



## THE USE OF DANCE/MOVEMENT THERAPY IN PSYCHOLOGICAL ADAPTATION TO BREAST CANCER

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### Introduction

Breast cancer is the most common cancer occurring in women, is the second most common cause of cancer deaths in women after lung cancer, and is the major cause of death for women between the ages of 35 and 45; 180,000 cases of breast cancer are diagnosed and 50,000 deaths are attributed annually to breast cancer in the United States. The incidence of this disease appears to be increasing—in 1975, 1 out of every 10 women was likely to develop breast cancer; by 1995, the number had risen to 1 out of every 8. The chances for survival, however, have improved—during the 1940s, 78% of women were disease-free 5 years after the onset of the disease; in the 1990s, this rate had risen to 91% (American Cancer Society, 1995). This increasing survival rate has encouraged health professionals to focus greater attention on the quality of survival, including physical, psychological and social adjustment to the trauma of breast cancer.

### Review of the Literature

The literature provides clear documentation of the deleterious effects on patients of both the disease and its treatments, such as mastectomy, lumpectomy, chemotherapy and radiation (Holland & Mastrovito, 1980; Hughes, 1982; Mages & Mendelsohn, 1979). Studies report that the experience of diagnosis and

treatment of breast cancer raises three main concerns: (a) fear of death and grief over multiple losses, (b) anxiety over bodily disfigurement, and (c) worry about alienation from others, namely, in a primary relationship with a partner, and in relationships with family, friends and society. These concerns may be expressed by somatic, interpersonal or psychiatric symptoms, or by some combination of these (Silberfarb, 1984). The most common psychological symptoms are: disturbance of mood, increased level of distress, distorted body-image and diminished self-esteem (Ervin, 1973). These were the symptoms that were examined in the present study (Dibbell-Hope, 1989, 1992).

In 1986, a major nationwide study was undertaken to provide a precise and definitive picture of the physical and psychosocial morbidity associated with breast cancer, including a focus on body-image and self-esteem (Penman et al., 1986). The goals of the study were to identify predictors of psychosocial morbidity and to develop a morbidity-risk index. The results showed that: (a) breast cancer interferes with both intra- and interpersonal functioning for at least 1 year after diagnosis and treatment; (b) the psychosocial symptoms of negative attitude, anxiety and irritability, concern with physical distress, interpersonal difficulties, body dissatisfaction and poor feminine self-image may be worse after 1 year than after 3 months (presumably because of the decreased need

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for defense mechanisms of avoidance, denial and displacement); (c) women with more advanced stages of the disease who require either surgery and chemotherapy or radiation have more severe psychosocial symptoms; and (d) women who reported greater concerns with body-image and self-esteem were younger, were overweight, had external locus of control, felt little social support, had experienced early parental loss, had both mastectomies and adjuvant treatment, and had completed treatment 12 to 18 months prior to the study. The results of that study influenced some of the choices of subjects and research variables used by this author in the present study, particularly the effects on psychological adaptation to breast cancer of age, stage of cancer, type of treatment and time since treatment.

Clinical research indicates that effective psychological intervention for emotional, interpersonal and somatic symptoms help the patient to manage and alter stress conditions, work through unresolved grief, stimulate the will to live, promote realistic positive expectations, mobilize mental capacities, constructively handle denial, increase appropriate emotional expression and strengthen personal traits (Feinstein, 1983). Group therapy is the most common form of treatment offered. It provides an effective, efficient and economical system of peer support, offers information, hope and understanding from other patients facing similar issues, and often leads to increased responsiveness to medical treatment and longer survival time (Shavin, 1984; Spiegel, 1979).

The most common group treatment for psychosocial adjustment to breast cancer has been a combination of a directive, educational approach and a non-directive support group that offers both social and emotional support and specific information about coping with the physical and psychological aspects of the disease (Kriss, 1982; Spiegel, Bloom, & Yalom, 1981). In addition, some innovative treatment programs have been developed in both the United States and Europe to improve physical and psychological recuperation from breast cancer. Some of these programs were designed primarily for physical rehabilitation—they include aerobics, ballet, modern dance, gymnastics and yoga (Molinaro, Kleinfeld, & Ledbed, 1986; Schule, 1983; Sendgraff, personal communication, 1987). Other programs have included creative arts therapies such as dance, music, art or drama therapy. The claim has been made that these therapies help in recovery from traumas such as breast cancer by increasing patients' awareness and expression of

emotions, by decreasing negative mood such as depression and anxiety and by improving body-image and self-esteem (Heyde & von Langsdorff, 1983; Welch, 1975). Reports about these programs have been enthusiastic but the research has been mostly anecdotal, descriptive and based primarily on case studies.

Recently, more objective studies have been conducted that were based on clinical observation and assessment using both quantitative and qualitative measures. In a comprehensive summary of research on the use of dance/movement therapy for recovery from the psychosocial and psychophysical effects of physical trauma and medical disease, McKibben (1988, November) described studies in the fields of: oncology, cardiology, neurology (hemiplegia, brain injury), internal medicine (systemic lupus), surgery (limb amputation), chronic pain and physical disability. Results of those studies indicate that dance/movement therapy produced such subjective and objective improvements as: redefinition and strengthening of body-image, clarification of ego boundaries, outlets for relief of physical tension, anxiety and aggression, reduction in cognitive and kinesthetic disorientation, increase in capacity for communication, pleasure, fun, and spontaneity and support for therapeutic medical goals.

Other individual research studies describe the use of dance/movement therapy with specific medical populations, including people with cardiac problems, AIDS, cancer and neuropathology. At Chestnut Lodge Hospital in Rockville, Maryland, Seides (1986) worked with cardiac patients on their rehabilitation. She found that dance/movement therapy increased body awareness, expanded the range of movement and affective expression, helped resolve conflicts through action, decreased depression through rhythm and movement, provided a way to externalize inner thoughts and feelings and encouraged active participation in a group experience. At New York University Medical Center, Chang (1988, November) worked with AIDS patients on an innovative live-in rehabilitation unit for patients and their families or care partners. She used dance/movement therapy, deep relaxation and imagery to increase body awareness and self-confidence, reduce blood pressure, increase formation of T-cells and reduce symptoms of stress, depression, bodily weakness, pain and feeling out of control. At Northridge Hospital, Chiquiar (1988, November) used Authentic Movement and music with cancer and chronic pain patients

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