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Morfoanalitica Therapy as a therapeutic resource post breast cancer surgery for women

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ABSTRACT

Introduction: Women with breast cancer may present, in addition to physical limitations, changes in emotional aspects. In physical therapy, it is unusual to consider the mind-body dialogue, even when it comes to diseases with great impact on bio-psychosocial aspects, such as breast cancer. However, therapies are emerging with a psychosomatic nature, such as morphonalitic therapy, which includes bodily, sensory, emotional and verbal aspects. **Objective:** To verify the effects of morphonalitic therapy on the treatment of anxiety, depression and self-esteem in women after breast cancer. Furthermore, it presents some verbal reports of sessions in order to include the feelings and sensations of these women and recognize, in addition to objective factors, the subjective factors that are an integral part of human stories. **Method:** Ten women participated in the study, undergoing 16 individual morphonalitic therapy sessions, once a week, lasting 60 minutes. They completed a scale on anxiety and depression and the Rosenberg self-esteem scale. The sessions were arranged through a structured therapeutic framework, which varied according to the therapeutic process of each participant. This included bodywork, empathetic touching contact, eye contact, stimulation of body awareness, and analysis of the patient's body structure; during the session, the patients verbalized their feelings. **Results:** Depressive symptoms decreased (p = 0.0418) and self-esteem increased (p = 0.0020) after treatment. **Conclusions:** During the sessions, these women experienced various feelings, beyond the awakening of body awareness. It is hoped that morphonalitic therapy be applied on a larger scale as an adjunct therapy for women with breast cancer, as well as in other populations.

Key-words: Anxiety, Depression, Breast cancer, Complementary Therapies, Mind-Body Therapies, Self Concept.

INTRODUCTION

Cartesianism presupposes the machine body and not the human subject.[1] This philosophy influenced Western medical-scientific thought, with the design of the fragmented body: physiological and psychological, which ignores all and whole human being.[2,3]

However, it is known that the human being is, in itself, indivisible. In order to overcome this division, Integrative Medicine emerges, which uses evidence-based practices associated with conventional medicine, which Integrative Oncology is a branch of it. Conventional oncology treatments are accompanied by alternative and complementary therapies such as: biology-based practices, mind-body techniques, body manipulation practices, energy therapies, and traditional medical systems such as traditional Chinese medicine and Ayurvedic medicine.[4]

In this context, in physiotherapy is unusual considering the mind-body dialogy, with direct involvement in physical therapist-patient relationship[3] and in understanding of psychic phenomena present in the behavior of patients[5], even when it comes to diseases such as breast cancer, which has great repercussion in the bio-psychosocial aspects.[6] Women with this disease may have, in addition to physical limitations, changes in emotional aspects such as anxiety, depression[7,8] and decreased self-esteem.[9]

Thus, it has been emerging in physiotherapy, therapies of psychosomatic nature, such as the Godelieve Denys-Struyf (GDS) muscular and joint Chains and the Morphoanalytic Therapy (MT) of Serge Peyrot.[10]

The MT is a body psicho analytical technique that provides harmonization of muscular tension, the adjustment of muscle chains compensation and the development of body awareness

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and sensory [11,12], and those being integrated into the analytical verbal work, based on the psychoanalysis of Jean Sarkissoff , Freud, Winnicott and Melaine Klein.[13]

The present study aimed to verify the effect of MT in the treatment of emotional aspects such as anxiety, depression and self-esteem of women after breast cancer surgery. In addition, it exposes some verbal reports of the sessions with the TM contributions.

It is important to emphasize that the present study is not intended to discuss and reflect the effects and causes of cancer, but instead, to relate the sensations and feelings of these women and to recognize, besides the objective elements, the subjective as an integral part of human stories.

METHOD

This is an experimental study approved by the Research Ethics Committee of FCT/UNESP (CAAE: 03195912.7.0000.5402). Approximately 40 women after breast cancer surgery were referred to the Gynecology and Obstetrics Section of the Center for Studies and Care in Physiotherapy and Rehabilitation (CEAFIR) of the Faculdade de Ciência e Tecnologia/Universidade Estadual Paulista (FCT/UNESP). Ten agreed to participate in this study and received clarifications on its objectives and procedures, signing the "Free and Informed Consent Term".

The inclusion criterias were: women submitted to surgical treatment of breast cancer, regardless of the type of surgery, from zero to 10 years postoperatively, with medical consent, without diagnosed metastasis, outside the stage of chemotherapy or radiotherapy treatments. No patient was excluded from the study.

All the participants went through a collection of personal data. They were invited to respond to the anxiety and depression scale - Hospital Anxiety and Depression Scale (HADS). This is composed of 14 multiple choice items: seven refer to the subscale of depression and the remaining to anxiety subscale. Each question can receive from zero to three points, so the overall score of each subscale can range from zero to 21. If the respondent obtains a value greater than or equal to nine points in each subscale it means that it presents possible anxiety and/or depression.[14]

They then responded to Rosenberg's self-esteem scale. [15-17] This is a unidimensional measurement which consists by 10 claims related to a set of feelings of self-esteem and self-acceptance, which evaluates the overall self-esteem. Half of the items are stated positively and the other half negatively, which total score ranges from 10 to 40. Obtaining a high score reflects high self-esteem.[15,16]

Participants were submitted to 16 individual MT sessions, once a week, during 60 minutes.[18] All meetings were held only by the researcher, with full training in MT.

The MT sessions, designed by Serge Peyrot, were organized through a structured therapeutic framework, and may vary according to the therapeutic process of each participant. These sessions it is include in the body works the empathic touches of contact, eye contact, the stimulation of body awareness and the analysis of the patient's body structures, while the patient verbalizes what he feels.[18] The proposal of the body work was chosen on the basis of physical and/or mental patient complaints at the time of the session.[18] Global stretching of muscle compensation chains were performed, associated with diaphragmatic breathing, superficial and connective tissue massage, body experiences and sensory awareness, concurrently with the analytical verbal work.[11,18]

The sessions were started with the patient standing, followed by dorsal decubitus, and was terminated again standing. In each phase of the session, the patient was invited to perceive the new body references, while the therapist performed the analysis of the psychic aspects reported by the patient.[18]

The verbal reports of the patients during the cares, when directly related to the proposed variables, were transcribed, as they more clearly demonstrated their relationship with feelings of anger, fear and rejection - the word allows us to classify, understand and express a feeling. The patients were identified by numbers in order to guarantee the secrecy of their identity.

Statistical analysis

In the scales used, the sample distribution was tested for normality by the Kolmogorov-Smirnov test. For intra-group comparison (before and after treatment), Student's T-test was performed when the data were parametric and the Wilcoxon test was performed when the data were non-parametric. The analyzes were performed using GraphPad Prism 5.0 software and the level of significance adopted was 5%.

RESULTS

The sample consisted of 10 women, mean age of 53.2 ± 7.72 years and mean time of surgery of 5.7 ± 2.94 years. Of these, 5 performed radical mastectomy (2 right and 3 left) and 5 quadrantectomy (3 right and 2 left). Only two women did not undergo chemo and radiotherapy. As for marital status, 80% of them are married and 20% are divorced.

Table 1 shows the mean values obtained on the anxiety and depression scale (HADS) after MT intervention.

The values obtained in the Rosenberg self-esteem scale are described in Table 2.

Table 1. Mean and standard deviation and p-value of the anxiety and depression score (HADS) of women post-breast cancer surgery, before and after 16 sessions of Morphoanalytic Therapy. n = 10.

	Before	After	p-valor
HADS - anxiety	8.1±3.2	7.4±3.9	0.3185
HADS - depression	7.5±3.3	6.1±4.1	0.0418*

Note: *p<0,05 (significant difference).

Table 2. Mean and standard deviation and p-value of the Rosenberg self-esteem scale scores of post-breast cancer surgery women, before and after 16 sessions of Morphoanalytic Therapy. n = 10

	Before	After	p-valor
Slef esteem	31.1±4.48	32.9±5.53	0.0020*

Note: *p<0,05 (significant difference).

DISCUSSION

There was a significant reduction in depression score after MT intervention. It is noteworthy that, normally, depression is underestimated and poorly treated in post-breast cancer women.[19] Moreover, it is believed that risk factors for developing depression within five years after diagnosis would be more related to the story of the patient than with the disease or treatment.[19] In this context, the fact that MT provide individualized treatment, with integrated operations of body and verbal analytical aspects, may have favored this improvement, to allow the free expression of both factors related to disease and its treatment, as the content of its personal story.

About one-third of women post-breast cancer have symptoms of anxiety and depression.[20] The impact and consequences of cancer may cause feelings of distress[20] and lead to significant psychological distress, raising psychiatric morbidity rates.[21]

Although not statistically significant, the individual anxiety scores decreased after the MT intervention. The non-significance may be related to the anxiety generated in the period next to the finalizations of the sessions. This may be exemplified with the report of the patient four in its last session, after postural work: "I remembered that I was too poor in childhood and I starved". The Therapist/Researcher (T/R) interprets that, symbolically, she may be afraid of being hungry without the sessions, but that this is a food that will stay inside her. She agrees and cries.

Most studies addressing the presence of anxiety in post-breast cancer women do not present interventions with complementary therapies.[22,23] However, one study found a decrease in anxiety levels after interventions with Hatha-Yoga.[24]

Regarding self-esteem, although it was not low in the initial evaluations, a significant increase was observed after MT intervention and it may be related to the patient feeling valued with the care received. In agreement with the present study, a significant improvement of self-esteem was verified in women with breast cancer after an intervention with yoga.[25]

Overall, the results with MT sessions in women post-breast cancer surgery were satisfactory, as the depressive state decreased and their self-esteem increased. However, there is more qualitative information that may reflect the effects of MT on the lives of these women. In the course of the sessions, with the evolution of body work and the increase in synchronicity of the pair therapist-patient, these women could experience the expression of feelings such as anger, fear and rejection, as well as the awakening of their body consciousness.

Paim and Kruel[5] said that the patient, when looking for physical therapy for relief of physical pain, also seeks the physiotherapist someone who listen to it. The professional, understanding the importance of the patient's speech as something relevant to the healing process, starts to listen to this discourse not as an obstacle to the application of the technique, but as a facilitator of the therapist-patient relationship, thus generating an effective intervention.

The expression of feelings such as anger, may be exemplified with the patient one, who recalled a family event occurred, in which felt very wronged by his mother. In the course of the session, after performing postural work, focusing on body alignment, she says: "I feel very strange and crooked. I've always learned that I can not feel anger, it's very difficult for me to have an aggressive stance in situations". In the next session she arrives totally without a voice, saying that she felt deaf to an ear all week and associated with the last session and with the fact that she never to express her anger.

Feelings are difficult to evaluate, but there is evidence that, in patients with breast cancer, certain personality traits are frequent, such as the tendency to suppress emotions, especially anger, and the form of stress response, with repressive style.[26]

Silva[27] showed that women who had breast cancer expressed intense fear of rejection by his companions, children, other family members and friends, also reported that when they had that feeling it was like an annihilation. For Cesnik et al.,[28] affective-sexual disorders in post-breast cancer women should not be disregarded by health professionals.

Most of the women in this study reported fearful rejection in their sessions because they felt shaken when they saw themselves without a breast. They believed that they could be abandoned by their companions because they felt less attractive and unable to satisfy them. The patient one was specifically abandoned by her husband when she was diagnosed with breast cancer and resumed marriage when she was healed. The patient two reports that never went braless near the husband, including the sex and feels that he is ashamed to go out with her socially.

The patient eight divorced after diagnosis of breast cancer before surgery. After postural work, remember the time that her ex-husband tells that even "without breast", he could get back to her and says: "I felt a lot of hate! I am a human being and not a breast! After that I was never able to relate sexually to another man. I did not know that I still had so much anger inside me that I felt so rejected".

The feeling of rejection may also be prior to breast cancer surgery. This can be exemplified in the session patient ten who after massage on your feet, says: *"I am in pain in the right arm and feeling a tingling in the mouth and I feel uncomfortable,*

because the foot is dirty." The T/R, from the knowledge of the story of the patient's life, interprets and responds: *"It is very difficult to give the care and touches when you never received from his mother."* She gets emotional and cries and says: *"Mymother never touched my feet. I just wanted her care, but she always rejected me"*.

In the initial sessions, it was verified difficulty in the corporal consciousness and the expression of feelings in all the participants. The experiences with MT sessions provided the awakening of body awareness. Agreeing with Mendonca[29] to describe that when the therapist asks active participation of the patient, in the sense of presence and body awareness, notes often estrangement between the individual and his body, as if there were no relationship between the symptom of pain and its way of organizing itself under the action of gravity and of moving.

Therefore, patients undergoing bodily awareness work are encouraged to seek learning to express emotions and increase self-awareness by mobilizing their own resources to help themselves. Thus, they can recover contact with sensory and motor dimensions of their own body, restore balance and understand the body-mind unity.[30] In this study, women were able to start a process to be more in touch with the feeling, realizing, not intellectual or rational way, what happens in and out of itself. The patient six in one of the sessions realizes that is feeling more its body and, even divorced for 20 years, until now occupied only one half of the bed and now it can occupy the entire space.

It was also observed the manifestation of the consciousness of repressed feelings. The patient six comes reporting a lot of pain in the neck after postural work, starts crying and says, *"I remembered in our last session that my daughter was sexually abused by a neighbor when she was four. I took her to the doctor and the abuse was confirmed. I erased it from my memory."* She cries intensely and continues: *"I feel too guilty for did not defended her, I wanted to curse, beat and send the man to prison."* The patient leaves without pain in the neck and says that she took the biggest weight from her shoulders. At the end of the session she says: *"I'm fine. Why did I suppress so much?"*.

It is interesting to emphasize that, from the beginning, there was adherence to the treatment, without dropouts, by all the participants, with manifestation of receptivity. They verbally demonstrated satisfaction by having a space where somebody cared for their physical and emotional pains at the same time. One limitation of the study was that, when they realized that the sessions would be finished, several of them reported worsening, besides the difficulty in saying goodbye to T/R. It should be noted that, after the end of the research, they were referred to a specific therapeutic group for women after breast cancer surgery, conducted by the same T/R.

CONCLUSION

Post-breast cancer women in this study achieved improvement in emotional aspects, depression, and self-esteem with MT interventions. Thus, it is expected that such a therapeutic resource will be applied on a larger scale to post-breast cancer women as well as in other populations.

AUTHOR'S CONTRIBUTION

FSMP: implementation of methodological research, search of articles and preparation of the manuscript. MRP: article search and manuscript preparation. AMM: statistical analysis and manuscript preparation. CEPTF: study design, orientation and manuscript preparation.

CONFLICTS OF INTEREST

The author(s) declare that they have no competing interests.

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