EMDR Therapy Protocol for Oncological Patients

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In the context of psycho-oncology today, there is a specific need to develop better tools for psychological assessment, as well as clinical intervention, that address cancer-related stressors. Particularly, focus should be on the events that preceded and underpinned the onset of the organic disease to treat these throughout the entire course of the illness and to help the patient face cancer and its correlates. It is hypothesized that eye movement desensitization and reprocessing (EMDR) therapy promotes the elicitation of the innate self-healing capacity; its effect is believed to be mainly linked to the interaction between the natural healing process of the immune system and adaptive information reprocessing. Because of the specific characteristics of the "cancer event," seen as a "traumatic event," it is fundamental to develop and adopt specialized protocols focused on the illness. This article outlines a comprehensive model that helps to identify crucial target memories for EMDR psychotherapy with patients with cancer. Examining each stage of the cancer treatment may help in understanding the relationship between the body and EMDR and how the imbalance may be corrected. The EMDR protocol for patients with cancer is explained step by step, in detail, and illustrated with clinical vignettes and through a case history.

Keywords: eye movement desensitization and reprocessing (EMDR); cancer; psychotherapy; trauma; health psychology

Cancer is a deadly disease that places the person in a highly stressful and potentially traumatic condition. It is a destabilizing experience that can undermine the patient's sense of identity, causing him or her to create new and frightening meanings and scenarios (Drageset, Lindstrøm, Giske, & Underlid, 2011; A. P. O'Connor, Wicker, & Germino, 1990). Often, families have difficulties managing the emotional reactions and the dysfunctional thoughts of their ill loved ones. The intense, emotional deregulation increases organic stress and can have negative effects on the immune system (Kendall-Tackett, 2009). Today, despite constant progress in screening procedures, diagnosis techniques, and treatment processes, cancer remains a critical event characterized by particular dynamics. For this reason, people affected by it need specific and personalized psychological and medical support (Faretta, 2014). Eye movement desensitization and reprocessing (EMDR) therapy addresses multiple cancer-related factors, including past traumatic events, to restructure cognitive/emotional/behavioral maladaptive schemas and to reinforce coping skills (Jarero et al., 2015; Murray, 2008, 2010). It can also provide valid support to families and professional caregivers. For these reasons, EMDR has been identified as an effective psychotherapy for patients suffering cancer (Capezzani et al., 2013; Faretta, 2014; Faretta, Agazzi, Poli, Sacchezin, & Zambon, 2013; Faretta & Sacchezin, 2015).

Cancer and posttraumatic stress disorder (PTSD) seem to be closely related: Many studies confirm a similitude in their neurobiological consequences and brain remodeling (e.g., Hahn, Hays, Kahn, Litwin, & Ganz, 2015; Kangas, Henry, & Bryant, 2002; M. O'Connor, Christensen, Jensen, Møller, & Zacharie, 2011; Servan-Schreiber, 2008). Several posttraumatic symptoms related to the illness are in fact consequences of the failure in processing trauma-related cognitions (Civilotti et al. 2015; Dupont Bower, Stanton, & Ganz, 2014; Faretta, 2014, in press).

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A vicious circuit between the traumatic event and the subsequent emotional response increases the level of suffering, along with physical and psychological distress (Kenne Sarenmalm, Browall, Persson, Fall-Dickson, & Gaston-Johansson, 2013).

The adaptive information processing (AIP) model provides a valid theoretical understanding of EMDR's efficacy in breaking this dysfunctional loop (Faretta, 2014; Schubert, Lee, & Drummond, 2011; F. Shapiro, 1995, 2001). Treated with EMDR, the perception of emotions and physical sensations linked to "frozen" traumatic memories can be efficiently stimulated to reshape, enabling the reintegration of the most disturbing elements (F. Shapiro & Solomon, 1995).

Cancer: A Specific Traumatic Event

As already mentioned, cancer-related distress needs a specific psychological diagnosis and support (Peters, Wissing, & Du Plessis, 2002). It is possible to find some parallelisms with other kinds of traumatic events because it evokes a sense of threat to a person's life and decreases the sense of physical and psychological integrity, but cancer has several peculiar features (Mercadante, Girelli, & Casuccio, 2004). The traumatic event usually begins when the diagnosis of cancer is delivered. In that moment, personal security is severely threatened (Mager & Andrykowski, 2002): The patient feels shattered; his or her thoughts turn to eventual medical treatments, with an uncontrollable fear of the consequences. Suddenly, the future becomes uncertain. Moreover, during the course of the disease, several traumatic reactivations are possibly generated: Sense of vulnerability, loss of control, and hopelessness are some of the typical feelings that can alter the quality of a patient's life (Black & White, 2005; Timko & Janoff-Bulman, 1985).

Working on cancer issues means acting on the past, the present, and the future. According to the conception of psychotherapy that takes into account the historical dimension of the patient's illness, working with EMDR means considering five clusters of clinical factors (F. Shapiro, 2001, 2014): traumatic memories, disease-related memories, current problems, triggers, and work on the future. Depending on the stage of the disease, as well as on the personal history of the patient, in this kind of context, EMDR targets may significantly change.

"Traumatic memories" are classical trauma or trauma-related memories linked to the patient's personal history (e.g., adverse childhood experiences—see Felitti et al. (1998)—and traumatic events experienced in adulthood). These memories are sometimes, but not always, connected to "disease-related memories" (a current, emotionally disturbing memory related to traumatic aspects of the cancer experience or to the traumatic consequences of the disease) and can be embedded in complex, negative blocking cognitions (F. Shapiro, 1995, 2001). Moving on to the "current problems" (targets related to the present stages of the disease and to how the patient experiences the illness in the *hic et nunc*), EMDR psychotherapy focuses on triggers existing in the present situation that are linked to fear and/or anxiety (F. Shapiro, 2001, 2014).

Outline of Protocol

Empirical Studies

The studies on the traumatic aspects of cancer are mainly descriptive in terms of prevalence, type of symptomatology, and aspects linked with the etiopathogenesis of the psychological suffering (Kangas et al., 2002; Kangas, Milross, Taylor, & Bryant, 2013; Mehnert & Koch, 2007; Phipps et al., 2014; Posluszny, Edwards, Dew, & Baum, 2011). Only few researchers tested the efficacy of EMDR with patients whose primary presentation is cancer. The first randomized controlled study of EMDR protocol for patients with cancer was conducted in 2013 by Capezzani and colleagues. This research emphasized the greater efficacy of EMDR compared to cognitive behavioral therapy in treating PTSD symptomatology during the active treatment and in the follow-up phase, whereas anxiety and depression improved equally in both psychotherapy groups.

In 2014, Civilotti et al. presented a pilot clinical study on 18 "mixed" patients with cancer. After 12 sessions of EMDR, preliminary results showed an attenuation of various forms of psychological complications that arise as a result of the diagnosis of cancer. In particular, were reported a remission of PTSD symptoms, a decrease in the levels of anxiety and depression, and in the perception of pain. Another pilot clinical study (Jarero et al., 2015) intended to evaluate the effectiveness of EMDR Integrative Group Treatment Protocol (EMDR-IGTP), specific for women with different types of cancer, on the related PTSD symptoms. Results showed a significant improvement, both in the active phase of cancer and in the follow-up phase, after psychotherapy with the EMDR-IGTP.

Description of the Protocol

Faretta (2014) has recently developed a specific EMDR protocol for patients whose primary presentation is cancer, aimed to help them resume personal control over aspects experienced as unmanageable since

receiving the severe diagnosis. EMDR intervention in psycho-oncology is focalized on present difficulties related to the different stages of the illness (Murray, 2010; F. Shapiro, 2001). The level of distress linked to each stage requires specific reprocessing workout to promote coping skills and to strengthen the resilience necessary to confront the disease.

- Phase 1: *History taking and data gathering* are identical to standard procedure, with special attention to emotional coping skills and self-regulating ability, vulnerability to traumatic and/or disturbing experiences (e.g., past traumatic events), triggers that lead to reexperiencing cancer-related events and/or previous episodes, and relational factors significative for the patient.
- Phase 2: *Planning the intervention* is identical to standard procedure, with special attention to hope, safety, and supportive networking. Improving self-care, empowering resilience, and coping skills is essential to guarantee therapeutic compliance and to preserve a sense of well-being.
- Phase 3: *Target selection* differs from the standard procedure because priority is given to targets of the present and/or recent past that are connected with the experience of illness (see Capezzani et al., 2013). That is, because in the hospital context, the intervention is strictly related to the progression of the disease, and the time available is often limited to 6–10 sessions. Even if traumatic memories that precede the onset of cancer are taken into account, the intervention is calibrated on the situation that the patient is facing. Coherently, special attention should be paid to cancer-related events and experiences, management of present problems, and effects on the patient's context and attachment patterns.
- Phase 4: *Desensitization and reprocessing* are identical to standard procedure, with special attention to the quality of therapeutic alliance: Identifying the therapist as a "safe base" allows the patient to face the intense emotions that come along the process.
- Phase 5: *Installation of positive cognition* (PC) is identical to standard procedure.
- Phase 6: *Body scan* is identical to standard procedure.
- Phase 7: *Closing the session*. Focusing on the "safe place" with no bilateral stimulation (BLS) but instead, guided imagery of health resources. If the session is incomplete, it is particularly important to leave the patient well-grounded to support him or her in the management of contingent difficulties.
- Phase 8: *Reevaluation* is identical to standard procedure. The selection of the next target follows the same criteria as in "Phase 3."

Application of Protocol for Patients Whose Primary Presentation Is Cancer

The EMDR protocol for cancer proposed by Faretta (2014) will be illustrated step by step through the case history of Sandra. Her therapy lasted 1.5 year for 63 sessions. The names used in the case histories of this article have no relation with real people's names. Every person whose personal experience is illustrated here has given formal consent to the publication of the parts referring to him or her.

Case Example. Sandra was a 36-year-old patient suffering from a relapse of breast cancer. She accessed the psychological support service complaining of disturbing, sometimes overwhelming, feelings of fear, anxiety, and sadness. She felt depressed and appeared introverted. Sandra reported sleep disorders (frequent nocturnal awakenings and difficulties in falling asleep), loss of appetite, and anhedonia. She requested psychotherapy because, as in self-description, she was "always frantic, incapable of finding a moment of rest." She appeared emotionally fragile (e.g., she easily cried but could not verbalize her sadness), and her mother accompanied her everywhere.

Sandra and her mother looked like they had an ambivalent relationship, alternating episodes of emotional closeness with outbursts of anger and frustration. She seemed very close to her family and did not have significant relationships outside. She used to spend most of her time at home, taking care of an aunt with disabilities (her mother's sister). She had no real job perspectives for the future; she worked occasionally as a clerk. She left university after less than a year, after enrolling in a literature course. She dropped out because of "little interest in the subjects." She verbalized a low sense of self-efficacy and feelings of helplessness, first experienced with the original diagnosis of cancer. In her own words, "the illness has distanced me from the few activities that I was able to maintain, and that allowed me to stay in touch with the world."

The onset of Sandra's cancer was in 2010, followed by a protocol of surgery and adjuvant chemotherapy. When she came in for consultation in 2013, the breast cancer had recurred, and a new surgical operation and chemotherapy had been proposed. During assessment, Sandra reactivated the memory of a childhood trauma: From age 8 to 11 years, she was recurrently abused by a neighbor who involved her in an activity of mutual masturbation.

Phase 1: History Taking and Data Gathering

The first phase of the EMDR stage-oriented trauma treatment in psycho-oncology is history taking and significant data gathering. It is fundamental for the therapist to identify and reinforce emotional coping skills and self-regulating ability because, during the treatment, the patient will probably experience states of hyperarousal and distress. The establishment of the safe place (F. Shapiro, 2001) and guided imagery techniques (Faretta, 2014) are effective therapeutical tools for this purpose.

Current traumatic events and painful situations related to the disease as well as past traumatic events and risk factors are evaluated. Within the context of cancer disease, the therapist should especially focus on the following elements: vulnerability to traumatic and/or disturbing experiences, triggers that lead to reexperience cancer-related events and/or previous episodes, relevant environmental factors and triggers to the EMDR psychotherapy, and relational factors significant for the patient.

Case Example. Asking specific questions to understand the cancer experience, the following information on Sandra's history were retrieved. The diagnosis of the disease led to a traumatic reaction by Sandra and her entire family. Sandra had hidden the sexual abuses suffered at the hands of the neighbor during her childhood years until the neighbor moved to another city; at that point, she found the courage to talk to her mother. The cancer had reactivated memories of the abuse and related thoughts and feelings.

Sandra had been bullied at school and experienced difficulties in scholastic performance. She had experienced negative cognitions (NCs) such as "I'm weak," and "I'm helpless." During her adolescent years, the family had been through a period of economic difficulties. At present time, she experienced NCs and feelings of confusion. Especially when alone at home, she felt overwhelmed by sensations of fear and terror for her personal safety and refused to be left on her own.

Phase 2: Planning the Intervention

The second phase is the planning the intervention: defining psychotherapy goals in accord with the patient and allowing the establishment of the therapeutic alliance. The patient should be able to regain a sense of self-efficacy to experience a feeling of mastery and emotional competence and to improve the control over his or her life. To promote these skills, undermined by the oncological disease, the therapist first explains the connection between the cancer-related trauma and the current feeling of distress.

A clear yet emphatic communication helps the patient to gain a better sense of control on the events. In this phase, therapeutic work consists mainly of psychoeducative interventions to explain the nature of pain and the psychological repercussions of oncological disease. The patient should also be informed on EMDR psychotherapy in terms of premises (the AIP model) and inner workings (BLS). Besides, it would be useful for the patient to understand if the suffering that he or she feels is linked with past memories, which tend to overlap his or her present emotional condition. The ultimate goal of this phase is to stabilize three oscillating qualities in patients with cancer: hope, safety, and supportive networking. Improving self-care as well as empowering resilience and coping skills is essential to guarantee therapeutic compliance and to preserve a sense of well-being.

Case Example. The development of a good therapeutic alliance allowed Sandra to trust the therapy and to proceed in the treatment. She was suffering from the continuous reexposure to stressors (a new surgical procedure and chemotherapy), so it was necessary to work on the resources and to strengthen the coping skills.

We proceeded with the installation of the safe place. The image chosen by Sandra was "Me, in my room, caressing the cat." The sensation that characterizes the image is one of physical well-being and is located in her abdomen, stomach, arms, and hands. After a few sets of BLS, the keyword chosen by Sandra was "serenity," which became the keyword that allowed her to recall the safe place in autonomy. She was asked to repeat the process to strengthen and intensify the positive feelings.

Further situations in which Sandra felt good and experienced PCs ("I am strong," "I am worthy of love," "I can manage my feelings") were analyzed and then we proceeded to the installation of the resources to strengthen the adaptive system. The therapeutic goal was to help Sandra deal with her present condition, allowing her to regain stability and security. For this reason, the episodes of abuse perpetrated by the neighbor, and reactivated by the experience of powerlessness generated by the disease, were set back at first and elaborated in a second time. The focus was on the relapse of the oncological disease. It was essential to process all the traumatic events connected to the past episode that triggered discomfort in the present (e.g., anticipatory anxiety, hyperarousal, sleep disturbances). Then, we proceeded to work on the present and gradually projecting into the future, with respect to the traumatic events of the first diagnosis.

Phase 3: Target Selection

At this stage, it is important for the therapist and the patient to define clusters of events related to the trauma. Phase 3 differs from the standard EMDR procedure because priority is given to targets of the present and/or recent past that are connected with the experience of illness. Coherently, the guideline to highlight major themes of reference should consider the following issues: cancer-related events and experiences, management of present problems and the cancer-related effects on the patient's relational context, traumatic experiences before the onset of cancer, and attachment patterns in the patient's life.

After identifying the target memories related to these main themes, the therapist asks the patient to think of the selected event and to formulate a negative belief about himself or herself (NC). Typically, NC in patients suffering from cancer are related to *safety* (e.g., "My body is no longer safe," "My body doesn't belong to me anymore," "I can't trust my body," "I can't trust myself," "I'm about to die," "I can't run away," "I'm alone," "My body is damaged"), *control* (e.g., "I'm not in control," "I'm weak," "There is nothing I can do," "I'm not able to deal with this," "I have no control over pain/my emotions"), and *responsibility* (e.g., "I'm the cause of my cancer," "It is my fault," "I should have done better," "I'm a loser," "I do not deserve to heal," "I'm a bad person," "I'm not lovable," "I didn't do enough," "I can't trust my judgment," "I'm defective," "I deserve to suffer"). At this point, the therapist asks the patient to focus on the traumatic memory related to the oncological condition and to identify the worst image that, at the present moment, represents it. In particular, it is important for the image to contain the most emotional part of the event. The patient is encouraged to focus on the image and to describe what he or she perceives emotionally, bodily, and cognitively. After the individuation of a working NC, the patient is led to identify a PC about himself or herself: A favorable statement that he or she feels to be authentic.

Case Example. In Sandra's case, she selected a scene related to the first diagnosis:

> I see myself sitting there, with my mother nearby and the doctor in front of us, telling me that I have cancer and that I'm going to have surgery immediately. And then we have to wait for the results of the histological examination. Suddenly, I felt stuck: I stopped breathing; my head was in such a confusion that I thought I would faint. I look at my mother and I see tears. I can still feel her despair. In contrast, I do not feel anything. It seems like I'm not even there. I often have this kind of feeling. Sometimes, in my dreams, I can see the doctor's face.

The worst image: "Watching my mother's desperate glance and feeling nothing."

The associated NC: "I am helpless."

The PC that she would like to have: "I am strong; I can handle my feelings," with a perceived validity of 2 out of 7 (Validity of Cognition [VoC] = 2).

The connected emotions were "anxiety" and "confusion," with a score of 8 out of 10 on the Subjective Units of Disturbance Scale (SUDS = 8).

Regarding the physical location, she was sensing discomfort throughout her body and particularly, in her head.

Phase 4: Desensitization and Reprocessing

This is the phase of desensitization through BLS: The patient elaborates the worst aspects of the experience simultaneously with the BLS. At this stage, the therapeutic alliance is very important because the patient generally experiences intensely negative emotions: Identifying the therapist as a safe base is the condition that allows the patient to move into a painful process. When traumatic memories are reactivated, the patient may relive past experiences, and this process could generate intense and disturbing reactions. Eventually, the patient may even dissociate. In this situation, the therapist must be a firm and steady point for the patient, allowing him or her to reexperience scary feelings, while reassured by a safe setting. In some cases, after BLS, the patient detects no improvement and, indeed, even a worsening: It is a block, and the therapist can help unblock it through questions and cognitive interweaves which facilitate the flowing of the adaptive process.

Case Example. Sandra concentrated on the image, on the NC, and on the body parts in which she felt the distress. The focus was double: the traumatic memory and the BLS. After a few sets of BLS, she had a somatic abreaction: She began to perspire and sweat as the image moved away and became less defined. The discomfort began to decrease. With the progress of desensitization, new considerations emerged, such as "Now I can watch the scene without reliving it" and "I know what happened but I also know that I am beyond it."

Sandra experienced relaxation and gained a better awareness of her strength. She began to rediscover her resources and to understand how to tackle the

medical care following the intervention. At the end of the desensitization, Sandra reported no ailment remembering the episode. Her score on the SUDS was 0 out of 10 (SUDS = 0).

Phase 5: Installation of Positive Cognition

After verifying the perceived VoC identified by the patient during assessment, the therapist proceeds to install it. This is possible only if the patient does not experience any discomfort in relation to the traumatic experience that has been reprocessed.

This phase goes on until the material becomes more and more adaptive for the patient. It is therefore associated with the desensitized memory and reinforced with a few sets of BLS. Strengthening this association modifies the emotional connotation of the memory target: When recalled, it reactivates positive feeling and adaptive thinking. This step also helps to reelaborate the cognitive meaning of the event. Once desensitized, the experience can finally be integrated.

Case Example. The feedback that emerged during installation was increasingly positive: Sandra felt progressively stronger and more skillful. She recalled memories of situations linked to her first admission that she was able to successfully manage, thus modifying the associated network of experiences and improving the adaptive potential. At the end of the installation, the VoC was 7 out of 7 (VoC = 7).

Phase 6: Body Scan

At this point, the therapist proceeds with the verification of the process through body scan: He or she asks the patient to recall the event, focusing on PC, and to mentally explore his or her own body like a scanner, from head to toe, registering any possible hint of residual distress. The body scan is an essential part to complete the process of reinforcement and stabilization and to capitalize the changes achieved with the EMDR intervention. If any residual stress emerges, the therapist proceeds with further sets of BLS. The body scan is complete when the patient feels completely free of somatic tension and/or with the appearance of positive feelings, which may be reinforced.

Case Example. After the body scan, Sandra referred increasingly positive feelings, such as "I feel my body lighter and less tired," "I feel stronger than what happened to me," "I feel relaxed," "It's strange, but I even feel like I have more energy . . . . "

Phase 7: Closing the Session

At the end of every session, the therapist verifies the stability gained by the patient. The session should end when the patient is in an acceptable emotional condition. To further stabilize the situation, it is useful focusing on the safe place (with no BLS, but instead, guided imagery of health resources) and on a positive schedule for the rest of the day. It is essential to explain to the patient the importance of observing, monitoring, and taking note in a diary of thoughts, feelings, dreams, and any memories that might emerge in the following days. It is equally important to give the patient all the possible tools to develop an alternative lifestyle, one which is more oriented to well-being.

A small note on the procedure for closing an incomplete session: When a client's material is still unresolved, and you have run out of time, it is fundamental with patients with cancer to acknowledge what they have accomplished and to reduce the level of arousal. The therapist should leave the patient well-grounded to support him or her in the management of contingent difficulties.

If the session is incomplete, do not use the installation of PC and/or the body scan: The safe place or containment/relaxation exercises (e.g., guided imagery) are better in these cases.

Case Example. When Sandra and the therapist had to end the session before the processing of a target was completed, they used the visualization of the beams of light technique: "I feel the blue ray of light entering in my body," "This light calms my body and my mind, it helps me letting go," "I feel quiet and confident," and "I am ready to go on."

Phase 8: Reevaluation

Before confronting the next target, the therapist reevaluates the previous session's target to assess any possible persistence of distress. The evaluation is corroborated by the SUDS and by the VoC. If the results are not in line with expectations, the therapist must complete the unfinished session. The reevaluation phase enables the therapist to recheck the targets, especially the most relevant ones and to identify new areas of work. The selection of the next target follows the same criteria as in Phase 3.

Case Example. Different factors were considered in the evaluation of the therapeutic process; among the others, the quality of dreams that Sandra reported between the sessions was also significant. For example, she dreams to drive alone through unknown roads. At first, the roads are rough, with many obstacles that

make it difficult to go ahead, but then, the landscape changes, becomes more naturalistic, and the driving gets easier. Sandra finds a house that reminds her of the one she used to live in as a child. She goes inside and finds out that she can rest there for a while.

After completing the desensitization of the first target, the succeeding traumatic memories linked to the different stages of the illness were treated. In a chronological order, Sandra and the therapist worked on the following memories: the first chemotherapies and related targets, a crisis that occurred during the administration of a chemotherapeutic drug, the physical side effects of the cure that she experienced as disabling, the communication concerning the relapse, targets related to the admission time in the hospital before the transplant, and targets related to the disturbing physical sensations she experienced.

Future Scenarios and Installation of Adaptive Responses

Visualization of future scenarios is an important activity in psycho-oncology: It strengthens adaptive patterns against the challenges entailed by cancer. Anticipating and identifying potentially distressing future scenarios enables the preventive installation of adaptive responses—abilities, attitudes, and behaviors—that help the patient to perceive himself or herself as competent and effective. Only after completing the desensitization and reprocessing of all the assessed targets, therapist and patient consider what is coming on, looking for the triggers linked to the critical event in a future perspective.

Case Example. The therapist invited Sandra to visualize helpful images linked to the PC she had chosen. All of these images were reinforced until VoC score was 7 out of 7. This helped Sandra to regain confidence and stability (e.g., dealing with medical controls without getting restless).

Special Issues for Patients With Cancer

Even if the experience of cancer disease is a highly subjective one, it is possible to individuate eight steps accordingly to Murray (2010) and Faretta (2014). The level of distress related to each stage of the illness requires specific, reprocessing workout to promote the patient's coping skills.

Each stage of medical treatment provides new challenges for the patient to face. Special issues should be considered in relation to cancer screening, diagnosis and treatment planning, intervention, additional therapies, remission, possible recurrence, death process, or identity reassessment. The specificity of therapeutic alliance in psycho-oncology is also enlightened.

1. Cancer Screening

The onset of the illness may elicit an alarm response exhibited by suppressed anxiety and by downplaying the severity of the medical condition. Patients may tend to ignore symptoms for some time before reaching out for medical assistance, and the delay potentially influences prognosis (Faretta, 2014; Murray, 2010). Many people experience the stigma of being ill, together with feelings of shame and defectiveness which negatively affect both self-perception and social projection. Self-victimization and self-sacrificing behaviors are common. This is the point at which learning to accept one's illness is the hardest thing to do. Upon entering this stage, patients may develop irrational thoughts, such as viewing the doctor as "a messenger heralding bad tidings" (Faretta, 2014). At this stage, an appropriate EMDR intervention can pinpoint the most challenging aspects of the situation by focusing and enhancing the patient's personal resources. The aim is to help patients identifying any condition or trigger that may cause distress (Murray, 2010).

2. Diagnosis of Cancer and Treatment Planning

The most common reaction at the communication of the diagnosis is shock, followed by acute emotional responses, subsequently giving rise to depressive states. Feelings range from devastation, fragmentation of the sense of self-continuity, to disruptive despair, along with disbelief and numbing (Murray, 2010). Eventually, the patient will elaborate the reorganization of the structural properties of his or her personal meaning system as reflected in his or her beliefs, emotions, and behavioral patterns (Leeds & Korn, 2002). Intervention must entail a collection of useful information and the identification of a support network for stabilization (Leeds & Korn, 2002). The EMDR therapist uses various techniques to encourage and reinforce resources, starting with the development of a safe place (F. Shapiro, 2000). Working on coping skills (Foster, 2000) leads to the identification of internal and external resources, useful to support the patient's compliance in the screening procedures and in the diagnostic treatment plan as well as helping him or her achieve a clear mental state conducive to good decision making. In the event of surgery, patients need to be sustained in raising their awareness concerning any possible/necessary mutilations as well as in creating a plan for psychological self-healing (Murray, 2010).

3. Cancer Intervention

Once the person becomes a proactive patient with cancer, the emotional turmoil tends to settle down, restoring security and a sense of control over the disease (Faretta, 2014). This new awareness enables him or her to cope with the unwanted side effects of treatment and with feelings of distress, sadness, isolation, anger, and anhedonia. If surgery becomes an option, deep fears arise, and unavoidably, general distress increases, promptly causing acute responses. The patient's appraisal of the body site designed to undergo surgery will give it a special meaning, involving anguish and deep worry. Physical pain and body modifications greatly impact a person's inner and relational world. Pain, anxiety, and uncertainty can cause irritability, anger, and overwhelming negative feelings (Murray, 2010). Moreover, the challenging psychological situation may reverberate negatively on the patient's entire system, impacting on the physical level as well (Neeman & Ben-Eliyahu, 2013). Waiting for the screening response, dreading the bigger picture, and receiving the diagnosis and prognosis of the disease make it even harder to cope with uncertainty. Relevant psychological therapeutic goal setting at this stage should include stabilizing the acute distress phase, reducing or mitigating the intense reactions caused by the event, alleviating and preventing anguish, providing instructions, stabilizing emotions, and resuming pre-illness global adaptive functioning (Faretta, 2014; Murray, 2010).

Each goal involves and integrates different psychological techniques. The clinical interview helps to release the tension caused by the prospective of surgery by letting the patient talk about his or her experience spontaneously, liberating him or her from the deep sense of isolation: Communication has a regulating effect on activated states (Leeds, 2009). Psychoeducational intervention contributes to reinforce personal sense of control as well as providing information aimed to normalize emotional reactions linked to feelings of alarm and worry. Allowing the patient to describe his or her subjective experience within the various stages of the illness and reflecting on possible future reactions improves awareness and the perceived self-efficacy because many patients tend to develop feelings of guilt toward their anger and their need to cry (Faretta, 2014). This phase requires assessing internal and external protective factors, such as personal resilience, significant relationships, and the presence of a supportive social network (Leeds, 2009). Before proceeding with the intervention, the therapist needs to create and reinforce a safe, calm, and peaceful "place." This imagery technique reinforces preexisting protective factors and helps to develop grounding, orientation, and resources for emotional regulation, getting the patient's mind off the hospital so that positive emotions may again be experienced. This offers the opportunity to reclaim self-continuity, despite the illness, through the activation of self-soothing functions (Faretta, 2014). The therapist may guide the patient in remembering positive role models who inspire internal resources that enhance PCs against the pervading feeling of powerlessness (Foster, 2001). EMDR relaxation and breathing techniques are also useful at this stage (Faretta, 2014).

Clinical Vignette 1: Laura and Her Mastectomy. Laura is a 34-year-old dentist. She was diagnosed with breast cancer 2 months after separating from her boyfriend. She asked for psychological support because she was extremely frightened by the prospective of the mastectomy (removal of the left breast), which was causing feelings of fragility and impotence.

Laura came in for consultation 1 month before surgery, presenting symptoms related to acute stress, with a strong fear of death. Specifically, she reported symptoms of hyperarousal like feeling irritable, an overwhelming sense of sadness and helplessness, shortness of breath, tachycardia, and difficulty in maintaining sleep because of frequent nightmares.

The main NC was "I am responsible for my cancer." Exploring her history, I noted that her mother had had cancer when Laura was a teenager but never spoke with her about the illness. Of that period, Laura remembers, with anguish, several disturbing scenes (e.g., "mother lying on the sofa," "mother weeping in secret"). Today, Laura enjoys a good network of family and friends.

The work plan initially focused on her ability to better manage the upcoming surgery and then, later, processed the targets related to her history of attachment and the scenes of her mother's illness. We worked first on stabilization, with the safe place technique. Laura chose her little hut in the mountains. Then, we proceeded to work on the installation of resources by tying each resource to each step of the surgery. The future scenario was articulated in a sequence that started (a) with the nurse bringing her to the operating room and continued (b) with the instant in which she was lying on the operating table, followed (c) by the administration of the anesthesia. The conclusion (d) coincided with the moment Laura is awakened after surgery and returns to her room.

The resources that Laura chose were (a) calming herself through reconnection of mind and body by slowing her breathing and associating the phrase "I breathe in and I breathe out, I calm my body and I heal my body"; (b) identifying a relational resource in her friend, Tania, who she imagined being near her, holding her hand at the moment she would be transported to the operating room; (c) confidence and self-healing powers were resources that were strengthened with the image of a healing light that entered her body as she went under anesthesia; and (d) strength and courage were installed through the image of a large oak tree and associated with being awakened after surgery to be taken back to her room.

After strengthening these resources, we proceeded to make the "movie in the future" by combining all of the given resources, first through verbalization only, to check the adequacy of the narrative, and then with eyes closed and BLS (tapping) up to the successful completion of the entire EMDR routine. Only after this step did I ask her to connect the PC to the entire "movie" which in this case was "I am able to do it" with a VoC score of 7 out of 7 (VoC = 7). This work was later repeated by Laura at the time of surgery and allowed her to address and better manage the situation by making use of her resources, thereby promoting a strengthening of the factors of safety and protection.

Two weeks after surgery, Laura reported that she felt calm and confident. In her own words,

> The day of the surgery, I was able to keep a deep, inner calm, breathing slowly and deeply, and repeating to myself: I calm my body, and I heal my body. Then I recalled the entire sequence, step by step, until the anesthetist came near me to get me to sleep. I felt very serene and—later they told me—I fell asleep and then woke up with a smile. . . . All of this just to say that I could personally verify the power of the mind, and that the synergy between mind and body promotes well-being even when you're experiencing a traumatic situation.

The aim of the EMDR intervention in this phase was to strengthen protective factors and to promote a feeling of security to better face breast surgery. After surgery, the Recent Traumatic Event EMDR Protocol (E. Shapiro & Laub, 2008) can foster the reprocessing of the event, promoting adaptive integration of each specific disturbing aspect and strengthening resources and coping skills. This protocol is an extended version of the standard EMDR protocol because it addresses discrete elements related to an event occurring from 2 up to 3 months before. Recent memory of surgery comprises several disturbing targets, which need to be processed separately: physical pain, impairment, feeling vulnerable, and the perception of threat (Faretta, 2014; Murray, 2010). Potentially, any difficult experience during hospitalization may represent an appropriate target for EMDR processing.

Clinical Vignette 2: Giuseppe and Postsurgery. Immediately after undergoing throat surgery and prior to being released from hospital, Giuseppe, 67 years old, had a hemorrhage and was put in intensive therapy for several days. Once he returned to the ward, he clearly exhibited symptoms of hyperarousal (e.g., intense feelings of fear, hypervigilance, intrusive thoughts, aggressiveness toward health care personnel). Our first meeting took place 15 days after surgery. The first session focused on stabilization and psychoeducation to normalize his emotions. Giuseppe was guided in the creation of his safe place and instructed to use it between sessions. He was provided with a clear explanation of postsurgery psychological response and with an outline of useful integration strategies. Giuseppe was not willing to share his experience because of its strong emotional impact: He did not want anyone to see him cry, especially his wife. This attitude had caused him to withhold his emotions over time and to talk about "other things."

Once he had been debriefed on the stress reaction mechanism, which helped him feel entitled to his emotions, sessions proceeded with recounting personal narratives and with the administration of the Recent Traumatic Event EMDR Protocol, addressing the main disturbing points. During the sessions, Giuseppe had several abreactions, such as crying and experiencing fear. A week later, Giuseppe resumed his normal sleep pattern and was able to relax. He referred feeling "more confident and relaxed: I know all of this belongs to the past and that I overcame it." The validity of PC was 7 out of 7 (VoC = 7); the SUDS score was 0 (SUDS = 0). Giuseppe felt so much better that he suggested his wife to arrange some sessions for herself. His wife had witnessed her husband's hemorrhage and fainting from a distance because health care operators and paramedics asked her to stand aside. Those minutes were frozen in her mind and seemed never-ending. She exhibited acute stress symptoms and received Recent Traumatic Event EMDR Protocol in the presence of her husband who, having rebalanced his functioning, was able to serve as a protective factor.

4. Additional Therapies (Radiotherapy, Chemotherapy, Hormones)

Making choices concerning treatment can be difficult for a patient: Additional therapies usually include chemotherapy, radiotherapy, and hormonal therapy. Health care operators need to be updated on the latest research developments and statistical outcomes for the proper implementation of correct treatment yet must not ignore undeniable evidence: Cancer requires intensive treatments which cause severe fatigue in the great majority of patients (Wagner & Cella, 2004). Patients feel as if their bodies, their time, and their lives no longer belong to them. These conditions can frustrate the psychotherapeutic process in terms of scheduling (Murray, 2010).

Clinical Vignette 3: Luisa's Avoidance Behavior Toward Additional Therapy. Luisa had to face a difficult choice. Her illness (mammary carcinoma) relapsed, and this time, she would have to undergo chemotherapy with the consequent hair loss. Up until the present time, she had chosen therapies that did not have this kind of side effect. She said that she would be able to endure further surgery but could not accept losing her hair. She felt it to be, in her own words, "abusive." During sessions, Luisa talked about her illness, toward which she always had a strong and defiant attitude. Gradually, the memory of her mother's illness emerged. Luisa had been very young at the time (10 years old). She described her mother as a strong woman who never felt sorry for herself and that was never "a burden for the family." The therapist asked her how she, as a little girl, experienced her mother's illness, in particular, where and how she felt the strain. The following targets emerged: the image of her mother wearing a scarf on her head, seeing her mother with no hair under the shower, and sensing that this was "something bad" that one could not talk about.

Many abreactions followed the reprocessing of these targets. After a few sessions, Luisa came to terms with the idea of losing her hair: She could talk about it with less activation and was finally willing to undergo chemotherapy. "Now I can accept the idea of chemotherapy because it's just a way to take care of myself. I feel trustful . . . I know I can do it." The VoC was 6 out of 7 (VoC = 6); the SUDS score was 1 out of 10 (SUDS = 1).

5. Remission

The end of treatment can reawaken memories linked to the original traumatic event (Murray, 2010). Each person reacts differently in readjusting to normal life: It depends on the individual's coping style, which may be predominately characterized by avoidance behavior, thriving personal growth or worries, and rumination (Faretta, 2014). Patients who suffer from lingering pain can be assisted by the application of the "pain control with EMDR" protocol (Grant, 2012). The end of standard and complementary therapies can induce highly contrasting emotions, including euphoria, fear, uncertainty, regret for the end of the routine care, and for losing contact with health care operators or with other cancer survivors. This is the moment in which patients are more likely to request psychotherapeutic assistance (Murray, 2010).

6. Possible Cancer Recurrence

The recurrence of cancer can be understood as a traumatic event with a high risk for stress response. A patient can feel as things are hopeless or think that, from now on, cancer will be a chronic illness (Faretta, 2014; Murray, 2010). Patients who did not expect such a recurrence, especially after a long-term recovery, can feel betrayed by a harsh fate, displaying reactions of disbelief, denial, anger, despair, helplessness, and may even refuse treatment (Faretta, 2014). Many patients perceive that adjusting to a recurrence is more problematic than adjusting to the initial diagnosis, possibly showing a severer psychological disorganization with a higher risk of affecting relationships with partners and family members (Faretta, 2014).

The administration of EMDR must be adequately calibrated bearing in mind the intensity of medical treatments and their effect on the patient throughout all phases. Considering the new, challenging circumstances, previously installed resources need to be revised, and new resources should be added, if necessary (Foster, 2001).

On the other side, a very distressing, future-oriented consequence of the illness is the fear of cancer recurrence, that is, to say the fear or worry that the cancer will reappear or progress in the same or in another organ. This is a very common, distressing, complex emotion that can have repercussions throughout the patient's life (Deimling, Bowman, Sterns, Wagner, & Kahana, 2006). One of the most invalidating characteristics of fear of cancer recurrence is that it tends to persist for a prolonged time after the ending of cancer treatments (Simard, Savard, & Ivers, 2010; Smith et al., 2011). Another relevant aspect, specifically in the light of EMDR psychotherapy and within the posttraumatic spectrum, is that fear of cancer recurrence is not just an emotional issue characterized

by fear or anxiety but a complex psychophysiological reaction that could lead to the development of high levels of distress, functioning impairment, and/or dysfunctional behaviors (e.g., excessive health worries, avoidance, or over-checking; F. Shapiro, 2014).

7. Death Process

At this stage, emotions described in the Kübler-Ross grief cycle (Kübler-Ross & Kessler, 2005) can be reactivated. To identify and address the patient's needs, the therapist should have specific knowledge of physiological and safety issues: A terminally ill patient must not feel abandoned, and his or her basic needs (e.g., symptom reduction, pain buffering, mobility impairment) have to be managed and integrated into the therapeutic process (Faretta, 2014). The patient needs to perceive active assistance and effective professional attention, support, and consideration. It is important for the patient to promote a sense of belonging and to be surrounded by significant "others" as well as to communicate and express thoughts and feelings while reconsidering the meaning of life (Servan-Schreiber, 2008).

8. Identity Reassessment

Cancer is an "identity-altering process" (Murray, 2010). To promote the reintegration of the self and the reorganization of working/social life, it is useful to understand which kind of "alliance" the patient establishes with his or her illness. This means pinpointing the identification processes, enlightening the role played by the illness in the expression of the self (e.g., investigating possible disease-maintaining factors; Faretta, 2014; Murray, 2010). In particular, the EMDR therapist should evaluate possible "positive" consequences inherent to current issues, for example, if and how the patient takes a secondary advantage of illness-related distress (e.g., fear of abandonment). The therapist should also pay special attention to dissociative adjustments; for example, a patient could split the "ill" emotional parts identified with the disease and, therefore, experience these emotions as "symptoms" that must to be avoided at all costs (Faretta, 2014). An illness disidentification process can only take place through the integration of all the emotional parts, so that the patient can relate to the disease, instead of being defined by it. Working on identity helps the patient not to disown feelings of frailty and vulnerability but rather to look at them as part of the richness of the "inner child" who claims to be reintegrated within the adult psychic functioning (Faretta, 2014).

Other Issues

Besides the prototypical stages listed earlier, Murray (2010) and Faretta (2014) describe additional cancer-related risk factors which can trigger negative reactions. Among these, there are suspicious symptoms, diagnostic screenings, being on waiting lists, being mutilated or left with deformed body parts, undergoing chemotherapy, fatigue, radiotherapy, the end of treatment, having a new social and family role and readjustments/changes in relationships, medical follow-ups, pain and its physical effects, anniversaries, friends' remission or friends' lost, recurrence/disease progression, advanced cancer stage, and the end of life/death.

The Therapeutic Alliance

Within this context of intervention, it is very important to establish and ensure a strong alliance with the patient. Trusting the therapeutic dyad, defining mutual roles, being responsible toward the patient as well as empathic mirroring of his or her needs, and timing are fundamental prerequisites to the intervention in psycho-oncology (Dworkin, 2010).

The main purpose is for the patient to regain that feeling of control undermined by the disease. The therapist must ensure balance and cooperation by placing himself or herself in the position of facilitator and coleader. Patients with cancer may need time to familiarize with their therapist and to reactivate relational skills eventually depleted by the illness (Dworkin, 2010):

> Therapist and patient are simply two people exploring the unknown, with different responsibilities and different roles. They both need a lot of courage. Using EMDR from a relational perspective doesn't mean that the therapist should emphasize too much or share at all costs his intuitions. Therapist and patient are travel partners and companions: they are expected to collaborate in order to identify treatment targets and their sequencing, as well as access state-dependent memories together. (Dworkin, 2010)

Discussion

Numerous research studies have highlighted a strong correlation between adverse life events and several psychophysiological symptoms (F. Shapiro, 2014). This study draws preliminary suggestions for the application of EMDR psychotherapy with patients whose primary request is cancer. The EMDR therapeutic intervention with patients with cancer is aimed at restoring the balance of emotional and

relational aspects, promoting resilience factors and allowing traumatic experiences related to the disease to be processed. This protocol has not contraindications regarding the occurrence of possibly coexisting psychological disorders as long as EMDR therapy demonstrated efficacy in various psychiatric populations. In the meanwhile, it is important to underline that a cancer diagnosis does not automatically implies trauma: According to the AIP model and to *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; "PTSD," "diagnostic features"), a life-treating disease is not to be necessary considered a traumatic event because trauma originates from a combination of objective as well as subjective factors. If cancer is "a necessary but not sufficient condition" to experience trauma, then EMDR protocol for patients with cancer is indicated only for the ones who effectively develop a PTSD or "syndrome."

Development of EMDR psychotherapy in the oncology setting requires further research and validation, starting with the replication of the protocol in a wider cancer population. According to the results of this study, future research should also focus on the relevance, in anamnesis, of previous/precocious traumas, eventually comprehending a transgenerational prospective (see "Clinical Vignette 3: Luisa's Avoidance Behavior Toward Additional Therapy"). Special attention should be paid to the conceptualization of the case through the implementation and validation of assessment questionnaires (see "Psychopathological Anamnesis for Cancer Patients" in Faretta, 2014, and "Risk Factors Evaluation Inventory" in Grant, 2012). The standardization of the assessment tools helps to enlighten the specific weight of each factor—or clusters of factors—involved in the psychological impact of the diagnosis.

This study shows that EMDR protocol for patients with cancer can be used as an efficient treatment protocol in providing support to patients, their families, and professional caregivers. It also expands EMDR's area of applicability to include the treatment of cancer-related trauma because it demonstrates efficacy in "desensitizing and reprocessing" this highly specific and potentially traumatic event.

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