20	8	When I put the negative restricting part of me in the chair. And I listen to what she was saying, how she controls me. And then I made the decision whether I would keep this relationship going	I recognise that I will not continue this relationship with myself, unless she changes her ways to supporting, reassuring and believing me	quarter in	45 mins
21	7.5	Recalling the memories of mother, as a little girl	I realised that I didn't feel re-assured by my mother when I was small. I felt I was a bother to her at times and therefore I needed to become useful	quarter in	40 mins

22	7.5	When the therapist and I discussed my experience when I'm having panic attacks	I realised that maybe I needed comfort and reassurance when I experience these panic attacks. Maybe I need to allow myself the recognition that these feelings and emotions are important	quarter in	40 mins
23	7.5	Recognising the way I have adjusted my life and created better balance, that this had made me aware that people who are close to me can also do this (older sister and me)	I learnt that maybe my sister is just doing what I was doing, trying to prove herself	Mid-way	30 mins
24	7.5	When the therapist put my pet in chair and got me to explain I'm only human	On saying that I realised that may I don't need to feel guilty	quarter in	40 mins
25	8	When the therapist was discussing recent events in relation to fund raising. Reflecting on how I feel	Reflecting on feedback from my fundraising and the therapist made me feel really good and positive	quarter in	40 mins

Emily's comments regarding her first session highlighted the newness of experiencing emotions that had previously been avoided or out of awareness, including the link between her father's historical treatment of her and her own emotional experience in the present day. Emily was also able to apprehend some softening towards her father on the basis of an increased understanding of his emotional limitations, stating that the chair task had encouraged her to *"recognise my dad might not have been aware of how he was making me feel."* Her second session continued on the same theme of her relationship with her father, whereby she continued to process his impact on her feelings, including a sense of not doing a

"good job", and judging herself harshly as a consequence. Session 3 demonstrated some emotional transformation took place, where a shift from a focus on her father's treatment of her provided Emily with an opportunity to address historically unmet needs attached to her core pain, including the need to receive validation as a child from him and hear *"he is proud of me."*

In her fourth session, Emily focused on the loss of her pet dog, and demonstrated an ability to face the painful emotion associated with it, remembering both the sadness that their time was *"cut too short"* but also being able to acknowledge *"the feelings that me and her shared,"* which eased her pain "*using Jess to tell me to remember the good years will help me."* In her 6th session, Emily felt it had been helpful to connect with an empathic self and *"be the part of me that needed nurturing, encouragement and self-belief"* which moved her emotionally from a place of hopelessness to connecting to suppressed healthy desires for growth and personal expression; "*I realised there is a potential creative side of me, a part that dreams a lot of positive possibilities."* Hearing this part of herself allowed Emily to recognise its validity and needs for *"equal space as the strong part [of me]"* that historically kept her *"in check"* to succeed along more familiar and self critical lines.

Session 7 had two chair dialogues that Emily identified as helpful I that they prompted a contrast between supportive and encouraging words, which she needed to hear more of in her relationship with her partner, and she drew strength from hearing them in a chair task with her (remembered) pet dog, "*I realised how warm his words are,"* suggesting an increased capacity to take in compassion and support. Session 8 promoted contact with *"slight determination"* in the face of conflict with her partner, hinting she was harnessing assertive anger and felt an increasing entitlement to having her needs named and met. Emily was able to name the pain of loss and the missed and

longed for connection associated with her grief, and the chair task facilitated her drawing on her relationship with her pet dog for needed comfort. Following on in session 10, Emily experienced validation from her partner directly, which further developed her experience of being valued, loved and experiencing compassion.

Session 11 was found to be helpful as it was used to look at her fertility challenges associated with her breast cancer treatment, and while Emily would have traditionally not leaned on other for support, she had learned *"how important maintaining close connections I have in times of struggle,"* demonstrating a more adaptive approach to her feelings of sadness. In session 12, a two chair dialogue with a self-interruptor that *"constricts"* feelings allowed Emily to have increased awareness and *"lay down new patterns"* in the way she related to her emotional experience in times of distress, where increased self-directed compassion and self-supporting capacities stem from a recognition of her own worth.

In session 13 the therapist prompted her to speak about mortality and her fears around death and dying, which Emily named as helpful and alluded to her feelings needing clarity. Session 14 was helpful in that it focused on her emotions attached to her relationship with her mother and letting out the *"behaviours and the attitude within the family"* and expressing her own feelings of how her mother's vulnerability impacted her.

Sessions 15 and 16 were found to be helpful in furthering Emily's awareness of her need for support and connection with others that would benefit her confidence, "*It's important to have someone who allows you to celebrate experiences….I need more of this in my life."* Similarly, Emily found Session 17 and 18 helpful in connecting with compassion "*when the therapist spoke of the need for my emotions to be given some space, comfort and reassurance"* and enjoyment, which in turn enables

her to stand up to the part of herself that absorbed historical messages about her worth as a woman, *"I'm hindering myself with my own thoughts instilled in me that led me to believe 'I'm just a girl so I don't really count."* Sessions 19-22 included helpful dialogues that facilitated Emily to stand up for herself assertively and acknowledge unmet needs from members of her family of origin, and grieving the losses associated with these memories, connecting with primary sadness and core pain, *"I realised I didn't feel re-assured by my mother when I was small"* that connected her to an adaptive need within her cancer experience of needing *"comfort and reassurance when I experience these panic attacks…I need to allow myself the recognition that these feelings and emotions are important."*

Session 23 involved a reflection over her accomplishments in the weeks prior, and Emily was able to take ownership of changes, including "*the way I have adjusted my life and created better balance"*, which also was seen to be helpful to explore in therapy as it increased her insight of others in her family of origin, alongside herself, benefitting her relationships "*I learnt my sister is doing what I was doing, trying to prove herself"* and a recognised capacity to support her. In session 24, Emily found the process of self-forgiveness in relation to her pet's death facilitated her to connect with the vulnerable and fallible side of herself, "*I'm only human"* seemed to facilitate her realisation *"I don't need to feel guilty."* Emily's use of tentative language throughout her helpful aspects of therapy forms reflects how her emotional processing extends beyond the sessions themselves. Her final session was seen as helpful in that it reinforced Emily's growing self-confidence, "*reflecting on feedback from my fundraising and Allison made me feel really good and positive."*

Retrospective Recall of Helpful and Unhelpful Aspects and Client Report Changes (Client Change Interview)

In her Client Change Interview Schedule meeting with the researcher upon the completion of therapy, Emily observed that she felt a significant improvement in her well-being since beginning therapy; stating "*I'm doing great. I am at two different ends of the spectrum. From where I was when we started to now."* She described herself as lost at the start of therapy, with "*these huge emotions obviously within me that were completely scattered.*" Emily referred to how, traditionally she would have characterised herself as an "*introvert*", where her emotions wouldn't have been shared with others, and that before therapy "*fear and anxiety would have stopped from doing things, trying new thing, I'd be predicting the outcome as bad before I'd even tried."*

Identifying herself as someone very "*driven and perfectionistic,*" Emily saw therapy as place where "*I let go of some of the anxiety."* Emily took the perspective that therapy was a place to build self-reflective insight, and one where she could recognise historical patterns in the standards and strictness with which she lived her life:

> *Before I would have been more rigid in the way that I sort of managed my life and my work. I would have I would have been a soldier in my work. My son related to me as an iron fist. Do you know what I mean? I think now I would allow more of the humorous side of me to come into my work that allows me to enjoy it more. There a deeper level to me now that I hadn't before. And it's even deeper than that.*

Making observations about her approach to living and work historically and her increased flexibility marked an increased self-confidence and ease in allowing more of her personality to emerge around others.

When asked to identify whether there was anything missing or unhelpful from her therapy, Emily reiterated that she found it only to be a positive experience and could not pinpoint any unhelpful events across the sessions. Emily was able to look back and see the value of examining difficult experiences "*I had to understand and accept where these emotions and feelings were coming from. And ultimately why I am who I am."* Emily reflected on the main challenge brought up through therapy; *"I had an awful fear of dying, and an awareness of death and my mortality, that has, the fear that drives, has subsided. Not completely dissolved but it's less overwhelming, it's diminished."* Noting that before she would have found thoughts about death or dying intolerable, she felt she was able to open up and persevere with difficult emotions surrounding mortality and in fact the prospect of mortality itself, stating, "*it's like taking back the control and the fear of death. I was surprised, it would have been quite unlikely without therapy. That's very important to me."* Her increase in emotional tolerance is a significant achievement, and though difficult, is recognised as holding value, "*talking about the fear of death and the subject of losing Jesse was painful and still is, and the fear of losing my parents and when they die and that they are going to die. That's uncomfortable, it's painful, but actually it's okay for it to be that way."* Emily recognises with acceptance losses and fears that cannot be changed with tolerance and a matter of factness.

In her own self-description, Emily was able to offer herself significant esteem, highlighting her own positive traits of being "*loving and caring*" and a "*kind of teacher*" to others, and in turn heavily emphasised the empowerment she drew from

taking in the recognition of her positive traits and drive from others, stating how others had characterised her recent charity fundraising activities as "*inspirational*" "*motivating*" and "*having something to offer."* Pride was evident in Emily's voice as she spoke about receiving praise and admiration from others. Emily also described her relationships with her nieces and nephews as strong attachments where she is *"seen as very lovable"* which demonstrates her own ability to see herself as worthy of appreciation, fondness and connection.

Her development of self-understanding and her increased self-belief translated into her behaviour, "*now I feel I am more grounded. And I've changed, I've changed what I'm doing as well. I have changed my activities."* She attributed these changes in her activities as being a result of "*no longer being confined by fear*." Emily's gains from therapy are perhaps in part attributable to her observation that she is "*extremely driven and a hard worker*", which is equally observable in how she fared in therapy and her utilisation of the process to make changes in herself. Emily noted that the high standards she set for herself was something she was continuing to work on, to be able to go into "*new things and experience then, do them, and just enjoy it,"* which reflects a level of motivation to continue her own self-development and a clear goal for the future.

3.7 Cross-case Analysis

3.7.1 Cross-case Quantitative Analysis of Pre-post Outcome Data

Cross-case, pre-post outcome data for all participants are presented in Table 3.7.1.

Table 3.7.1

Cross-Case Quantitative Analysis of Pre-Post Outcome Data

Scale	Pre-Treatment		Post-Treatment		Effect Size (Cohen's d)
	Mean	***SD***	***Mean***	***SD***	
HADS	**23.66**	**5.95**	**8.83**	**2.92**	**3.16**
FACT-G	**62.16**	**24.39**	**91**	**17.08**	**-1.36**
SCL-90-R (GSI)	**1.41**	**0.71**	**0.41**	**0.15**	**1.94**
DERS	**99.83**	**18.32**	**58.33**	**12.53**	**2.64**

HADS= Hospital Anxiety and Depression Scale; FACT-G= Functional Assessment of Cancer Therapy (note for this scale alone higher scoring indicates better Quality of Life); SCL-90-R= Symptom Checklist 90 Revised; DERS= Difficulties in Emotional Regulation Scale.

In order to test the efficacy of treatment on the HADS, a Paired *t* test was conducted. Note that given the very small sample all of the analysis is tentative only. This test was found to be statistically significant, t (6) = 5.47, p< .05, two tailed; d= 3.16. The effect size for this analysis was large (d= 3.16). These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment (M= 8.83, SD= 2.92) then in the pre-treatment assessment (M= 23.66, SD= 2.92).

In order to test the efficacy of treatment on the FACT-G, a Paired *t* test was conducted. This test was found to be statistically significant, t (6) = 2.37, p< .05, two tailed; d= - 1.36. The effect size for this analysis was d=-1.36. These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment (M= 91, SD= 17.08) then in the pre-treatment assessment (M= 62.16, SD= 24.39).

In order to test the efficacy of treatment on the SCL-90-R, a Paired *t* test was conducted. This test was found to be statistically significant, t (6) = 3.34, p< 0.5, two tailed; d= 1.94. The effect size for this analysis was d= 1.94. These results indicate that participants reported fewer symptoms on this measure in the post treatment assessment (M= 0.41 SD= 0.15) then in the pre-treatment assessment (M= 1.41, SD= 0.71).

In order to test the efficacy of treatment on the DERS, a Paired *t* test was conducted. This test was found to be statistically significant, t (6) = 4.57, p< .05, two tailed; d= 2.64. The effect size for this analysis was d= 2.64. These results indicate that participants reported fewer symptoms on this measure in the post treatment assessment (M= 99.83 SD= 18.32) then in the pre-treatment assessment (M= 58.33, SD= 12.53).

3.7.2 Cross-case Analysis of Qualitative Data

3.7.2.1 Cross-case Analysis of Data from Client Change Interviews

The following section analyses data from six participants' post-treatment assessment interviews (Client Change Interview).

Client Experience of Change

Participants' comments on their "Experience of Change" are presented in Table 3.7.2.

Table 3.7.2 Client Experience of Change

Experience of Change	**Number of respondents***
Increased awareness/insight	6/6
Improved relating to others	6/6
Increased self-acceptance	6/6

Increased emotional resilience with improved emotional experiencing	5/6
Increased assertiveness	5/6
Reduction of depressive symptoms	5/6
Reduction of anxiety symptoms	4/6
Increased self-worth	4/6

*Number of participants who identified with the experience of change.

In total, eight categories of experience of change were reported by participants in their post-treatment assessment interviews. Five out of six of the participants commented on a sense of **increased emotional resilience with improved emotional experiencing**. Statements such as "*I'm no longer volatile"* (Laura), "*I can deal better and be optimistic about things"* (Ruth) and "*before, I would have been more rigid in the way I managed my life and work, now I would allow more of the humorous side of me to come into my work that allows me to enjoy it more"* (Emily) were identified as changed stemming from therapy.

Four out of six of the participants referred to a **reduction in anxiety**; "*fear and anxiety would have stopped me from doing things, trying new thing…I let go of the anxiety"* (Emily) and *"I'm not having the sleepless night where my mind is buzzing and buzzing"* (Laura). Five out of six of the participants described a **reduction in depressive symptoms**; "*I'm not the weepy wreck I was"* (Laura) and *"the darkness has come out of my thoughts from when I was diagnosed, and its lighter"* (Jane). For those who felt lingering distress, they still were able to offer commentary that suggested improvement was in progress: "*I still get tearful a lot, but I'm working on it. And it doesn't last as long"* (Sophie).

Increased self-acceptance was expressed by all participants; *"I got to see myself…and accept myself and stop pushing myself so hard"* (Ruth) and "*now I*

regard my [disfigured] body as part of me, and I'm proud of it. It's part of who I am and I'm okay" (Jane). Self-acceptance came with an increased acceptance of changes and losses stemming from breast cancer; "*When you get sick and when everything changes, when everything goes wrong for you and you can't get back on track…its' hard. But I had the space to adjust to what I thought I had lost forever and when I had the time to adjust, I grew out of that and started to rebuild a sense of myself*" (Ruth) and "I *have an openness and ability to come out and speak about the cancer now, and share that with others in my life. I have an ability to share my story now and talk about it"* (Jane).

Participants also expressed **increased self-worth**; *"I was able to discover the value in me, I have come to understand and even love myself"* (Jane) and "*I was actually shocked by the inner confidence, and my confidence wouldn't have changed without therapy. Before therapy it was almost gone, it was on the floor*" (Ruth). Four of the six participants referred to an **increased assertiveness**; *"I'm more assertive, before I used to feel I had to be there everybody but now there is a layer of cling film just separating it…I'm learning to say no, being assertive at home"* (Laura) and *"I started to rebuild a sense of myself…before I'd probably say yes just to please other people, but now I'm able to ask myself and decide, well do I want to go? I'd stick up for myself."* (Ruth). **Increased awareness and insight** was identified and commented upon in all six of the participants; *"I'm learning. I'm getting to know myself, which is strange saying that at this stage" (Sophie)* and *"I don't let those feelings scatter me, it's about understanding them and doing something with them"* (Emily).

Improved relating to others was remarked on by all six of the participants; *"I'm more supportive of him [husband] but I'm expecting to be more supported from him as well"* and *"I have far closer relationships with friends…I would have always*

had good relationships with friends but they are a lot closer now" (Laura). Improvements in relationships also included a sense of empathy; "*I would listen to people more and take their views into account"* (Kate). Trusting others more also formed a component of improved relationships for Kate, and she referred to her marriage specifically; "*We are really honest with each other now, it's changed us massively in a very, very positive way."* (Kate).

Helpful Aspects of Therapy

Participants' comments on the aspects of therapy they considered helpful are presented in Table 3.7.3.

Table 3.7.3

Helpful Aspects of Therapy

Helpful Aspects of Therapy	**Number of respondents**
Safety in therapeutic relationship/empathic listener	6/6
Emotional processing of painful life experiences	6/6
Facilitated emotional expression	5/6
Experiential Techniques (i.e. Chair-work)	4/6

In their post-treatment assessment interviews, participants identified four categories of helpful aspects of therapy. Six of the respondents commented on the value of having the **therapist as an empathic listener and the sense of safety in the therapeutic relationship**, *"the therapist was great, she put a lot of work into finding the words for me that helped me* (Sophie) and *"I felt very secure with the therapist, always protected and I was never left feeling too vulnerable. Never"* (Laura). Emily also commented; "*it was so supportive, and we established a lot of understanding…I*

felt very lost before I came to the therapist and now I feel I am more grounded. I knew I could speak to her and she would understand me" (Emily). Five participants regarded the **facilitation of their emotional expression** as being particularly helpful, "*...the opening up and getting air into this tunnel that never had air (point to centre of chest). The therapist explained that things needed to be aired, discussed and felt. So only from my therapy would that have come out"* (Jane) and, *"the therapist knows the right questions to get me to explore my feelings and attitudes that I don't think I would have taken the time to do, or really even know how to do on my own. It's the assistance of therapy that's helped me."*(Kate). Six of the participants felt that the **emotional processing of painful life experiences** was constructive and significant in their therapy; *"I had these huge emotions within me that were scattered…and I had to understand and accept where these emotion and feelings were coming from. I would have been very lost at the beginning (*of therapy*) as I said, but now I feel I am more grounded."* (Emily) and for Jane, *"it was difficult to share how painful it was to go through cancer and hearing all of my own life experiences, but from that I realised that I was alright, that there was an alright Jane there and I could come to understand myself and even love myself"* (Jane). Four out of the six respondents identified **experiential techniques such as imaginary chair work** as a valuable part of their therapy, "*It was very helpful at certain times using the chair, moving from one chair to another because it helped me to say things out loud…really brings it out into reality and makes it easier and makes it seem real rather than when you just talk about it."* (Kate) and *"there was a lot of chair talking and that was phenomenal."* (Laura).

Unhelpful Aspects of Therapy

None of the participants reported finding any aspect of the therapy as being unhelpful in any way on their helpful aspects of therapy forms completed at the end of each session.

Aspects of therapy identified as difficult but therapeutic

The majority of participants responded to this question in the affirmative, acknowledging that therapy was not always an easy process, which was mainly attached to the experience of talking about and emotionally processing painful life events. For example, Kate found that getting used to the process of therapy was initially challenging, "*I found it very difficult at the start, not having gone thought it* (therapy) *before I wasn't familiar with it. And facing up to things that are not working in your life is quite difficult"* (Kate), however, she reported also "*it's less intense now than after the first few session, and I've learned now how to deal with more difficult things from it and it's all been very helpful and good to do that*" (Kate). Laura also reported finding the process of therapy initially *"draining, where I wouldn't be in great form in the evening after"* but found that *"just looking for time on my own and a good night's sleep always sorted it out"* and *"there wasn't anything that I wanted from therapy that I didn't get from therapy"* (Laura), implying that the toll of therapy in terms of energy was nonetheless valued as worthwhile. For Sophie, the emotional demand of therapy remained high throughout, "*every session is painful, but that's okay. I find the sessions hard, I get emotional and teary but it's not hindering"* (Sophie).

Chair tasks in EFT were specifically identified as being difficult while also being therapeutic; "*the chair work was exceptionally and deeply emotional. And tiring. I really felt the person was there, and sometimes it was very sad, and sometimes I was exceptionally angry. And hearing back their responses could be upsetting. It was hard. And it was also perfect for me"* (Laura). Ruth similarly identified the chair work as *"very intense…the chairs would not be my favourite, but then after doing them for a white it wasn't so hard then, and the outcome of the whole thing was just great in the end"(Ruth).* Sophie experienced the chair work as *"difficult, and it took a while to get used to, but I think it's good, because I'm always in two minds, and when there's a conflict, you can work it out when you have the chairs. It's more tangible"* (Sophie), indicating that she found the chair work within EFT gave a structure that helped her understand and symbolise her internal states, including self critical processes.

3.7.2.2 Cross-case Analysis of Helpful Events and Impacts from HAT forms

An analysis of HAT forms was performed to extract the events and impacts which were deemed to be helpful on the basis of client post-session reports. In total, six categories of helpful events and seven categories of helpful impacts were identified (See Table 3.7.4).

Table 3.7.4

Cross-case Analysis of Helpful Events and Impacts from HAT forms

Helpful Events	**No.**	**Helpful Impacts**	**No.**
EFT Tasks (i.e. chair work)	6/6	Emotional Relief	6/6
Attending to Pertinent Issues	6/6	Empowered	6/6
Accessing Core Pain	6/6	Reassurance	6/6
Identifying Needs	6/6	Problem Clarification	6/6
Expressing Cancer related Emotions	5/6	Feeling Understood	5/6
Therapist Validation	4/6	Feeling Worthy/Coming Back to "Me"	5/6
		Awareness/Insight	5/6
		Grieving cancer related losses	4/6

Helpful Events

Six participants identified engaging in **EFT tasks** (i.e. imaginary chair work) as being helpful during therapy, for example, "*when I leave this session today what I have acted out by changing seats will be of great help to me, later today and over the next few days."* (Ruth). Five participants referred to the helpfulness of **expressing cancer related emotions**, "*talking about the changes cancer has brought about (was helpful)"* (Sophie).

Accessing core pain was identified as a helpful event for six out of six of the participants, "*dealing with my sense of worthlessness"* (Sophie) and "*when I let out my emotions and sobbed for some time. It really made me aware how deeply hurt and angry I am"* (Kate). Four out of six participants named the **therapist' validation** as a helpful event in therapy; *"when the therapist spoke of the need for my emotions to be given some space, comfort and reassurance."* (Emily).

All six participants referred to the **identification of needs** as valuable events in therapy, *"describing my emotional needs from my father (and others) in the weeks prior to my surgery"* (Jane; referring to unfinished business dialogues). Lastly, all six participants refer in their HAT forms to the **attendance to pertinent issues** as being a helpful event in therapy which were often cancer related, "*talking about how to manage my return to work in relation to being absent* (on sick leave) *for 15 months."* (Laura), and "*discussing my fertility challenges."* (Emily).

Helpful Impacts

Five participants referred to therapist **understanding** as a helpful impact of therapy. Examples from this category include, "*sometimes the therapist knows what I'm going to say before I even speak"* (Ruth). **Awareness/insight** was also reported by all participants, which appeared to support coping with distress; "*talking with the therapist makes it very plain for me to see things as they are, this is very helpful and the best thing for me"* (Ruth) and; "*hearing, listening and receiving words made me realise how strong all these emotions and feelings are. No wonder I feel exhausted all of the time*" (Jane).

All six of the participants reported that a sense of **emotional relief** was a helpful impact drawing from therapy. One participant stated the following; "*there was so much stuck in me at the beginning of therapy, and it's opened right up, and it was such a surprise to feel all this air rushing in and clearing out so much of the past"* (Jane).

Six of the participants found **emotional reassurance** to be a helpful impact in that it helped normalise their feelings; *"to know that it's okay to feel, to feel some fear*

somtimes…it's like taking back the control that I have the tools to deal with these feelings, and the feelings often subsided" (Emily).

Problem clarification was commented on as a helpful impact of therapy by six of the participants. Examples of this category suggest increasing insight about their emotions, and include comments such as, "*I need to talk about me more often to my husband, to help him understand what is going on."* (Sophie). Another participant noted: "*it demonstrated that I am suppressing my emotions at time"* and facilitated "*being able to clearly see the importance of opening up parts of my life which I tend to ignore or skirt away."* (Laura). **Grieving cancer related losses** was a helpful impact for four of the six participants, *"being open with my feelings of loss when my grandfather died (of cancer) reassured me that it is okay to feel the loss, but also that he is still there (in my memories)* (Laura), and another participant stated; *"I'll never have my breasts again, which used to make me feel so lonely and sad, but I now feel that I am still a woman, and I never thought I would feel that again"* (Jane). All participants described feeling **empowered**; "*being open and being able to discuss that I was recovering from breast cancer. Being encouraged, I realised my ability, now and today, to move on. <u>I can</u> handle things."* (Jane).

Five out of six participants identified a sense of **coming back to "me"** as a helpful impact of therapy that included feeling worthy. For example, one participant commented, "*I've reached full circle- the warmth and love I felt physically and emotionally towards the end of the session made me realise how much of a woman I really still am. This is possibly the first time I've felt this connection. The love, feeling and care are still in my heart and chest, even without breasts. I am so thankful"* (Jane).

3.7.3 Cross-case Conceptualisation

The analysis of all six cases with regard to case conceptualisation is based on the retrospective recall of the therapists involved in the particular cases (see Chapters 3.1-3.8., sections on case conceptualisation).

All participants reported states of undifferentiated global distress and frequent worry of further loss of control over the course of their illness, consistent with death anxiety involving fears of bodily failure, body pain separation and loss of power. The experience of abuse, aggressive mistreatment or neglect during their upbringing were also part of triggers that affected the cases of Jane, Ruth, Sophie, and Emily. For Kate, the experience of learning her siblings were abused was vicariously traumatic. As criticism and negative evaluation formed a part of the abuse or mistreatment, participants' global perceptions of themselves similarly (negative self-treatment) was correspondingly shaped by internal sense of the self as worthless, deficient or flawed (core pain).

More than half of the participants (Laura, Kate, Sophie and Emily) reported post natal depression (global distress) and perhaps relatedly, also described their own past experience of insufficient emotional support from their mothers. Struggling with parenthood contributed to a sense of shame and engagement in self-criticism, self-blame and self-doubt and a feeling of not measuring up to maternal expectations. Feelings of self-doubt and shame in part fuelled feelings of guilt (e.g. *I'm failing as a mother)* and contributed to the women over-burdening themselves in terms of caring for others (behavioural avoidance of core shame). For Laura, Jane, and Kate, this also involved caring for their elderly parents as well. At times, this sense of being over-burdened (and unsupported) would result in secondary maladaptive expressions of anger.

For Kate, being overwhelmed emotionally was a recurring reflection of her difficulty in staying with core pain within sessions. While she was able to respond compassionately towards herself, she was also highly fragile and reported marked global distress between sessions as well as falling into states of global distress easily within sessions. Jane also displayed fragile processes however her longer number of total sessions in therapy in contrast to Kate may have contributed towards further development of new emotional responses- in particular the protective anger that helped anchor and empower her sense of self. Emily, by contrast, had difficulty throughout her therapy expressing vulnerability as she, prior to therapy, viewed it as detestable and pitiable. Laura, Ruth and Sophie similarly treated their feelings of vulnerability with dismissal and harshness; interrupting primary emotional experiencing

In all of the cases, trauma and loss was a central aspect of the core emotional pain of the participants. For Jane and Ruth, a sense bodily loss in the form of disfigurement and chronic pain from surgery was one component of their traumatic loss. Emily and Jane also felt a poignant sense of grief and sadness around the loss of fertility stemming from their breast cancer and its treatment. For others, loss from cancer related bereavement within their family (in the cases of Ruth, Sophie, Emily and Kate) contributed to their perception of cancer as frightening and sense of abandonment, which was marked by a longing for that person as a source of soothing and loneliness in the wake of their absence. For Emily and Kate a family history of psychiatric illness contributed to their sense of abandonment.

With an internalised sense of failure, core shame affected all of the participants. Loneliness was also a common emotional factor stemming in part from low perceived support within marital and family relationships across the cases. In

terms of their current circumstances, aggressive mistreatment by significant others or in partnerships/marriage was an additional trigger to current core pain for Jane, Ruth, Emily, and Laura and reflected unmet needs for support, protection and closeness. Existential fear added a new dimension to currently activated core pain, (e.g. shame based feelings of not having lived up to their or others expectations in the face of a threat to mortality and fear of emotionally damaging/impacting their loved ones through the course of the illness). Separation and loss, feelings which are invariably triggered with the diagnosis of a potentially life threatening illness such as breast cancer, elicited fear, anger, sadness, distress and grief as well as feelings of forlornness and abandonment. Core shame was expressed as a sense of powerlessness and feeling exposed, and was accompanied by self-directed disgust and a wish to hide, withdraw and avoid further experience of the unbearable emotion. Painful feelings of loneliness, loss, fear and shame reflected unmet needs for feeling loved and connected, to be safe and protected, and validated and accepted.

3.7.4 Cross-case Emotion Transformation

A cross-case analysis of emotional transformation is based on the therapists' retrospective recall. Generally, participants would present in states of global distress. The therapist attended to this distress initially by working towards increasing the participants' respective awareness of triggers and negative self-treatment. Across therapy sessions there was a high level of emotional avoidance seen across cases, a pattern that was pervasive and illustrative of the shame-prone, self-critical and trauma backgrounds all the participants cases exhibited. Triggered by the threat of cancer, and with initial difficulty accessing compassionate soothing or protective anger, these participants would often interrupt or halt their emotional processing in the service of

containing overwhelming affect. Avoidance processes, such as Jane relying on pain and anxiety medication in times of emotional overwhelm, or Laura expressing secondary anger towards others, served as some of the mechanisms by which participants remained stuck in maladaptive emotional strategies.

All participants described trauma related guilt that contributed to their sense of emotional burden. Successfully processing guilt through imaginary dialogues with significant others in two chair and empty chair dialogues involved expressing unmet needs for apology (to express or receive) or making a commitment to change behaviour were also a significant component of the grieving process. As part of working through unfinished business in the face of significant hurts, forgiveness (self or other) did not necessarily include reconciliation with the other offending significant other. In the cases of Jane and Kate, emotional transformation included an imaginary dialogues with a consultant/surgeon for her cancer with whom they held an asymmetric relationship and in part perceived violation. Part of imaginary dialogues for unfinished business involved moving past secondary emotions such as vengefulness and rage in order to access adaptive sadness and unmet needs for protection and safety. These dialogues often included an increase in interpersonal understanding of the feelings, motives and limitations of the offending person.

Within imaginary chair dialogues for unfinished business as well as self-self-dialogues, there was often a sense of exoneration that included in part insight and understanding for why the pain was inflicted. In part these dialogues involved expressing unmet needs and either the re-establishment of some relational trust and forgiveness, or alternatively letting go. In the case of Laura, her letting go was in part an acknowledgement of the loving relationship she would never have with her in laws. For Kate, her unfinished business dialogue with her father included an element

of empathy that re-established some connection, which was soothing to her. Similarly for Laura she as the injured party in imaginary dialogues with her husband was able to re-connect with the awareness "*I am more like those who have hurt me than different from them*," contributing to her letting go.

Accessing core pain was facilitated by the therapist, involving opening up to feelings of shame, sadness, loneliness and loss. Imaginary dialgoues were employed to facilitate softening or opening up to core emotional pain. By experiencing and differentiating these feelings unmet needs could be articulated towards significant close others which stemmed from that emotional pain. Harnessing protective anger to instate recognition and entitlement towards having emotional needs met for themselves and with others was an important avenue that experientially enabled participants to feel worthy and deserving of love, appreciation, respect and protection.

Seemingly, across the cases the emotional work of coming to terms with the life they had lived formed part of reconciling their identities and their newfound path as women who were also now living with breast cancer. In part the emotional transformation relating to their cancer involves a grief process alongside existential review, and these processes provide interesting parallels. Across the cases and therapeutic work there was a process of acknowledging the reality of the loss (or injustices/ emotional injuries); experiencing the pain (or working through one's shame or the emotions preceding forgiveness); making needed adjustments; and reinvesting emotional energy from grieving to living with hope (letting go, reconciliation).

The ability to generate compassion from a nurturing other or themselves involved several components that varied by case. Kate was able to be empathic with herself when things were difficult but found it harder to protect the use of her energy

as part of valuing herself. Laura similarly found it difficult to set limits for herself in terms of providing for others with a sense of understanding. For Emily, accessing compassion was more difficult in terms of reaching out and receiving collaborative support and encouragement when needed, and her chair dialogues were structured accordingly in order to transform her sense of core shame, name her need for validation and acceptance, and feel connected to herself as valuable and agentic. As part of reconciling their cancer experience, adjustment in all the cases included coming to terms with painful experiences and reinstating a hope for the future, without denying the loss itself. For Jane and Ruth, compassion involved naming unmet needs for validation as more than their illness and changed bodies, or roles are carers, and appreciating worthy as women in their own right. The focus on emotion across therapy sessions with case formulation guiding process and intervention, served as an organising map towards emotional transformation. Increased emotional flexibility varied in magnitude across cases yet reflected a newfound resilience that served to buffer the emotional adversity attached to living with breast cancer.

4.0 Discussion

The aim of the current study was to contribute to the development of EFT as an effective treatment for women with CAD and a diagnosis of breast cancer. By examining the impact of treatment across six case studies in terms of quantitative (from a battery of outcome measures; HADS, SCL-90-R, FACT-G, and DERS) and qualitative data on the outcomes of therapy as well as helpful and unhelpful aspects of the therapy process, it was hoped to establish a preliminary assessment of the potential efficacy of EFT for CAD in women with breast cancer and the processes that may or may not contribute to it. Gathering the therapists' perspectives, case conceputalisation and case transformation (i.e., therapeutic change) facilitated the development of an elaborated model of emotion transformation specific to a cancer context that tailores the transdiagnostic application of EFT to CAD in women with breast cancer.

4.1 Discussion of Cross-case Quantitative Analysis of Pre-post Outcome Data

The data presented in Section 3.7.1, suggests that the pre-post difference in mean scores for the treatment group was statistically significant, with large effect sizes across all measures. On the HADS, the mean score shifted from 23.66 pre-therapy to 8.83 post therapy, with an effect size of Cohen's d= 3.16; suggesting that participants had moved from the clinical into the non-clincal range of anxiety and depressive symptoms, improving significantly. On the FACT-G, the mean score shifted from 62.16 pre-therapy to 91 post-therapy, wth an effect size of d= -1.36; suggesting that participants had improved significantly in terms of quality of life. On the SCL-90-R, the mean score shifted from 1.41 pre-therapy to 0.41 post-therapy, with an effect size of d= 1.94; suggesting that participants had moved from the

clinical into the nonclinical range. Finally, on the DERS, the mean score shifted from 99.83 pre-therapy, to 58.33 post-therapy, with an effect size of d= 2.64. The effect sizes in the current study are large in that they exceed Cohen's (1988) convention for a large effect (d=0.80), however it was not possible to benchmark pre-post effect sizes found in empirical studies of psychological therapy for women with breast cancer and CAD specifically. Jassim, Whitford & Hickey's (2015) Cochrane review of psychological interventions for women with non-metastatic breast cancer reports on anxiety and depression symptoms indicates that of twenty-eight randomized controlled trials investigating cognitive behavioural therapy or generic psychotherapy, however the review results could not be used for comparison given effect sizes were provided by calculating the intervention against the control for each reviewed study. Of the studies cited by Jassim, Whitford & Hickey (2015), data was not available from the individual RCT's which provided pre post effect sizes where clinical anxiety and depression was assessed.

In terms of overall performance on the various measures, six out of the six participants moved from the clinical to the non-clinical range on the HADS. Four out of the six participants moved from the clinical to to non-clinical range on the FACT-G. Four out of 6 participants moved from the clinical to the non-clinical range on the SCL-90-R. All participants moved from the clinical to the non-clinical range on the DERS. The following discussion compares the results of the current study to those of other studies focussing on psychological therapies applies to women with breast cancer, however given the size of the sample for the current study (n=6), statistically meaningful comparisons are difficult to establish. As a result, comparison will be drawn by mean outcomes and by reviewing pre post effect sizes using the same

measures in representative studies and benchmarking them against the current study. Where possible, pre post effect sizes of the same measures were drawn from studies applied to a cancer population where participants evidenced symptoms of CAD, however this was not possible across all measures as clinically significant distress was not always a criteria for inclusion across other studies. Studies were largely drawn from a Cochrane review of psychological interventions for women with non-metastatic breast cancer (Jassim, Whitford, Hickey, Carter, 2015) where the quality of evidence was moderate to high and lends confidence in the estimate of effect.

With regard to results on the HADS, when compared to Kissane et al's (2003) randomised control trial (n=303) of women with primary breast cancer receiving cognitive-existential group psychotherapy, the current study reported data which indicated a pre-post difference on the HADS of 14.83 (pre mean 23.66, post mean 8.83; Cohen's *d*= 3.16), while Kissane and colleagues report data for the cognitive existential group psychotherapy of a pre-post difference of 0.9 (pre mean 9.8, post mean 8.9; Cohen's *d*=0.13). Subject to tentative benchmarking, the results in the current study on the HADS are better than the cognitive existential group psychotherapy, and also suggests that participants in the current study were enduring significantly higher levels of comorbid anxiety and depression as part of the inclusion criteria for the study than those in Kissane's research. Savard and colleages' (2006) randomised clinical trail (RCT) on the effectiveness of cognitive therapy (CT) in women with depression and breast cancer reported a pre post difference in the CT group on the HADS of 8.95 (pre mean 20.37, post mean 11.42), however because the study does not state standard deviation scores, it was not possible to calculate Cohen's *d,* and could not be used for comparison. Subject to tentative benchmarking, the

results on the HADS in the current study are potentially better to the results in the cognitive existential group psychotherapy presented by Kissane et al. (2003).

With regard to the FACT-G, when compared to Foley, Baillie, Huxter, Price and Sinclair's (2010) randomised control trial (RCT) (n= 115) of MBCT for clinically significant anxiety and depression in patients with cancer compared to a waitlist control condition, the current study indicated an average pre-post difference of 28.84 (pre mean 62.16, post mean 91; Cohen's *d*= -1.36), while Foley et al's data for the MBSR group indicated a pre-post difference of 7.18 (pre mean 71.62, post mean 78.80; Cohen's *d*= -0.48) and data for the no treatment group indicated a pre-post difference of 2.8 (pre mean 71.38, post mean 74.18; Cohen's *d*= -0.19). A tentative benchmarking suggests that the results of the current study on the FACT-G are potentially better than the MBSR group and control group presented in Foley et al. (2010).

With regard to results on the SCL-90-R, when compared to Monti et al.'s (2006) randomised control trial (n=111) of the efficacy of mindfulness based art therapy (MBAT) for women with breast cancer, the current study indicated an average pre-post difference of 1.0 (pre mean 1.41, post mean 0.41; Cohen's *d*=1.82), while Monti et al's data for the MBAT group indicated a pre-post difference of 0.20 (pre mean 0.93, post mean 0.73) and data for the wait list group indicated a pre-post difference of 0.04 (pre mean 0.85, post mean 0.81), however cohen's *d* was not provided which means that it could not be used as a comparison. Noting that the pre mean GSI score for the SCL-90-R was 1.41 in the current study and the pre mean GSI score for the SCL-90-R was 0.93 in Monti et al. would indicate that the participants in the current study were enduring significantly higher levels of CAD as captured on this

measure than those in Monti et al.'s research study, suggesting that the sample in the current study was substantially more chronic and complex.

Robins, Keng, Edblad and Brantley's (2012) study assessing the efficacy of group based Mindfulness-Based Stress Reduction (MBSR) for emotional regulation in with general distress and symptoms of CAD found the data on the DERS indicated a pre-post difference of 17.66 (pre mean 89.66, post mean 72.00; Cohen's d= 0.95) in the MBSR group and for the wait list control, the data on the DERS indicated a pre-post difference of 0.49 (pre mean 82.89, post mean 83.38; Cohen's d= -0.02). Tentative benchmarking against the current study indicates the findings of the current study on the DERS to be potentially better as the current study exhibited an average pre-post difference of 41.5 (pre mean 99.83, post mean 58.33; Cohen's d= 2.64). Results would suggest potential superiority of the EFT model over other models, including models within the Mindfulness/Acceptance based paradigm.

The account of these six case studies demonstrates the application of Emotion Focused therapy in a Psycho-Oncology setting and offers a window into the processes of EFT as applied to women with breast cancer and concomitant clinical depression and anxiety. Results suggest that EFT could be potentially effective in helping these patients to adjust emotionally and to prevent exacerbation of chronic psychosocial distress six months following their treatment completion, as six of the six participants recovered on the principal measure (Hospital Anxiety and Depression Scale) at the end of therapy. The tentative findings in the current study suggest that in general, the pre-post outcomes achieved by the six participants are potentially better than outcomes reported in studies using the same measures and studying other

(predominantly CBT and Mindfulness based) interventions for CAD, or based in a cancer population that presented with distress.

4.2 Discussion of Qualitative Outcomes

While case accounts illustrate the process of emotion transformation, post-treatment assessment interviews enabled participants to offer comments on their own experience of change from therapy that were aggregated into nine categories. These findings are broadly consistent with existing research of humanistic and experiential therapies.

In a meta-synthesis of qualitative outcomes across eight research studies on humanistic-experiential therapies, Timulak and Creaner (2010) identified 11 meta-categories of client reported change that broadly mirror the categories captured in this current study. Healthier emotional experiencing, for example, was similarly reported as *improved emotional experiencing* in the current study, which may reflect internalisation of the therapeutic relationship and the provision of therapist empathy facilitating the patient to become more capable of recognising, naming, and effectively modulating emotions and levels of arousal (Bohart & Watson, 2011). Simlarly, mastery of symptoms in Timulak and Creaner's meta-synethsis resembles the *reduction of anxiety symptoms* and *reduction of depressive symptoms* reported by participants. *Acceptance of illness related losses* was reported as an aspect of change stemming from therapy by participants, which was also identified in research by Omylinksa-Thurston and Cooper (2014) on helpful processes in psychological therapy for patients with primary cancers.

Increased self worth, *increased self-acceptance* and *increased assertiveness* were three separate categories that were reported by participants, which were also distinctive experiences of change in patient studies by other interventions (CBT and psychodynamic therapy) (Nilsson, Svensson, Sandell & Clinton, 2007). *Increased emotional resilience* identified in the current study was caputured by Timulak and Creaner (2010) simply as resilience. The final two categories of *increased awareness/insight* and *improved relating to others* were also reported in Timulak and Creaner's meta-analysis and by McElvaney and Timulak (2013) in a study of client experiences of psychological therapy (integrative approach) in a primary care setting. Studies by Klein and Eliott (2006), Lipkin (1954) and Cooper et al (2015) also reported clients that experienced a changed view of self and others, and that gained awareness through better self understanding increased confidence to apply strengths to problems encountered in the future. By becoming more capable of relying upon internal strengths and emotional flexibility, a more adaptive self concept that places more emphasis upon strengths and less emphasis on weaknesses, prior traumatic experiences or feelings of vulnerability seemed to also translate into better interpersonal functioning, which is also reported in research by Elliott et al. (2009) in terms of marital relationships/partnerships, and Klein and Elliott (2006) and Omylinska-Thurston and Cooper (2014) across close relationships.

Helpful aspects of therapy- retrospective recall

Based on post therapy assessment interviews, participant responses on helpful aspects of therapy generated four categories. The first category described the *safety in the therapeutic relationship/empathic listening of the therapist* as a helpful aspect of therapy and was reported by all six of the participants. An empathic and validating

therapeutic relationship has been captured by other studies that used an EFT approach (Angus & Kagan, 2013; Elliott et al., 2009; Klein & Elliott; McLeod et al., 2012; McLeod & Elliott, 2012). A core helpful aspect of counselling identified by participants with breast cancer in research by Morgan and Cooper (2015) was comparably identified as experiencing a helpful therapeutic relationship. A qualitative account on being a client with breast cancer (Galgut, 2014) correspondingly named empathic listening and safety in therapeutic alliance as a key component that was helpful in therapy, which is further supported by Lelorain and colleagues (2012) systematic review of empathy perceived by patients in cancer care (across healthcare professionals) as beneficial to patient outcomes in terms of reducing psychological distress, promoting better psychosocial adjustment and improving perceived quality of life.

Research by Holowaty and Paivio (2000) identified helpful processes during EFT for child abuse trauma (EFTT) as the outward expression of emotion and allowing full experience of emotions and emotional memories, which would resonate with the category of *facilitated emotion expression* identified in the current study. Similarly, research by Morgan and Cooper (2015) on the helpful and unhelpful aspects of counselling following breast cancer identified expressing and exploring feelings, including processing strong emotions, as a core helpful aspect of the counselling process. This would also be consistent with the EFT emphasis on promoting client depth of experiencing, with the inclusion of concepts such as emotional processing (Foa et al., 2006) and specific EFT theories that require attention to affective experience as a prerequisite for trauma recovery (Paivio & Pascual-Leone, 2010). Notably, participants did not distinguish certain emotions are more helpful than others, and although promoting anger expression in therapy is

controversial (see Cavell & Malcolm, 2007), researchers in the area of complex trauma recognise it's important for clients who fear and suppress their own legitimate anger at violation (Cloitre et al., 2002). The finding that participants found emotions including intense anger and sadness expression as helpful also supports the model of resolution (Greenberg & Foerster, 1996) that forms the basis of EFT in so far as anger is thought to promote self-empowerment, interpersonal boundary definition, and holding perpetrators (rather than self) accountable for harm; while sadness promotes compassion for self and grieving losses.

Participants further specified helpful aspects that are germaine to EFT which have been identified in existing research literature. For example, in Holowaty and Paivio's (2012) study identifying client-identified helpful events in EFT for child abuse trauma, allowing painful feelings is a grouping that resonates with the third category of helpful aspects of therapy in the current study, *emotional processing of painful life experiences.* Allowing processing of painful life experiences can be understood as maintaining a therapeutic focus on the full range of emotional experience (e.g. anger, sadness, fear and shame) and is related to the construct of "experiencing" (Holowaty & Paivio, 2012). By exploring subjective internal experience as well as constructing new meaning from that process, experiential contact with emotion is recognised in the psychotherapy literature across therapeutic approaches as contributing to outcome in terms of client depth of experiencing (e.g. Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Pos, Greeberg, Goldman, & Korman, 2003; Silberschatz, Fretter, & Curtis, 1986) and supports the current study's observation around helpful aspects from participants points of view. Findings that participants found these processes helpful are consistent with the treatment model which includes a focus on reducing experiential avoidance and self-critical processes

(Paivio & Pascual-Leone, 2010), again reinforcing the identified value of processing emotion.

Experiential techniques (i.e. chair work) was endorsed as helpful by four of the six participants in the current study, and was similarly reflected in a pilot study of group based emotion focused therapy for anxiety and depression conducted by Robinson, McCague, and Whissell (2014), where the personal experience in chairs was viewed as the main tool and the most helpful component in the therapy. Clients in EFT research have consistently recognised two chair and empty chair tasks as helpful (e.g., Angus & Kagan, 2013; Klein & Elliott, 2006; Elliott et al., 2009; McLeod & Elliott, 2012; McLeod et al., 2012).

While the first category, safety in the therapeutic relationship is commonly attributable to general therapeutic factors, the latter three categories identified as helpful aspects of therapy by the participants are overarchingly germane to EFT, and rather specific to the psychological approach applied in the current study. In session processes such as chair work have been validated as key components necessary for task resolution (Greenberg, 1979, 1983; Greenberg & Malcolm, 2002; Whelton & Greenberg, 2000), and empty chair dialogues employed with complex trauma clients resulted in more pre-post change than for those who did not (Paivio et al., 2001), independent of the therapeutic alliance, which would corroborate participants identification of chair work as a helpful aspect of therapy.

Problematic or hindering aspects of therapy have been reviewed elsewhere (cf. Richards & Timulak, 2012; McElvaney & Timulak, 2013; Paulson, Everall & Stuart, 2001; Paulson, Truscott & Stuart, 1999; Glass & Arnkoff, 2000; Elliott, 1985; Levy, Glass, Arnkoff, & Gershefski, 1996) using varying methodologies and procedures of

data collection, however in the current study participants did not report finding any aspect of the therapy as being unhelpful in any way. Reasons for why participants have not have reported any aspect of therapy as unhelpful is unclear, however it could be that participants wished to please the researcher, who was independent to the author of the study, given the amount of time that was dedicated to them over the course of their therapy. Inquiry into aspects of therapy that were difficult but beneficial in the long run facilitated the identification of therapy being inherently challenging in that it involved attending to emotional painful events and losses related to breast cancer, yet it was also felt as therapeutic. Perhaps relatedly, getting used to the therapy process was also identified as a difficulty and simultaneously recognised as a valuable in that it was experienced as therapeutic.

It is worth noting what was not commented on across participants. Participants were compliant with forms and measures administered over the course of the research, indicating that this was not an identified area of difficulty, and correspondingly was not identified as such. Participants also did not mention their own fears or limitations as hindering, such as arriving late to the sessions, fearing approaching painful feelings, or not opening up in the relationship to the therapist. This could be interpreted as lack of insight into one's own processes of avoidance, as insufficient understanding of one's own role in the therapeutic process, a wish to please the researcher given the amount of time allocated to their psychological care, or as a limitation of the measures and interview schedule in terms of a prompt to encourage reflective consideration of this component of therapeutic interaction.

Helpful aspects of therapy- session report

Data collected from the clients' HAT forms provides a depiction of in session helpful events and helpful impacts as identified by each participant. Items reported in the current study are consistent with taxonomies of helpful events from published research (e.g. Cooper et al, 2015; Timulak, 2010; Timulak, 2007) including helpful impacts. All participants in the current study identified helpful events including engagement with EFT tasks such as chair work, accessing core pain, identifying needs and attending to pertinent issues. The importance of participants experiencing the therapist and therapy as attending to pertinent issues cannot be underestimated, as client-therapist consensus and collaboration have been found to be positively linked to positive outcomes such as global assessment of functioning (Caspar, Grossmann, Unmussig & Shramm, 2005; Yovel & Safren, 2006), reduced symptoms of depression (Caspar et al., 2005; Cowan et al., 2008; Zane et al., 2005) and stages of change readiness (Brocato & Wagner, 2008).

The helpful impact of these events included a sense of understanding, emotional relief, empowerment, reassurance, problem clarification, and feeling worthy, which demonstrated both important contributions to the therapeutic relationship and in session outcomes. Four out six participants identified therapist validation as a helpful event, and five out of six identified expressing cancer related emotions, which was similar to the finding that four out of six of the participants felt that readjusting to cancer was significant as a helpful impact. The ability to feel adjusted or in the process of adjusting to cancer can be seen in the context of overwhelming feelings that were the focus of therapy, the intensity of which were captures by pre-post therapy measures and which participants identified as helpful in the post therapy assessment interviews.

Apart from categories that were cancer specific, helpful event and impacts were broadly consistent with Elliott's (1985) research clustering events into a taxonomy of helpful events. Emphasis within the categories on attention to the therapeutic relationship would be consistent with decades of psychotherapy research (Bohart, Elliott, Greenberg, & Watson, 2002; Curtis, Field, Knann-Kostman, & Mannix, 2004; Llewelyn, 1988; McLeod, 1990a, 1990b; Rennie, 2000, 2002). Identifying therapist validation, understanding, attending to pertinent issues and feeling empowered could all be viewed as reflective of a strong therapeutic relationship in that it reflects the positive relational bond as well as agreement on goals and tasks, which would overlap with research that has identified the alliance as one of the most powerful factors for positive psychotherapy outcome (Horvath, Del, Re, Fluckiger, & Symonds, 2011).

4.3 Discussion of Case Conceptualisation

4.3.1 Case Conceptualisation Framework: Targeting Cancer Related Emotions

To date no model of psychological therapy used in a cancer context has theoretically approached apprehending the relationship between the emotional impact of diagnosis and psychological morbidity from a conceptual point of view. Themes seen across these six cases point to a relationship between the illness experience and core emotional pain that can be outlined within an emotion focused therapy perspective. Formulating this relationship facilitates an account for the high level of global distress seen in these women (captured in high distress levels across pre therapy outcome measures) and establishes the rationale for psychological intervention within a Psycho-Oncology setting. The course of their individual

journeys through psychological therapy and case formulations that capture the complexity of their circumstances highlights the importance of considering premorbid psychological vulnerability prior to diagnosis and the relevance of employing a medium term therapy such as EFT that can reasonably reduce distress and increase perceived overall levels of quality of life along with greater emotional resilience.

Considering depression (and frequently comorbid anxiety) is one of the most common and debilitating psychological presentations in a cancer context (Krebber et al., 2014), that there is a marked gender difference in prevalence rates of depression and anxiety in the broader population, and breast cancer is one of the most commonly diagnosed forms of cancer, case accounts highlight that breast cancer raises unique challenges emotionally which are dynamic over the course of the illness and idiosyncratic to each individual coming to therapy, yet interweaving themes across the cases capture how the illness evokes an abrupt shift in self-identity due to loss of physical integrity and places demands on intimate relationships.

For the sake of further discussion the above is delineated into five essential meaning constituents: a) entrapment within the cancer diagnosis; b) effects of pre cancer vulnerability; c) sensitivity to others' distress and negative judgement; d) avoidance of emotions, and; e) the present constraint of loneliness and existential fear, maladaptive guilt, shame and disenfranchised loss. It is important to note that these constituents are highly interrelated and can only be fully understood as part of a whole *Gestalt* and in relation to each other. These constituents reveal patterns across cases with regards to conceptualisation and shared constellations across these six cases offer a window into advancing an understanding of how depression and anxiety take shape in the respective lives of these women from an emotion focused perspective (core pain), in what ways it is being expressed in their perception of their

social contexts (triggers), and how it can be transformed to a more adaptive emotionally flexible position (emotion transformation). These components will be illustrated alongside the model of emotion.

4.3.2.1 Entrapment within the Breast Cancer Diagnosis

All of the women seen in this study presented with clinically significant levels of anxiety that contributed to being too overwhelmed to cope with their cancer. In terms of treatment for their breast cancer, the women's relationships to their bodies came to the fore as they underwent procedures that involved investigation and what Frank (1991) terms an *asymmetric relationship* with medical professionals where they share intimate details about their lives and bodies, exposure of sensitive body parts, and an altered appearance. In addition to the stress of treatment, its invasive nature and their pre existing psychological vulnerability, the women also had to contend with the sense of uncertainty attached to living with a diagnosis of breast cancer and long term medical follow up contributed to a sense of entrapment that disrupted each participant's internalized sense of safety and exacerbated premorbid symptoms of depression and anxiety. While EFT would generally conceptualize the experience of anxiety as a part of the insecure self or as a fear of painful emotions, when it is considered in the context of an illness experience anxiety stems in part from the cancer diagnosis itself. Research in the area of anxiety would similarly identify that people respond to situationally induced threats to meaning, self-esteem and relatedness (such as cancer) with increased anxiety (see Greenberg et al., 2008, and Mikulincer et al., 2004, for reviews).

From an emotion focused perspective, anxiety triggered by cancer can tentatively be seen as consisting of several components across these case accounts

including worries of pain, vulnerability, isolation, the physicality of death and a sense that one's life project has been interrupted. The threat of death, defined as involving fears of bodily failure, bodily pain, separation and loss of control and power (Noyes et al., 2002; Starcevic, 2005) associated with breast cancer seems to hold particular poignancy in those with psychological vulnerability as it has the power to evoke further fears of powerlessness, separation, loss of control, and meaninglessness (Noyes, Stuart, Longley, Langbehn, & Happel, 2002; Stolorow, 1979; Yalom, 2008). Death anxiety can consequently be seen to bear relevance within an understanding of CAD in a cancer context as it is considered to play a significant role in the development and severity of a range of anxiety disorders (Arndt et al., 2005; Strachan et al., 2001) and is also thought to exacerbate anxious responding in individuals with anxiety related problems (Strachan et al., 2007).

Confrontations with mortality embedded in a breast cancer diagnosis seemingly create a kind of fissure that separates life as it was from the here and now, and within the split compels the individual to look at spiritual and existential questions. From a cancer context standpoint spiritual and existential questions have been identified as typically surrounding death, purpose or lack of purpose in life, the meaning of suffering, isolation and uncertainty (Breitbart 2005; Taylor 2000). Upon initial consideration such existential considerations may seem superfluous to adaptive coping with chronic illnesses such as breast cancer, however contemporary research findings support that symptoms relating to existential concerns are significantly more prevalent than physical symptoms in cancer patients (Lee et al., 2006), pointing to their relevance for apprehending the psychological implications of the illness and utilising a model of therapy that may be able to encompass the concerns conceptually. Therapeutic gains made from working with the fear of death and through emotions

attached to mortality have been identified as helpful in past psychotherapy research (Boulton et al., 2001), in so far as it led to coming to terms with cancer and recovering a sense of control. Without the emotional flexibility to contend with the multiple challenges raised by breast cancer, particpants presented with global distress, and overarching hopeless and helplessness that rendered them stuck psychologically prior to therapeutic intervention.

4.3.2.2 Effects of Premorbid (Precancer) Vulnerability

A common factor across cases was a premorbid history of adversity and trauma at the hands of a significant other (e.g., parent). To date studies of psychological responses to cancer diagnosis and treatment have tended to focus on general anxiety and depression symptoms and have not examined either the impact of a patient's trauma history on her adjustment to cancer or recent life events that may have taxed the patient's capacity to cope with the illness. These considerations point to the importance of incorporating premorbid psychological reactions and coping skills pertaining to pain adversities including medical complications that could represent a subsequent cue for further distress when undergoing medical treatment or recovery from cancer.

4.3.2.3 Sensitivity to Others' Distress and Negative Judgement

Taking into account early experiences of being perceived as devalued, current relationships with partners/close others were also activating core pain. For Laura, Sophie, and Emily, pressure and criticism at work also contributed to their feeling of not being able to live up to expectations. Their subsequent feelings of competency and efficacy were diminished which left them depleted and self-doubting. Having

internalised hurtful episodes that included negative social feedback (from siblings, school mates, parents), their hurt seemed commensurate with the degree to which they perceived their early experience of acceptability to others as an internal metric of social value. Across participants were experiences of non-inclusion and/or rejection, for example Ruth experienced frequent verbal diminishment by her husband, and Sophie described shame from her speech impediment and bullying as a child. Participants' feelings of hurt influenced their behavioural avoidance in that it diminished their ability to find comfort through relationships.

In keeping with research by Sanford and Rowatt (2004), hurt and sadness are emotions that typically motivate the pursuit of comfort, support and assistance from others, and generates in adaptive circumstances the ability to signal to others vulnerability, need or weakness. Having developmentally attributed responsibility for those painful experiences to themselves, maladaptive emotion schemes prevented access to adaptive emotional responses such as self-soothing or compassion. For all of the women in the current study the need for comfort and soothing was perceived as unacceptable within self-critical processes, contributing to the aforementioned sense of "entrapment" within the breast cancer diagnosis and maintaining constricted, negative affect.

4.3.2.4 Avoidance of Emotions

Clearly many aspects of life can feel threatened by changes imposed by breast cancer and its treatment. Illness fears within an EFT framework are viewed as strongly painful experiences that impact one's ability to regulate emotional experience and arousal and swamp conceptual processing (Greenberg et al., 2004).

Shame also contributes to fear regarding the physical experience of treatment, exposure, and being judged by others as unhealthy, bad, or condemned. These six participants were seen to be engaging in emotional processes that were overwhelming and exhausting in relation to their illness. For some participants' chronic pain served as an additional burden, exacerbating their symptoms of depression and anxiety, and fuelling emotional processes such as catastrophic worry, anger and depression (Linton, 2013). Alert to the fear of further traumatization, anxiety and fear maintained their vigilance and precluded the processing of emotion due to its avoidant nature (emotional/experiential avoidance), in keeping with the wider literature on depression that identifies how individuals often attempt to regulate their emotions in unsuccessful ways such as using avoidance, distraction and rumination (Campbell-Sills & Barlow, 2007). All participants indicated finding core emotional pain too unbearable to tolerate (prior to transformation).

4.3.2.5 The Present Constraint of Loneliness and Existential Fear, Maladaptive Guilt, Shame, and Loss

4.3.2.5.2 Loneliness and Existential Fear

Qualitative research endorses loneliness as embedded in the phenomenology of women's experiences following breast cancer (Fogel, Albert, Schnabel, Ditkoff, & Neugut,2002; Samarel, Tulman, & Fawcett, 2002) and is further corroborated by the case accounts in the current study that conceptualised loneliness as belonging to the core pain felt by each of the participants. In the cases of Emily, Kate and Ruth, having experiences of traumatic loss (in the form of bereavement) of a parent, sibling or close other from cancer figured within their feelings of abandonment stemming from loss as

well as their core fear/terror that they were also losing their planned futures with their own families and partners. Profound loneliness was in part a reaction to this sense of abandonment and alienation from their previously cancer free bodies.

Emily, Jane, Sophie, Kate, Laura and Ruth all expressed fears of death and dying and fear of recurrence as sources of unbearable apprehension that added to their distress. Case accounts were rife with poignant moments of unbearable loneliness, which added to participants' core pain. Wider psychological research on loneliness suggests it may have contributed to clinical symptoms of CAD, in that loneliness increases negative thoughts and feelings including being more pessimistic (e.g. Cacioppo et al., 2000), less trusting (Rotenberg et al., 2010), and more anxiously attached (Wei, Vogel, Ku, & Zakalik, 2005) than non-lonely people, underscoring its importance for inclusion in case conceptualisation and as a target for intervention. In the context of breast cancer, where physical reminders (e.g., scars, sweats and hot flashes, fatigue, lymphedema, sexual difficulties), emotional sequelae (e.g., emotional upset and distress, alarm that any ache or pain signals recurrence, uncertainty about the future), and social challenges (e.g., pressure to get past the experience and "get back to normal," the burden of sustaining a heroic survivor narrative) (Arman, Arne, Lindholm, Hamrin, & Eriksson, 2004; Low, Stanton, Thompson, Kwan, & Ganz, 2006; Gil et al., 2004; Hoybye, Johansen, & Tjornhoj-Thomsen, 2005; Landmark, Strandmark, & Wahl, 2001; Mols, Vingerhoets, Coebergh, & van de Poll-Franse, 2005; Sinding & Gray, 2005) raise a number of ongoing challenges, the sheer volume and interplay of these factors may contribute towards the experience of loneliness. A sense of entrapment within a changed/changing body includes the struggle to find meaning within the personal crisis of the illness and has been proposed to heighten

consciousness of the self, the world, and others, functioning as a kind of trigger for loneliness (Mayers & Svartberg, 2001; Portnoff, 1976).

Being 'thrown' into loss, these cases highlight how trauma, in the words of Stolorow, "individualizes us, but in a manner that manifests in an excruciating sense of singularity and solitude." (Stolorow, 2011, p.44). Research on the experience of loneliness in women with breast cancer is compatible with existential philosophy, which has characterized loneliness as emerging from the realization of one's mortality and the meaning this gives life, including the idea that inner growth often is preceded by suffering (Heidegger, 1927/1962; Kierkegaard, 1843/1985; Moustakas, 1972, 1989; Sartre, 1957; Tillich, 1963). It is conceivable that existential fear and loneliness renders a deep estrangement and fundamental, dreadful alienation from the everyday world that was seen across cases in this research study.

Qualitative accounts from psychotherapists themselves offer a similar viewpoint on how a sudden major illness experience undoes the sense of self; in that they individual no longer knows themselves as they once were. Jung, for example, wrote after his heart attack that he felt as if he were in a "painful process of defoliation" in which "everything I aimed for, or wished for fell away or was stripped from me" (Jung, 1963, p. 292). The depth of perceived isolation and loneliness within a cancer diagnosis and elaborated in the case accounts can be further conjured by Stolorow's rendering: "It is in the essence of emotional trauma that it shatters the absolutisms...in a universe that is random and unpredictable...there is no safety or continuity of being that can be assured. As a result, the traumatised person cannot help but perceive aspects of existence that lie well outside the absolutized horizons of everydayness. It is in this sense that the worlds of traumatised persons are

fundamentally incommensurable with those of others, the deep chasm in which an anguished sense of estrangement and solitude takes form." (2007, p.16).

Loneliness, from an emotion focused perspective, is an important part of case conceptualisation and target for intervention and transformation that addresses current understandings of the clinical pathology of depression. Case accounts in this study are supported by Scattolon's (2003) research on depression in women, whereby the depressive experience is characterised by feelings of isolation and aloneness, and Rice et al.'s research (2011), which identified that women with depression were too *emotionally overloaded* to interact, feared being a burden and that others would not understand them. These isolating processes describe important facets of women's subjective experience of depression that propagates an avoidant/protective approach with others whereby a "brave face" belies the existential threat and fear attached to breast cancer.

4.3.2.5.1 Maladaptive Guilt

A diagnosis of breast cancer entails a sudden, unplanned and unwished for change in life course. It involves embarking on a personal mission to complete necessary medical treatment and an inherently stressful situation in circumstances where caring for others (e.g. as a mother, as a daughter of aging parents, with partner and wider family) creates additional demand. Despite the negativity of feeling overburdened and suddenly confronted by their own mortality, participants found themselves unable to loosen their expectations to maintain caregiving for others. Rather, their sense of failure induced more guilt, which spurred the women to work even harder to succeed in their tasks; *giving beyond their resources.* It would seem these women experienced guilt in the context of their breast cancer that was not justified and involved an inappropriate attribution of responsibility. In so far as they

attributed personal responsibility for their breast cancer, a negative experience over which they had no control, this guilt can be seen as maladaptive. While EFT theory typically conceives of guilt as belonging to shame, its prevalence across cases warrants highlighting and elaboration as a process within the shame experience. *Maladaptive guilt* can be seen in the cases along several different veins, including the guilt for perceived responsibility for perceived harm inflicted upon significant others for having been diagnosed. Research by O'Connor and colleagues identified the phenomenon in her research on interpersonal guilt (O'Connor, Berry, & Weiss, 1999; O'Connor, Berry, Weiss, Bush & Sampson, 1997). Kate, Laura and Sophie, for example, were terrified that their emotional and physical vulnerability stemming from breast cancer would psychologically harm their children. Participants in the study also appraised their actions or inactions in terms of care of their health prior to their breast cancer diagnosis with self-blaming and self-criticism.

In the wider context of breast cancer, it is possible maladaptive guilt may serve as a way to garner some control in an otherwise unpredictable disease. Within an EFT framework, maladaptive guilt can be seen as a primary maladaptive emotion that is the result of self-treatment. Contributing to global distress, maladaptive guilt leads to negative self-treatment in the form of over-burdening the self. Placed within case formulation, maladaptive guilt should be seen as a variation of core shame, which involves global attributions about the self as well as attributions about action/inaction.

In the wider literature on depression, gendered dynamics appear to corroborate this response; as one explanation of the divergent lifetime prevalence of depression in women compared to men indicates women suffer more from negative emotional reactions directed towards self, e.g. survivor guilt, omnipotent responsibility guilt and

separation guilt, all of which are associated with increased risk of depression (O'Connor, Berry, Lewis, Mulherin & Crisotomo, 2007; O'Connor Berry, Weiss & Gilbert, 2002). Within this line of thinking excessive shame and guilt, which are intimately connected to a "bad" or "weak" sense of self, can be portrayed as the organizing force in depression (Greenberg & Watson, 2006).

4.3.2.5.3 Shame

Similarly, a lack of self-compassion can be seen as a powerful predictor of symptom severity and quality of life (Van Dam, Sheppard, Forsyth and Earleywine, 2011). For all participants, painful emotions include *maladaptive guilt* stemming from self-criticism *(I'm not doing enough for others, I'm letting family down by being sick or I let them down by failing to maintain my health)* and *shame* stemming from experiences of the self as bad, flawed or disgusting (*I'm less of a woman without my breast, fertility, I'm sick because there's something broken in me).* These views of the self would be consistent with existing definitions of shame as the affect of deference (Scheff, 1988) and in tandem, the affect of inferiority (Kaufman, 1989). Embedded painful feelings of shame hindered the potential of interpersonal relationships where comfort was not sought, or made it more challenging to obtain comfort in partnerships or with close others that were characterised by dominance or criticism/rejection (across the cases with Sophie, Jane, Laura, Ruth, Emily and Kate). Collapsing into secondary emotional experiences of hopelessness and helplessness occurred as the primary underlying painful emotion of shame was unbearable and avoided, obscuring needs to be appreciated, valued, validated, prized and seen as worthy of connection, care and protected in the face of illness.

With undercurrents of shame based processes in depression; shame in relation to cancer features on two counts; both the process of pre-existing sources of shame before diagnosis and how these may exacerbate self-blame and shame post diagnosis. In the case of Ruth, her sense of inadequacy and core pain as unworthy and unlovable was longstanding, and her breast cancer, treatment and subsequent chronic pain further hindered her from meeting her own high standards (driven by a harsh inner critic) and fueled her sense of herself as defective and failing (as a mother and wife). Shame secondly features in relation to understanding one's own difficulties and limitations in terms of the illness, both internally and from the empathy and criticism (real and imagined) of others. Shame was also important in terms of body image and coping for Ruth, Sophie, Emily, Laura, and Kate. Breast cancer and the subsequent changed body, within a depressive framework, was experienced as further corroboration of the self as defective. A history of shame and loss, in some cases relating to negative medical experiences or cancer of a family member, added to the difficulty of participants in the study coping with medical procedures for their breast cancer and contributed to the stressful/threatening aspect of treatment as it shaped the participants perception that they were fundamentally defective, weak or flawed in some way. Jane's prior adverse hospital experiences and surgeries, for example, were a major trigger for distress while undergoing radiotherapy treatment for her breast cancer.

In part what appears to account for the high levels of clinical depression across the case accounts involves the dynamic between self-criticism and the demands these women placed on themselves given their difficulty with accessing compassion prior to therapy. Scattolon (2003) explored general major themes in women's experiences of living with and managing depression. She found that women experiencing depression

as being filled with feelings of depression and aloneness, that they were unable to carry on as usual and that they were "going on" for the sake of others. Rice et al. (2011) found that depressed women's difficulties with social interaction involved a lack of interest in others; that they were too *emotionally overloaded* to interact; that they feared being a burden; and that others would not understand them.

4.3.2.5.4 Disenfranchised Losses

Within these cases what emerged for all of the women were stories of loss that had previously been unvoiced to others, and at times even to the self. For Emily it was the loss of fertility, with Jane it was the loss of body parts due to medical procedures prior to and alongside her double mastectomy, with Ruth it was the sudden loss of family members as well as her own changed body, and for Kate it was the loss of her father and the resulting inability to reconcile family trauma.

The open-ended aspect of living with breast cancer involves adapting to life with accompanied stress and renegotiation of a relationship with a changed and more vulnerable body. As there is little recognition of the loss attached to breast cancer, the demands of living with the illness remain (medical monitoring, continued risk for recurrence particularly in the first five years after treatment) and involves no customary, socially recognised or acceptable ways to grieve the loss of the healthy body prior to diagnosis. Often there is little time and space in which to grieve because the loss demands drastic and immediate actions related to diagnosis and treatment. Others in the social world may consequently fail to recognise the real grief that is experienced as was seen in these cases in women who were not facing a poor prognosis at the time of the study nor terminal cancer.

This lack of social sanction reflects how sorrow is often experienced as an internal process, invisible and withheld from significant others and perhaps also exacerbated by observable practices and processes in the social world, including pink ribbon culture that promotes a concept of survivorship that is limited in emotional dimensionality and negates the multiplicity of selves wherein there may be many simultaneous reactions to having a chronic illness such as breast cancer (e.g. relief for treatability, fear of recurrence, gratitude for being alive, anger with the burden of the illness). Grieving and letting go is considered an adaptive process within emotion focused therapy theory, however current models of emotion transformation do not adequately conceptually capture the open ended and ambiguous losses associated with illness experiences.

Ambiguous loss (Boss, 1999) is a construct that can refer to self-loss, where there is an unclear or incomplete relational change that generates a painful disparity between thoughts and dreams of what should have been, might have been and still may be hoped for, versus what is actually the present reality. Ambiguous losses are frequently unrecognised, and for these cases can be seen as encompassing the impact of breast cancer on their lives.

What is called for is the articulation of *disenfranchised grief* (Attig, 2004) whereby losses that are not socially endorsed by society, losses that typically go unacknowledged by others, would otherwise preclude social support and remain unmourned (Doka, 1989, 2002, 2008). In other words, often associated with secrecy and shame, disenfranchised losses adds to the difficulty of processing the loss. Disenfranchised losses in these case accounts can be identified in the form of pet loss, miscarriage, loss of bodily parts, and disfigurement. Gone with a breast cancer diagnosis is the imagined future, the present loss of normal daily life, sense of

wellness and a changed body. In so far as these losses remain unarticulated and unsanctioned, the notion of empathic failure [a term originating in the psychoanalytic tradition (Kohut, 1977; Wolf, 1988)] describes the social element of failure to understand the meaning and experience of another (Neimeyer & Jordan, 2002) which impedes the growth of empathic support for the grieving person and may be conceived of as an element contributing to core pain. Kauffman (2002) delves deeper into the phenomenon in his analysis of self-disenfranchisement, which he defines as the silencing of the self because of perceived social expectations. Self-disenfranchisement can be seen in the context of breast cancer and comorbid anxiety and depression as becoming a bondage to grief that is disavowed and cannot be mourned.

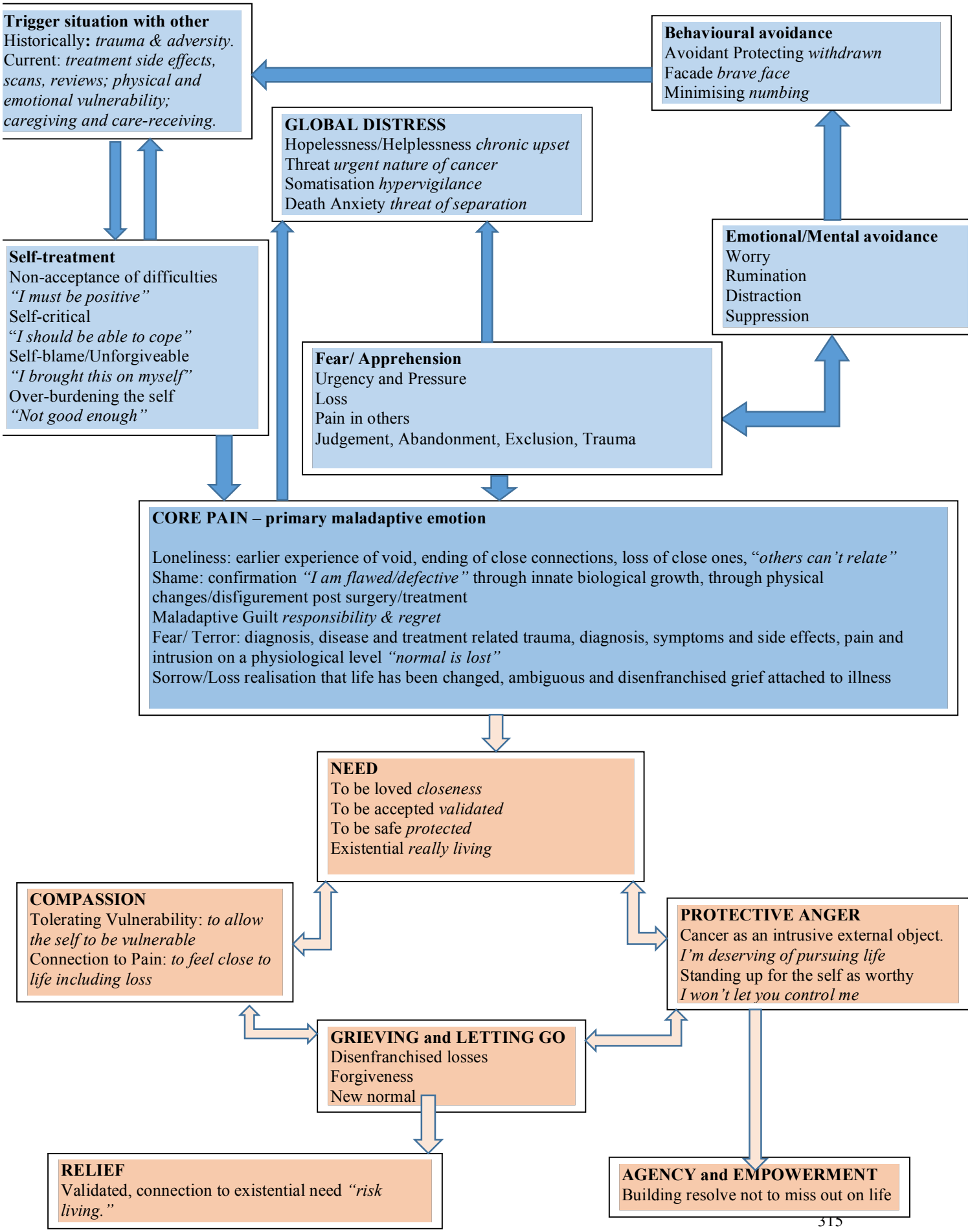
4.4 Discussion of Emotion Transformation: An EFT Framework for Women with Breast Cancer and CAD

Given the uncanny aspects and disenfranchised aspects of losses attached to the cancer experience, the aim in therapy is not resolution or decathexis of the loss but rather to restore resilience, which involves knowing and being able to put meaning on what has been lost, and includes emotional experiencing that is without censorship and facilitates use of the adaptive value of emotion and adaptive emotions. Within an emotion focused therapy framework in a cancer context, this involves bearing witness to core pain, holding memories, and transforming or reconfiguring a conflicted emotions linked to relationship with significant others and/or the self, and integrating new understandings of the self in relation to the loss.

Across any model, the therapeutic field offers opportunity for new understanding, shifts in perspective, growth and new attributions of meaning. What

these case accounts in emotion focused therapy in a Psycho-Oncology setting highlight is a new case conceptualisation framework (see Figure 4) to demonstrate emotion transformation of comorbid anxiety and depression for women with breast cancer, that incorporates death anxiety as part of global distress, negative self-treatment in the form of over-burdening the self as part of worry based avoidance and disenfranchised grief and maladaptive guilt as part of core pain. Emotion transformation (see Figure 4) includes experiencing and articulating disenfranchised grief, expressing unmet existential needs and access to compassion for experiencing sadness within the loss as well as agency and empowerment stemming from adaptive protective anger to stand up for the self and having a resolve to overcome limitations and live fully. While it could be seen as undesirable to focus on difficult feelings at a specifically challenging time such as contending with breast cancer, emotion focused therapy offers a way through these emotions that involves focusing in and meeting what is, opening to core pain and facilitating emotion transformation.

Figure 4


Trigger situation with other
Historically: trauma & adversity.
Current: treatment side effects, scans, reviews; physical and emotional vulnerability; caregiving and care-receiving.
Behavioural avoidance
Avoidant Protecting withdrawn
Facade brave face
Minimising numbing
GLOBAL DISTRESS
Hopelessness/Helplessness chronic upset
Threat urgent nature of cancer
Somatisation hypervigilance
Death Anxiety threat of separation
Emotional/Mental avoidance
Worry
Rumination
Distraction
Suppression
Self-treatment
Non-acceptance of difficulties
"I must be positive"
Self-critical
"I should be able to cope"
Self-blame/Unforgiveable
"I brought this on myself"
Over-burdening the self
"Not good enough"
Fear/ Apprehension
Urgency and Pressure
Loss
Pain in others
Judgement, Abandonment, Exclusion, Trauma
CORE PAIN – primary maladaptive emotion
Loneliness: earlier experience of void, ending of close connections, loss of close ones, "others can't relate"
Shame: confirmation "I am flawed/defective" through innate biological growth, through physical changes/disfigurement post surgery/treatment
Maladaptive Guilt responsibility & regret
Fear/ Terror: diagnosis, disease and treatment related trauma, diagnosis, symptoms and side effects, pain and intrusion on a physiological level "normal is lost"
Sorrow/Loss realisation that life has been changed, ambiguous and disenfranchised grief attached to illness
NEED
To be loved closeness
To be accepted validated
To be safe protected
Existential really living
COMPASSION
Tolerating Vulnerability: to allow the self to be vulnerable
Connection to Pain: to feel close to life including loss
PROTECTIVE ANGER
Cancer as an intrusive external object.
I'm deserving of pursuing life
Standing up for the self as worthy
I won't let you control me
GRIEVING and LETTING GO
Disenfranchised losses
Forgiveness
New normal
RELIEF
Validated, connection to existential need "risk living."
AGENCY and EMPOWERMENT
Building resolve not to miss out on life

4.4.1 Living with a Threatened Body: Transforming Core Pain

The experience of cancer represents a distinctive stressor within a comorbid anxiety and depression framework as it involves a potentially chronic and debilitating illness that may be accompanied by a range of aversive associated events (including medical treatments, disease and treatment side effects). Within the dual therapeutic strands of adjusting to living with cancer and increasing emotional flexibility around maladaptive emotion schemes that are contributing to symptoms of anxiety and depression there are three overlapping working goals that reflect processes of emotion transformation across cases. Namely, to conceptually grasp the idiosyncratic impact of the losses incurred as a result of cancer on the self-concept. Secondly, to find meaning in this new psychological and actual world, and thirdly, to transform self-treatment through adaptive emotional transformation and interweave the illness experience with the lost/changed of aspects of oneself (e.g. disfigurement, loss of fertility, loss of career, loss of sexual self). These constituents reflect the processes in EFT that contribute to transforming emotional pain and promoting adjustment and increased emotional flexibility.

Emotion focused therapy in patients with cancer uses imaginary chair dialogues to experientially attend to unfinished business that may have been triggered, harnesses adaptive emotions such as compassion (from the self or significant others) around healthy grieving for illness related losses (healthy body, sexual self, altered future potential), soothing fear with protection and compassion, and asserting the self with protective anger. As unmet needs are attended to, the promotion of agency, safety and a sense of feeling connected in the here and now attenuated existentially related fears that may have been exacerbated by harsh negative self-treatment and emotional avoidance, including fears around mortality.

4.5 Clinical Implications

This study has a number of important clinical implications, in terms of assessment, case conceptualisation with emotion focused therapy and for treatment of women with breast cancer with symptoms of clinical depression and anxiety. Women with histories of trauma and prior psychological vulnerability as well as those who have recently experienced stressful events may be at particular risk for problems adapting to illness, and assessment of these domains would be helpful in identifying who might need additional psychological support. For these women, some attention to history might contribute positively to current adjustment to cancer. Current findings within this study indicate that cancer might trigger emotions associated with prior unresolved events, and this knowledge would be helpful for patients to place their reactions within an emotional context. Useful screening tools for trauma history and premorbid experiences of vulnerability would benefit practice guidelines currently being developed for Psycho-Oncology in Ireland in relation to survivorship.

Psychological services to support patients with cancer are already in place within many hospital settings as it is recognised that distress can affect ability to comply with treatment and addressing psychological distress may not only improve quality of life for women with breast cancer but also be more efficient for providers of medical care as well. While comprehensive cancer centres offer support services to patients and their families, the range and content of these vary, and emotion focused therapy may serve as an alternative to existing models of psychological therapy for patients. These cases also highlight the emotional responses in women with breast cancer and symptoms of depression and anxiety, and demonstrate that core emotions

such as shame, loneliness, existential fear and loss are important targets for intervention. For these women, it was extremely difficult and overwhelming prior to therapy to be self-compassionate and receive compassion from others, since the experience of these feelings reactivated memories such as being shamed by an attachment figure which then triggered avoidance or interruption of emotions. With high-shame and high self-criticism, these cases illustrate the relevance of targeting shame memories through imaginary chair dialogues when working with women who present with comorbid anxiety and depression to build emotional flexibility and increase access to adaptive emotions such as compassion and protective anger.

Broader Implications: Need for Flexible Application across the Survivorship Phase

Advances in medicine and technology have brought about an increase in life expectancy and longevity—inevitably accompanied by an increase in the number of people who live with chronic illness conditions. The latter might be defined as "long term conditions, lasting more than 6 months, are non-communicable and involve functional impairment or disability and are usually incurable" (Department of Health, Ireland, 2008). Among the most common chronic disease conditions is cancer, with factors such as chronic pain contributing to the major health challenge and burden of chronic disease conditions (Croft, Blyth, & Van der Windt, 2010; Dagenais, Caro, & Haldeman, 2008; Haldeman, 2008; Ranjan, 2001).

Chronic illness has been described as one of the major health challenges in Europe today and in Ireland; "meeting the complex needs of patients with chronic conditions is therefore the single greatest challenge facing our healthcare system today" (Department of Public Health and Primary Care, Ireland, 2015). It is well

recognised and documented that the care of people with chronic illness consumes between 70-80% of all healthcare spending, costs which include patients being far more likely to attend their General Practitioner (GP), present at Emergency Department (ED), be admitted into inpatient care, use more inpatient bed days than those without a chronic illness, and suffer increasing morbidity with compromised quality of life (DOH, 2008, p.3). Meanwhile it is also documented that approximately 30% of individuals with chronic disease such as cancer have major depression (and concomitant anxiety) as a comorbidity (DOHC, 2008, p.7) yet absent from many Irish documents currently is a strategy or framework around their mental health.

Pertaining to cancer care in particular the National Cancer Control Programme in Ireland has published review documents (NCCP, 2014) of patient services where *cancer survivorship* and its concomitant needs was identified as a high priority, as 60% of diagnosed patients are likely to survive free of disease (NCCP, 2014) and must live with the associated challenges of adjustment and management of chronic disease. The goal of the document is to guide the national strategy that is now (at the time of publication) currently in development and will delineate clear care pathways for patients and help establish standards of care. Problematically, however, the review document holds a focus on medical and physical survivorship care of patients with cancer, with little mention of their psychological healthcare.

It is timely that the World Health Organization has published a document calling for integrating the response to mental health disorders amongst chronic diseases in existing healthcare systems (WHO, 2014), which demonstrates the fundamental connection between mental health issues and chronic diseases, citing how they frequently co-occur and identifying that “changes are needed from micro-level patient interactions to macro-level policy and financing for integration to take

hold and flourish" (WHO, 2014). Of equal relevance, in two evaluations of current models of cancer survivorship care (Halpern, Viswanathan, Evans, Birken, Basch & Mayer, 2015; Chubak, Tuzzio & Hsu, 2012), a key highlighted need was for survivorship programs to address fear of disease recurrence specifically. Screening for psychological vulnerability and clinical distress and providing appropriate intervention (e.g. evidence based psychological therapies such as EFT that have been *researched and tailored* for chronic disease populations, including addressing cancer related sources of distress such as body image, existential anxiety and fears of recurrence) should be seen as part of integrated evidence based care at the specialist level that ultimately will improve patients abilities in terms of self-management and improve quality of life for patients, fulfilling key targets that are already recognised goals for care in a proposed chronic illness framework in Ireland (HSE, Chronic Illness Framework, 2008). Given that psychotherapy research is a marginal component within the general output of psychological research, identifying the need for the refinement and further development of existing evidence based psychological therapies to be tailored for chronic disease populations and utilised as part of patient care towards survivorship could be an important future step.

Psychotherapeutic research and clinical work within a chronic disease/survivorship context may also benefit from explicitly capturing transdiagnostic constructs within case conceptualisation, as it would more accurately reflect that approaches to psychopathology are increasingly being examined in so far as many symptoms and predispositions occur across multiple diagnostic categories, are thought to potentially increase vulnerability to the development of any mental disorder, and may contribute to maintenance of these disorders. Examples of transdiagnostic constructs that are thought to elevate psychological vulnerability and

risk for a range of mental disorders include behavioural inhibition and avoidance (Dozois, Seeds, & Collins, 2009), low positive affect (Brown & Barlow, 2009), perceived lack of control (Naragon-Gainey, Gallagher, & Brown, 2014), intolerance of uncertainty (Mahoney & McEvoy, 2012), and death anxiety (Furer & Walker, 2008), which are all themes that formed part of the case accounts within the current research study. The essential core of any psychological therapy remains the same in a Psycho-Oncology setting for delivery of care, namely; it must be person centred and appropriately responsive within the context of a multidisciplinary team to the physical (biological), psychological and social needs of the person engaged in the process of therapy (e.g. the "biopsychosocial model" (Sarafino, 2002).

4.6 Limitations

There are several limitations to consider when drawing conclusions about the results. One of the most significant limitations is that the focus was on a small sample of clients in emotion focused therapy treatment. Although cumulative statistical analysis was employed, this has to be seen as very tentative, and firm conclusions about its effectiveness cannot be drawn due to the small sample size. The generalisation of the results are also weakened by the fact that the follow up period was restricted to six months. The outcome results of this study given the small sample size in terms of outcome should be viewed cautiously and hopefully replicated in larger samples and particularly in an experimental (randomised controlled trial; RCT) design using a control group. It is hoped that the promising results of this study encourages replication and expansion on this type of research with larger samples.

There are limitations to the research with regard to the question of "fit" between participants and the treatment received which reflect enduring issues of routine psychotherapy practice. While feedback forms after every session provided an account from the participant's point of view about the helpfulness and unhelpful aspects of therapy, initial asessments and clinical judgement formed the basis for determining suitability for EFT as a potential therapy for each participant. Clinical judgements were based on psychological capacity, clinical history, contextual factors and the patient's reasons and goals for coming to therapy. Besides the basis for clinical judgement, the limited available research in EFT on predictors of success in EFT, which would facilitate the optimal matching of clients to treatments, renders it difficult to ascertain whether some of the participants might have achieved better outcomes with another modality of treatment.

In terms of EFT as a model of therapy, it currently attends little conceptually to a larger cultural context and considerations around dynamics between the individual in therapy and the dynamics of gender role socialisation, power, cultural ideals, oppression, maginilisation and its impact on the acknowledgement and expression of unmet needs in an individual. The current study provides some additional conceptual framework around the gendered component of depression in women, and attempts to begin to develop feminist informed EFT for women with CAD and breast cancer, however further research that focuses on feminist informed EFT in terms of gender role analysis and intervention and power analysis and power intervention is needed.

Therapist effects contribute to the limitations of the current study, however in practice it is the meaning that the client/patient gives to the experience of therapy that is important. A typical limitation of qualitative research in psychotherapy is therapist

allegiance to the treatment model, identified by Wampold (2001) as a contributing determinant of outcome in clinical trials in that the therapist practitioner's levels of tenacity, enthusiasm, hopefulness and skill is greater. The phenomenon of researcher allegiance to a treatment being positively associated with the treatment effect size may be particularly important in the early stages of evaluating a treatment (Gaffin, Tsaousis & Kemp-Wheeler, 1995) such as the current study focusing on the development of EFT for patients with CAD and cancer. As a result, research is needed where EFT in psycho-oncology is evaluated by investigators less directly affiliated with its development, and would be augmented by observer based analysis of individual cases or analysis of specific aspects of the therapeutic process by additional researchers outside of the current study research team, which would offer a further degree of objectivity.

As the analysis of data involves gathering and presenting a variety of data to provide a rich case account for each participant, and as the author of the study who was also the therapist for four of the six cases there is perhaps an implicit bias. This implicit bias is somewhat mitigated by the research supervisor auditing the case accounts and analysis, self-reports gathered from participants and the use of objective indicators of psychological change (e.g. pre post outcome measures), interviews being conducted by research assistants rather than therapists, and that the psychotherapy itself was tape and video recorded and the process of therapy was examined in real time. Additionally the candidness of participants experiences of therapy, including statements about what they did and did not like, lends support to the belief that the qualitative portions were by and large authentic and representative of participants' experiences, but the possibility of bias cannot be controlled for. A better balance of cases between the two therapists may have been preferable. Also, the use of only two

therapists may limit support for the feasibility of the treatment by different therapists and an external (i.e. non research team member) auditor contributing to the analysis of the cases would have strengthened the rigour of the qualitative research. Although the author chose to study the individual application of EFT, the possibility to explore alternatives (couple therapy, group based work) is encouraged.

The fact that all patients treated were Caucasian though highly representative of the Irish population in terms of religious and cultural beliefs may limit generalisation of results. An absence of Irish psychometric norms with which to benchmark results equally contributes to the limitations. Studies against which the results were benchmarked were subsequently drawn from RCT's conducted in other Westernised countries. Although the sample was representative of patients who would be seen in the psycho-oncology department where the study was conducted in terms of pre-treatment characteristics and outcome, results cannot be generalised to patients who withdrew from the study and therapy (n=2). It is possible, for example, that patients who withdrew, alongside having acute medical needs in relation to their cancer that may have precluded completing therapy, may have found EFT therapy too stressful and evocative. While participant feedback for those who did complete therapy included being asked to volunteer hindering events and processes generated no themes or unhelpful events or impacts, and was conducted by a designated researcher and not the therapist, the very nature of being invested in the therapeutic process and involvement in the study may have precluded richer feedback in this regard.

The sample of patients involved in the research had a diagnosis of breast cancer, and therefore the results do not necessarily reflect different patient categories in terms of oncology and cancer type who present with comorbid anxiety and

depression. While cancer type homogeneity strengthens the results with regard to internal validity, the results may not hold the same or similar outcomes for patients with other cancer types and the associated differences in quality of life and psychosocial impact based on the disease and treatment side effects. Despite these limitations, the findings of this study provide preliminary evidence that EFT for CAD in women with breast cancer is acceptable to patients and produces outcomes which are within the range of other psychological interventions. This is particularly encouraging given that the participants in the present study had longstanding, complex histories of vulnerability.

4.7 Implications for Future Research

This is one of only a handful of studies that have used EFT in a cancer context, and it is the first study to further case conceptualisation and treatment development. These cases support and add to recent emotion focused therapy research on emotion transformation, underlining the importance of case formulation to guide intervention in relation to core pain involving shame, loneliness and fear. The current study contributes to existing research by adding a conceptualisation framework around the illness experience including disenfranchised losses and the presence of maladaptive guilt.

These six case studies are the first step in developing this treatment for CAD, and should be followed by a randomized control trial. Future research may also want to examine the application of emotion focused therapy across different cancer types with patients who present with clinical significant depression and anxiety, triggered by their cancer diagnosis. Equally, testing the limits of EFT's clinical utility, for example exploring the type of therapeutic effects possible when patients with

different cancer types present with CAD, would be important in further developing and refining EFT as a treatment for patients with cancer. EFT might be a therapeutic alternative to other currently used psychological therapies (e.g. adjuvant psychological therapy, existential therapy, and acceptance commitment therapy) in Psycho-Oncology that merits to be evaluated with larger samples, in different stages of cancer, and compared to an active control group.

4.8 Reflective Perspective of the Author

My personal experience with the women in this study and in the area of Psycho-Oncology has given me an appreciation for the haphazard way in which illness unfolds. In Psycho-Oncology we speak of "illness trajectories" and "disease progression" as though illness was a linear sequence of events. Yet the emotional transformation tracked across case accounts for these six women demonstrates that emotional recovery from illness is not linear, but rather a process, that continues to mature beyond therapy. Having worked in Psycho-Oncology for nearly a decade, it is an ongoing part of my personal reflection that the work involves more than empathic attunement and a theoretical model driving applied techniques and therapy tasks. It entails confronting my own fears about illness and death, loss and abandonment, time and time again. It does not seem possible to work with people who have a potentially life threatening disease without having to face one's own existential plight. While some of the women in the study contemplated "why me", I sometimes had to question not only "why not me" but also "when me." Professional distances are more difficult to assume when faced with matters of mortality.

The nature of this work and its tender connections to the unpredictable, painful and mysterious aspects of being alive and the human body invites inquiry into my own draw to grief work and its significance, responses to which I can only partially draw from momentary recognition within various forms visual art, and occasionally words. Kahil Gibran captures a sense of purpose with a line from The Prophet; "*the deeper that sorrow carves into your being, the more joy you can contain"* (1923). It is impossible not to carry this standpoint without connecting to the philosophical underpinnings of EFT that similarly sees the only way out of pain as through, and invites rather than pushes away sorrow as a valuable source of meaning, depth and discovery. While western contemporary culture places a high value on rising up, self-improvement, and attainment and achievement and deemphasises and closets loss, it can sometimes bypass the benefits of going down into the depths of parts of ourselves we would rather not see. Yet within the difficult territory of loss and grief is also richness, largely stemming from the full-throated expression of all emotion as a route to understanding and greater meaning. Having shared in this process with the women across these case accounts, I continue to be both bewildered and grateful for the privilege of such intimate, challenging and rewarding encounters.

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Appendices

Appendix A: Ethics Consent

Appendix B: Patient Forms

Appendix A

SAINT LUKE'S HOSPITAL

Ms. Allison Connolly,
Counselling Psychologist,
Psycho-Oncology Department,
St. Luke's Hospital,
DUBLIN 6.

22nd March 2011.

Re: Emotion focused therapy for patients with cancer: a case studies investigation in psycho-oncology.

Dear Allison,

Thank you for submitting the revised version of the above referenced research proposal together with the revised Patient Information Leaflet & Consent Form. This documentation has been reviewed and noted and I am now happy to confirm the approval of the Research Ethics Committee for this study. I should appreciate if you would forward confirmation of the TCD Research Ethics Committee approval in due course.

Kind regards,
Yours sincerely,

pp V. Burns.

Dr. Sheelah Ryan,
Chairperson,
Research Ethics Committee.

c.c. Dr. Niamh Coleman, Principal Psychologist.
Dr. Natalie Hession, Senior Psychologist.

St. Luke's Hospital
Highfield Road, Rathgar, Dublin 6
Tel: 01 406 5000, Fax: 01 497 2941

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH | TRINITY COLLEGE DUBLIN
Ollscoil Átha Cliath | The University of Dublin

31st March 2011

F.A.O. Allison Connolly

School of Psychology Research Ethics Committee

Dear Allison,

I am pleased to inform you that your application entitled "Emotion focused therapy for patients with cancer: A case studies investigation in psycho-oncology" has been approved by the School of Psychology Research Ethics Committee.

Yours sincerely,

Dr. Tim Trimble
Chair
School of Psychology Research Ethics Committee

SCHOOL OF PSYCHOLOGY
Aras an Phairsaigh
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Appendix B

SAINT LUKE'S HOSPITAL

Patient Information Sheet

Dear Participant

Purpose of the study

You are being invited to take part in a research study to explore the use of Emotion Focused Therapy in patients with cancer. Before agreeing to participate in this study it is important that you read and understand why the research is being done and what it will involve. The following information describes the purpose, why you have been chosen, procedures, benefits, discomforts, risks and precautions associated with this study. It also describes your right to refuse to participate or withdraw from the study at any time. In order to decide whether you wish to participate in this research study you should understand enough about its risks and benefits to be able to make an informed decision. This is known as the informed consent process. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking time to read this leaflet.

Title of the Research:
Emotion focused therapy for patients with cancer: A case studies investigation in psycho-oncology.

Background information
Significant psychological distress and difficulty with adjustment, sometimes experienced and/or expressed in low mood or anxiety, is typical for all stages of cancer. Gaining a better understanding of the experience of anxiety and low mood as it relates to patients' adjustment to living with cancer as well as improving treatment interventions may reduce emotional suffering and improve quality of life.

Who is organising the research?
This study is a joint venture between the research team at Trinity College Dublin and the Psycho-Oncology Department at St. Luke's Hospital.

Principal Investigator: Professor John Armstrong, Consultant Radiation Oncologist. St. Luke's Hospital, Highfield Road, Rathgar, Dublin 6.

Co-Investigators:
Allison Connolly, Counselling Psychologist
Dr. Natalie Hession, Principal Psychologist
Dr. Ladislav Timulak, Counselling Psychologist, Trinity College.
Dr. Leslie Greenberg, Clinical Psychologist, York University.

What is the purpose of the study?
The aim of this study is to explore the use of Emotion Focused Therapy in working with adjustment to cancer. Emotion Focused Therapy is a scientifically validated form of psychological therapy that works with emotions to increase adaptation. In other words, Emotion Focused Therapy helps to change feelings that may otherwise feel overwhelming or stressful and helps to create a logical understanding of these emotions.

What will happen during the study?
If you agree to participate in the study you will be requested to:

Sign your consent to participation and prior to beginning therapy you will be asked to fill out a number of questionnaires. Therapy itself will then commence as normal. Throughout the course of therapy your situation will be carefully monitored. You will also be asked to contribute to the evaluation of your therapy by means of self-report questionnaires filled out after therapy sessions. These sessions will be recorded by audio and video.

How long will I be on the study?
You will be in the study for approximately 15 to 20 weeks, but the length of your involvement in therapy will be decided according to your own needs and will be decided between you and your Psychologist. You will be invited for a follow up review six months and a year after the therapy. Please note that if after a number of sessions you feel that you are not benefiting from Emotion Focused Therapy, you are free to withdraw from the study. In this event, your Psychologist will discuss alternative psychological therapy options with you.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign the attached consent form and given a copy of this information leaflet to keep. If you decide to take part but later change your mind, you are free to withdraw at any time without giving a reason. The standard of care you receive and the opportunity to avail of psychological therapy will not be affected in any way.

Are there any benefits from my participation?
You will be offered therapy that will be closely supervised by experts in this therapy. The benefits listed below are common to all participation in psychological therapy. These include:

- Attaining a better understanding of yourself, your personal goals and values
- The development of skills for improving relationships
- Overcoming specific problems such as anxiety and low mood
- Finding resolution to the issues or concerns that led to seeking psychological therapy

Are there any risks involved in participating?
As you have already expressed a wish to seek psychological therapy to enhance and facilitate coping in relation to cancer, there are no additional risks in participating in this study. The majority of the risks listed below are common in all participation in psychological therapy. These include:

- Temporary distress, feelings of discomfort and/or tiredness may occur as a result of exploring emotions and emotional experience.
- Therapeutic work may result in changes in your self-understanding or approach to relationships that were not expected or intended at the outset.
- You may decide that you are uncomfortable being video or audio recorded.

You are free to discuss any of the above points with the research team and your Psychologist at any time to address your concerns.

Will my taking part in this study be kept confidential?
The study ensures your right to anonymity and confidentiality. Data collected will be coded and input on computer under a unique ID number. Information about you is stored confidentially in locked file cabinets and in computer files protected by password. Results from the study may be published in a scientific journal or presented at scientific meetings but your identity will remain anonymous. Data will be stored in keeping with the Hospital policy on healthcare records. Research abides by the Data Protection acts (1988. 2003) (The Data protection commissioner: Data Protection Guidelines on research in the Health Sector).

What are the costs of taking part in this study?
There are no costs associated with participation in this study. You will not be paid for your participation in this study.

What is the duration of the research?
You will be asked to complete tests prior to commencing therapy, at the end of therapy and at follow up. This will take approximately 30-45 minutes. You will be offered up to 20 sessions of therapy, lasting approximately fifty minutes each, and may be asked to complete a brief self-report measure after each therapy session. You will be contacted at 6 months and 12 months after the end of therapy to fill out the tests monitoring your well-being at those times.

Who has reviewed and approved this study?
This study has been approved by St. Luke's Hospital Research Ethics Committee.

Contact for further information:
If you have any questions concerning this research study, or if any problems arise during the study, you should contact the following people:

Ms. Allison Connolly Tel. (01) 406 5263
Dr. Natalie Hession Tel. (01) 245 6032

Study Title: Emotion focused therapy for patients with cancer: A case studies investigation in psycho-oncology.

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH
PLEASE TICK YOUR RESPONSE IN THE APPROPRIATE BOX

I have read and I understand the attached Participant Information:

YES ☐ NO ☐

I have had the opportunity to ask questions and discuss the study:

YES ☐ NO ☐

I have received satisfactory answers to all my questions:

YES ☐ NO ☐

I understand that I am free to ask questions at any time during the course of this study:

YES ☐ NO ☐

I understand that I can refuse to answer any item or question without prejudice or penalty:

YES ☐ NO ☐

I agree to my GP being informed of my involvement in this study:

YES ☐ NO ☐

I understand that my participation is voluntary and that I can withdraw from the study at any time without prejudice, penalty or giving a reason:

YES ☐ NO ☐

I understand that my participation in the study will remain anonymous and confidential:

YES ☐ NO ☐

I understand that I can request a summary of the results when the study is completed:

YES ☐ NO ☐

I understand that the results from this study may be published in a scientific journal, presented at scientific meetings or used in additional studies but my identity will remain anonymous.

YES ☐ NO ☐

I CONSENT TO PARTICIPATE IN THIS STUDY: YES ☐ NO ☐

Participant's Signature: _____ Date: _____

Participant's Name in print: _____

I have explained the purpose of the research, the study procedures, and the possible risks and discomforts, as well as any potential benefits. I have answered any questions regarding the study to the best of my ability. In my opinion, the participant is capable of understanding the material presented, including the evaluation of risks, benefits and alternatives.

Investigator's Signature: _____ Date: _____

Investigator's Name in print: _____

PARTICIPANT CONSENT FORM FOR TRAINING PURPOSES

Principal Investigator: Professor John Armstrong, Consultant Radiation Oncologist.
St. Luke's Hospital, Highfield Road, Rathgar, Dublin 6.

Co-Investigators:
Allison Connolly, Counselling Psychologist
Dr. Natalie Hession, Acting Principal Psychologist
Dr. Niamh Coleman, Clinical Psychologist
Dr. Ladislav Timulak, Counselling Psychologist, Trinity College
Dr. Leslie Greenberg, Clinical Psychologist, York University

Declaration of Participant

I, _____ understand that I am consenting to the following:

I am aware that the data in this research may be published in professional outlets and used in workshops and seminars. I understand that my personal details will not be revealed in the published research or in any subsequent published material, which uses the information contributed to the study.

I understand that my participation in any part of this research is entirely voluntary. I may withdraw my consent and terminate my participation at any time without affecting any future treatment at St Luke's Hospital and in the Psycho-Oncology Service.

I have been provided with the contact details of the researchers should I have any questions or concerns regarding this study.

Name:_____

Signed: _____ Date: _____
(Participant)

Declaration of Researcher

I have explained the nature of the study to the above named participant. I have answered any questions and addressed any questions and addressed any concerns with him/her. I am confident that the participant understands the nature of the study and that s/he is freely giving consent.

Name:_____

Signed: _____ Date: _____
(Researcher)

If you have any questions regarding this consent form, please contact Allison Connolly (01) 406-5263.

AUDIO CONSENT FORM

I am aware that this consent is granting permission for my therapy sessions to be audio-recorded. I understand that audio recordings will be used for the purpose of my psychologist receiving expert supervision in emotion focused therapy. I understand that all audio-recordings will be stored securely in a locked cabinet and in keeping with St. Luke's record keeping guidelines.

I understand that my participation is entirely voluntary. I may withdraw my consent and cease recording at any time without affecting any future treatment at the St. Luke's Psycho-Oncology Service.

Name:_____

Signed: _____ Date: _____
(Participant)

DEBRIEFING SHEET

Emotion Focused Therapy for Patients with Cancer: A Case Studies Investigation in Psycho-Oncology

PRINCIPAL INVESTIGATORS:
Ms. Allison Connolly (01) 406-5263 Dr. Natalie Hession Dr. Niamh Coleman

Thank you for participating in this research study. The time you give up and information you share is appreciated. Please note that all information (both written and video recordings) you share will be held in the strictest of confidence. Paper records will be safely stored in a lockable storage container. Your name will be replaced by a non-identifiable code and data will be saved under this code, to ensure anonymity. Video recordings will be saved electronically under a non-identifiable code and viewed solely by the researcher team. When reporting the results of the study, any identifying information will be replaced and your name will not be published or disclosed to anyone. Quotes may be used in academic papers, however as explained, your identity will not be revealed at any point.

This research aims to examine the effectiveness of Emotion Focused Therapy for patients with cancer. The information you provide may be valuable to how psychologists offer therapy and support to others in the future. By gaining a richer understanding of the change processes occurring for the participants over the course of therapy, it is hoped that the most adequate and effective psychological support can be offered to patients with cancer.

When all the data is collected and analysed (this should be within in 1 year of your participation), a summary of the main findings will be available upon request. Again, the identity of participants will not be revealed in these findings.

If you have any concerns whatsoever about the study or would like further information, please do not hesitate to contact **Ms. Allison Connolly** on (01) 406 5263.

If you have any concerns about this study and the service delivery in the Psycho-Oncology Department, you may contact: **Dr. Natalie Hession,** Principal Psychologist on (01) 245-3530.
I would like to thank you for your participation in this study and appreciate the valuable contribution and commitment you have made.

Kind Regards,
Ms. Allison Connolly

Principal Investigator	**Principal Investigator**	**Academic Research Supervisor**
Allison Connolly Counselling Psychologist Psycho-Oncology Dept St. Luke's Hospital Highfield Road, **Rathgar, Dublin 6** **(01) 406 5263**	Dr. Natalie Hession Principal Psychologist Psycho-oncology Dept St. Luke's Hospital Highfield Road **Rathgar, Dublin 6** **(01) 245 3530**	Dr. Ladislav Timulak School of Psychology, Trinity College Dublin Dublin 2 timulakl@tcd.ie **(01) 896 2094.**

Client Change Interview Schedule: Follow-up Version (v5: 09/2008)

At follow-ups, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. Your therapist will not be shown this information until you have finished counselling with them, and only then if you give us permission to do so. This interview is recorded for later transcription. Please provide as much detail as possible.

1. General Questions: [about 5 min]
1a. How are you doing now in general?
1b. How has it been for you since therapy ended?
1c. What medications are you currently on? *(interviewer: record on form, including dose, how long, last adjustment, herbal remedies)*

2. Changes: [about 10 min]
2a. What changes, if any, have you noticed in yourself since therapy ended? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*
2b. Has anything changed for the worse for you since therapy ended?
2c. Is there anything that you wanted to change that hasn't since therapy ended?

3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following three scales:)*
3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)
(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)
(1) Very unlikely without therapy (clearly would not have happened)
(2) Somewhat unlikely without therapy (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without therapy (probably would have happened)
(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)
(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

4. Attributions: [about 5 min] **In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about?** (including things both outside of therapy and in therapy)

5. **Resources**: [Optional Question; ask if < 1 hr at this point; about 5 min]
5a. What personal strengths do you think have helped you deal with your problems since therapy ended? (what you're good at, personal qualities)
5b. What things in your current life situation have helped you deal with your problems since therapy ended? (family, job, relationships, living arrangements)

6. **Limitations:** [Optional Question; ask if < 1 hr at this point; about 5 min]
6a. What things about you do you think have made it harder for you to deal with your problems since therapy ended? (things about you as a person)
6b. What things in your life situation have made it harder for you to deal with your problems since therapy ended? (family, job, relationships, living arrangements)

7. **Helpful Aspects:** [about 10 min] **Looking back on your therapy now, what would you say was helpful about your therapy? Please give examples.** (For example, general aspects, specific events)

8. **Problematic Aspects**: [about 5 min]
8a. Looking back on your therapy now, is there anything about the therapy that you would say was hindering, unhelpful, negative or disappointing for you? (For example, general aspects, specific events)
8b. Were there things in the therapy that were difficult or painful but are now OK or perhaps helpful? What were they?
8c. Was anything been missing from your therapy? (What would have made your therapy more effective or helpful?)

9. **The Research:**. [about 10 min]
9a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)
9b. Can you sum up what has been helpful about the research so far? Please give examples.
9c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

10. **Suggestions:** [about 5 min] **Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?**