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A NONRANDOMIZED COMPARISON STUDY OF SELF-HYPNOSIS, YOGA, AND COGNITIVE-BEHAVIORAL THERAPY TO REDUCE EMOTIONAL DISTRESS IN BREAST CANCER PATIENTS

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Abstract: The authors asked breast cancer (BC) patients to participate in 1 of 3 mind-body interventions (cognitive-behavioral therapy (CBT), yoga, or self-hypnosis) to explore their feasibility, ease of compliance, and impact on the participants' distress, quality of life (QoL), sleep, and mental adjustment. Ninety-nine patients completed an intervention (CBT: $n = 10$; yoga: $n = 21$; and self-hypnosis: $n = 68$). Results showed high feasibility and high compliance. After the interventions, there was no significant effect in the CBT group but significant positive effects on distress in the yoga and self-hypnosis groups, and, also, on QoL, sleep, and mental adjustment in the self-hypnosis group. In conclusion, mind-body interventions can decrease distress in BC patients, but RCTs are needed to confirm these findings.

Breast cancer (BC) is the most frequently diagnosed cancer and the leading cause of cancer death among females, accounting for 23% of total cancer cases and 14% of cancer deaths (Jemal et al., 2011). BC diagnosis and treatments including chemotherapy, radiotherapy, and endocrine treatment have significant side effects. Pain, physical

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dysfunction, fatigue, and hair loss are prevalent (Ewertz & Jensen, 2011) and are associated with concomitant psychological and emotional reactions such as anxiety, depression, and distress (Tojal & Costa, 2015). Five years or more after the disease, many of these patients continue to show physical, psychological, sexual, relational, financial, and employment problems (Treanor, Santin, Mills, & Donnelly, 2013). Given the extent of these negative psychosocial consequences, several psychosocial group interventions were evaluated to reduce patients' distress (Faller et al., 2013). It is now well established that those interventions, especially cognitive-behavioral therapy (CBT), can lead to benefits for anxiety (Groarke, Curtis, & Kerin, 2013; Osborn, Demoncada, & Feuerstein, 2006), depression (Gudenkauf et al., 2015; Osborn et al., 2006), quality of life (QoL; Gudenkauf et al., 2015; Osborn et al., 2006), physical functioning and health (Andersen et al., 2007), fatigue (Kangas, Bovbjerg, & Montgomery, 2008), and pain (Tatrow & Montgomery, 2006).

However, clinicians have observed that a growing number of cancer patients used mind-body interventions such as yoga or self-hypnosis to cope with cancer (Carlson & Bultz, 2008). In fact, there is some recent evidence that yoga could lead to benefits for breast cancer patients for quality of life (Chandwani et al., 2014; Moadel et al., 2007), sleep quality (Mustian et al., 2013), anxiety and depressive symptoms (Moadel et al., 2007; Mustian et al., 2013), fatigue (Chandwani et al., 2014; Kiecolt-Glaser et al., 2014), and cognitive problems (Derry et al., 2015). Similarly, hypnosis also seems to be effective for BC patients for pain (Kwekkeboom, Cherwin, Lee, & Wanta, 2010), anxiety and depression symptoms (Cramer et al., 2015), fatigue (Montgomery et al., 2007), and sleep disturbances (Kwekkeboom et al., 2010). While there is evidence of the usefulness of mind-body interventions in cancer care, these interventions have not been compared with one another (Carlson & Bultz, 2008).

We performed a nonrandomized study with the primary aim of determining interest (by assessing the participation rate), feasibility (by assessing the attendance rate to the group sessions), and compliance (by assessing frequency of practice at home) of breast cancer patients in participating in one of three group interventions (CBT, yoga, or self-hypnosis). We gave participants a choice between the three groups, because it is likely that patient interest and preference, which drive the intensity of practice and its enjoyment, play a major positive role (Carlson & Bultz, 2008). The secondary aim was to determine whether participation in the interventions was associated with benefits in postintervention emotional distress, quality of life (QoL), sleep quality, and mental adjustment to cancer and to compare the interventions.

METHOD

Patients

Women who had been diagnosed with nonmetastatic breast cancer (up to 1.5 year after diagnosis) were recruited regardless of the type of treatment they received (neoadjuvant/adjuvant chemotherapy, radiotherapy, or hormonal therapy). Inclusion criteria were 18 years or older and the ability to read, write, and speak French. Patients with a diagnosed psychiatric disorder or dementia were excluded.

Design

Eligible patients were identified through an institutional database or by physician referral and were approached by phone to inform them of the interventions. They then received a brochure describing the three interventions before choosing between the three groups: CBT, yoga, and self-hypnosis. After giving written informed consent, patients completed a baseline assessment including self-reported measures. Follow-up assessment was conducted 1 week after the group intervention. The study was approved by the institutional ethics board, Comité d'éthique Hospitalo-Facultaire Universitaire de Liège (B707201215157).

Interventions

Considering the literature, CBT could be considered as the gold standard and was an obvious intervention possibility. Given the recent success of these alternative interventions outside the hospital and according to the expertise of our team, yoga, and self-hypnosis were also proposed.

CBT intervention. The CBT intervention included six weekly 90-minute sessions in groups of 3–8 participants led by CBT-trained psychologists with experience in psycho-oncology. This program was developed by team leaders (AME, IB, MD) and was modeled on the work of Andersen, Golden-Kreutz, Emery, and Thiel (A2009) and Savard (2010). The intervention targets were the following: (a) breast cancer, meaning of illness, understanding stress, and responses to it; (b) impact of treatment on body image; (c) impact of treatment on self-esteem; (d) fear of recurrence; (e) relationships with relatives and health professionals; and (f) life projects, return to daily activities, and work. Relaxation training took place at the end of each session and participants performed tasks between sessions.

Yoga intervention. Hatha yoga intervention included six weekly 90-minute sessions in groups of 3–8 participants led by Hatha yoga trained teachers. This program was developed previously in Montréal (Lanctôt et al., 2010) and the following were included at each session: (a) preparatory warm-up synchronized with breathing; (b) selected

postures (e.g., forward-, backward-, and side-bending asanas in sitting and lying positions); (c) deep relaxation; (d) alternate-nostril breathing or pranayama; and (e) meditation. Each participant received a DVD to encourage at-home practice (DVD was developed by a Canadian team from the Université de Québec à Montréal, G. Dupuis and D. Lanctôt, in collaboration with Dr. Bali at Montreal).

Self-hypnosis intervention. The self-hypnosis intervention included six sessions of 2 hours every 2 weeks in groups of 3–8 participants. This was developed and led by one of the authors (MEF), an anesthetist with experience in oncology and trained in hypnosis (Faymonville, Bejenke, & Hansen, 2010). A manual in French is available on request. Patients were asked to be actively involved and to give their consent to introduce changes to their usual daily routine. The following topics are addressed through tasks inspired by cognitive-behavioral therapy: adjusting self-expectations; revision of self-narrative; reinforcing a sense of self-esteem; adaptation of social roles; identification of situations and feelings of powerlessness; finding one's own boundaries and personal needs; accepting that not everything is controllable; and differentiating self from illness. Patients were also required to keep a work diary that was reviewed at the beginning of each session. At the end of the session, a 15-minute hypnosis exercise was conducted. They received CDs containing the hypnosis exercises they did during the session and homework assignments for between sessions (Vanhaudenhuyse et al., 2015).

Measures

The following measures were contained in the pre- and postintervention assessment battery.

Demographics and medical history. A questionnaire collecting age, marital status, education, and cancer-related variables (e.g., treatment types) was completed.

The Hospital Anxiety Depression Scale (HADS) (Zigmond & Snaith, 1983). The HADS is a reliable and validated 14-item measure assessing anxiety and depression in physically ill subjects (Zigmond & Snaith, 1983). Seven items for anxiety and seven for depression are rated on a 4-point Likert scale (0 = *symptom not present* to 3 = *symptom considerable*). Each subscale is scored from 0 to 21 (0–7: normal range; 8–10: borderline; 11–21: probable presence of anxiety or depressive disorder).

European Organization for Research and Treatment of Cancer-Quality of Life Core Questionnaire-30 (EORTC-QLCQ30) (Aaronson et al., 1993). The questionnaire (30 items) developed to assess the QoL of cancer patients incorporates five functional scales, three symptom scales, a global health status/QoL scale, and several single items assessing additional symptoms and the perceived financial impact of the disease. The responses indicate the extent to which the patient has experienced

symptoms or problems. Each item is scored on a 4-point Likert scale (*not at all* to *very much*), except for the global health status/QoL, which is on a 7-point scale (*very bad* to *excellent*). Scores could be transformed into standardized raw scores (0–100); a high score for a functional scale or the global QoL represents a high healthy level of functioning, but a high score for a symptom scale represents a high level of symptomatology.

Mental Adjustment to Cancer Scale (MAC; Watson & Homewood, 2008). This is a 40-item questionnaire addressing reactions of patients to having cancer. Items are given as statements, and patients assess their agreement using a 4-point Likert scale (*definitely does not apply to me* to *definitely applies to me*). There are five subscales—Fighting Spirit (cutoff ≥ 47); Helplessness/Hopelessness (cutoff ≥ 11); Anxious Preoccupation (cutoff ≥ 25); Fatalism (cutoff ≥ 22), and Avoidance (cutoff ≥ 3)—and two general subscales—Summary Positive Adjustment Scale (cutoff ≥ 47) and Summary Negative Adjustment Scale (cutoff ≥ 36).

Insomnia Severity Index (ISI; Savard, Savard, Simard, & Ivers, 2005). This is a seven-item measure of subjective sleep complaints and associated distress. Items are scored on a 5-point Likert scale ranging from 0 to 4 with higher scores representing more severe insomnia symptoms. The cutoff scores are 0–7 (no clinically significant sleep difficulties), 7–14 (sleep difficulties warrant further investigation), and 15+ (presence of clinically significant insomnia) for the total score.

Frequency of practice (specifically developed for the study). This questionnaire used a self-evaluation that asked about frequency of practice. The item (“How frequently do you use the techniques learned during the intervention?”) was scored on a 6-point Likert scale (1 = *at least once a day* to 6 = *not at all*).

Outcomes

The primary aim was to determine interest, feasibility, and compliance. The interest in the three interventions was assessed by the participation rate in each group. The feasibility was assessed by summing the total number of sessions attended by participants: We expected that 90% of patients would attend a minimum of four sessions (based on the clinical experience of the group trainers). The compliance was assessed through the questionnaire of practice frequency: We expected that 90% of patients would practice a minimum of 1 day per week (based on the clinical experience of the group trainers). The secondary aim of this pilot study was to determine whether participation in the interventions was associated with benefits in postintervention emotional distress, quality of life (QoL), sleep quality, and mental adjustment to cancer and to compare the three interventions.

Data analysis

Descriptive statistics (percentages, means, and standard deviation) were used to describe interest, feasibility, and compliance and to examine their demographic, medical, and psychological data. Baseline demographic, medical, and psychological data were compared between groups to test for initial group equivalency using inferential statistics: analysis of variance (ANOVA) and chi-square test, as appropriate. Multivariate analyses were calculated regarding group interventions and time of medical treatments (during or after chemo/radiation therapy). The pre- and postassessment comparison of each measure within each group was made using the Wilcoxon test for matched pairs. All statistical tests were two tailed, and a p value less than .05 was considered statistically significant. We also calculated the Cohen's d effect size for each group. The analyses were performed with SPSS Version 21.0 (IBM Corp., Armonk, NY).

RESULTS

Participants' characteristics

Table 1 presents demographics and medical history in each group. Table 2 presents pre- and postintervention mean scores on psychological variables in each group. The groups did not differ at baseline concerning demographics, medical history, or questionnaires. The mean scores on the HADS showed the presence of an adjustment disorder with anxiety or depressive symptoms; the mean scores on EORTC-QLCQ30 and BRC23 showed some problematic scales: role, emotional and cognitive functioning, fatigue, and insomnia; the mean scores on the ISI showed sleep difficulties warranting further investigation; and the mean scores on the MAC showed an overall positive adjustment to cancer, but low scores for anxious preoccupation and total negative adjustment (see Table 2). We selected these above psychological variables for statistical analysis.

Primary outcomes

Interest. Of 426 eligible patients contacted from January 2013 to March 2015 (end of grants allocation), 114 were included (26.8%) (see Figure 1). The most common reasons to decline help were "not interested in the proposed interventions" (51%), "I have no time for this" (16%), "too far from home" (13%), and "I am fine, I manage myself" (9%). Seventy-six participants were asked the reason for choosing an intervention, and their responses differed according to the selected intervention, $\chi^2(12) = 22.12, p = .036$. The majority chose hypnosis to manage the negative side effects ($n = 24$), because of curiosity ($n = 20$), or for other reasons such as having heard about it

Table 1
Demographic Data and Medical History and Comparison Between Groups

	Yoga (<i>n</i> = 21)	Self- Hypnosis (<i>n</i> = 68)	CBT (<i>n</i> = 10)	Significance
Patient demographics				
Age (years) ^a				$F(2, 96) = 0.045;$
Mean (<i>SD</i>)	54 (11)	54.3 (10)	53.2 (12.4)	$p = .956$
Range	27–66	29–72	33–73	
Marital status, <i>N</i> (%)				$\chi^2 (4) = 7.516;$
Single	4 (19)	5 (7.4)	2 (20)	$p = .111$
Married/living with partner	11 (52.4)	52 (76.5)	8 (80)	
Divorced/separated/widowed	6 (28.6)	11 (16.2)	0	
Education (years)				$F(2, 96) = 1.176;$
Mean (<i>SD</i>)	13.7 (3.2)	14.3 (2.9)	12.9 (2.8)	$p = .313$
Range	6–18	9–21	9–17	
Employment status, <i>n</i> (%)				$\chi^2 (4) = 3.051;$
Employed part or full time	1 (6.3)	9 (13.4)	0	$p = .549$
Employed, taken time off	8 (50)	38 (56.7)	7 (70)	
Not employed	7 (43.8)	20 (29.9)	3 (30)	
Patient medical history				
Stage, <i>n</i> (%)				$\chi^2 (6) = 4.106;$
0	1	1	0	$p = .662$
1	12	37	4	
2	7	22	6	
3	1	5	0	
Time since diagnosis (months)				$F(2, 94) = 0.750;$
Mean (<i>SD</i>)	5.6 (3.4)	6.8 (4.4)	6.7 (3)	$p = .475$
Range	1–12	1–19	2–11	
Surgery, <i>n</i> (%)				$\chi^2 (2) = 4.347;$
Mastectomy	6 (28.6)	35 (51.5)	3 (30)	$p = .114$
Tumorectomy	15 (71.4)	33 (48.5)	7 (70)	
Chemotherapy (CT), <i>n</i> (%)				$\chi^2 (4) = 2.118;$
CT completed	7 (33.3)	27 (39.7)	5 (50)	$p = .714$
During CT	7 (33.3)	20 (29.4)	1 (10)	
No CT	7 (33.3)	21 (30.9)	4 (40)	

(Continued)

Table 1
(Continued)

	Yoga (<i>n</i> = 21)	Self- Hypnosis (<i>n</i> = 68)	CBT (<i>n</i> = 10)	Significance
Radiation therapy (RT), <i>n</i> (%)				$\chi^2 (6) = 9.38$; <i>p</i> = .153
RT completed	10 (47.6)	30 (44.1)	6 (60)	
During RT	2 (9.5)	6 (8.8)	3 (30)	
Not yet started	7 (33.3)	16 (23.5)	1 (10)	
No RT	2 (9.5)	16 (23.5)	0	
Hormonal therapy (HT), <i>n</i> (%)				$\chi^2 (4) = 3.853$; <i>p</i> = .426
During HT	12 (57.1)	38 (55.9)	5 (50)	
Not yet started	9 (42.9)	23 (33.8)	3 (30)	
No HT	0	7 (10.3)	2 (20)	
Total patients after CT/ RT	12 (57.1)	42 (61.8)	6 (60)	$\chi^2 (2) = 0.145$; <i>p</i> = .930
Total patients during CT/RT	9 (42.9)	26 (38.2)	4 (40)	

(*n* = 6). For yoga, the main reasons were to manage the negative side effects (*n* = 10) and because of curiosity (*n* = 3) or for other reasons (*n* = 6) such as to find a physical activity. For CBT, the main reason was to manage the negative side effects (*n* = 5). Of the 114 participants, 15 (13%) were lost to follow-up after one or two sessions (*n* = 8 in self-hypnosis, *n* = 6 in yoga, and *n* = 1 in CBT). There were no significant differences in sociodemographic, medical, psychological variables, or intervention choice between those who were lost to follow-up after one or two sessions and those who continued. Among the remaining 99 participants, 10 chose CBT, 21 yoga, and 68 self-hypnosis.

Feasibility. The average attendance rate was 5.8 sessions for yoga, 5.4 for self-hypnosis, and 5.7 for CBT: 100% of patients attended a minimum of four sessions, and 88% attended the six sessions.

Compliance. The majority of participants (90%) in the three groups practiced at least once a week after the intervention (see Table 3).

Secondary outcomes

Global effects. A multivariate analysis of the psychological variables with repeated measures at time of evaluation indicated no significant effect for group, no significant effect for time of medical treatments

Table 2
Pre- and Postintervention Mean Scores for Each Questionnaire According to the Assignment Group

Questionnaires, means (SD)	Yoga		Self-hypnosis		CBT	
	Pre	Post	Pre	Post	Pre	Post
HADS						
Anxiety	10.1 (4.6)	7.4* (3.4)	8.9 (3.8)	7.1* (3.3)	9 (4.2)	7.7 (3.4)
Depression	5.2 (3.7)	3.9* (3)	5 (3.2)	3.8* (3)	5.7 (3.9)	5 (3.6)
EORTC QLCQ30						
Global health status/QoL	60.3 (16.8)	62.7 (17.6)	59.2 (16.2)	65.4* (15.8)	62.5 (16.8)	68.3 (12.9)
Functional scales						
Physical functioning	74.3 (21.9)	78.4 (15.8)	78.5 (16.2)	78.6 (15.8)	85.3 (12.9)	83.3 (10.1)
Role functioning	69.8 (35.6)	77 (33.1)	68.2 (26.7)	72.3 (26.2)	77.8 (22)	85.2 (13)
Emotional functioning	55.6 (25.6)	75* (23.6)	62.6 (24.9)	73.3* (21.4)	72.5 (17.1)	80.8 (11.1)
Cognitive functioning	64.3 (28.5)	69 (30.4)	63.6 (28.7)	67.9 (25)	79.6 (27.4)	78.3 (15.8)
Social functioning	71.4 (30.8)	78.6 (27)	68.1 (28.6)	76 (24.2)	86.7 (17.2)	86.7 (15.3)
Symptom scales/items						
Fatigue	48.1 (24.7)	46 (29.9)	52.9 (26.1)	44.8* (21.7)	40 (21.7)	35.6 (16.4)
Nausea and vomiting	6.3 (12.3)	4 (10.4)	6.4 (11.9)	4.9 (11.5)	1.7 (5.3)	0
Pain	36.5 (33.2)	34.1 (36.7)	28.9 (28.5)	32.6 (25.4)	11.7 (15.8)	22.2 (25)
Dyspnea	39.7 (35.9)	33.3 (31.6)	34.8 (32.3)	27.9 (28)	30 (24.6)	23.3 (31.6)
Insomnia	52.4 (37.4)	49.2 (38.9)	50.5 (37.5)	39.7* (32.7)	36.7 (29.2)	46.7 (32.2)
Appetite loss	12.7 (22.3)	9.5 (21.5)	10.9 (24.2)	8.8 (21.3)	13.3 (17.2)	0
Constipation	12.7 (19.7)	6.3 (13.4)	13.9 (24.7)	13.4 (24.7)	10 (31.6)	11.1 (33.3)
Diarrhea	22.2 (33.9)	17.5 (29.1)	15.7 (24.3)	12.7 (25.8)	3.3 (10.5)	13.3 (28.1)

(Continued)

Table 2
(Continued)

Questionnaires, means (SD)	Yoga		Self-hypnosis		CBT	
	Pre	Post	Pre	Post	Pre	Post
Financial difficulties	12.7 (24.7)	12.7 (24.7)	19.1 (29.5)	14.4 (26.7)	3.3 (10.5)	3.3 (10.5)
MAC						
Fighting spirit	51.7 (5.8)	52.6 (5.3)	50.1 (6.1)	50.7 (7)	47.7 (7.1)	47.8 (4.3)
Helpless/hopeless	9.2 (2.5)	8.3 (2.1)	9.6 (3.1)	8.5 (2.7)	9.7 (4.1)	9.5 (3.4)
Anxious preoccupation	24.3 (4.1)	23.6 (5)	23.2 (4.1)	22.3* (4.3)	22.7 (4.2)	22 (3.2)
Fatalism	20.1 (4.6)	20.2 (4.7)	19 (3.2)	18.9 (3.5)	18.1 (4.6)	17.7 (3.6)
Avoidance	1.7 (1)	2.1 (1.1)	1.8 (0.8)	1.8 (0.8)	1.5 (0.7)	1.9 (0.7)
Total negative adjustment	33.2 (6.6)	31.3 (6.2)	32.5 (6.9)	30.8* (6.6)	31.4 (9.4)	31 (7.8)
Total positive adjustment	53.4 (7)	53.7 (6.4)	51.2 (6.5)	51.7 (6.9)	48.8 (7.8)	48.2 (4.7)
ISI						
Severity of sleep difficulties	7.3 (4.3)	6.7 (3.9)	7.7 (3.7)	6.5* (3.4)	8 (3.8)	7.4 (3.3)
Impact of sleep difficulties	5.5 (3.1)	4.4* (2.8)	5 (3.2)	4.1* (3.1)	4.3 (2.7)	4.1 (2.6)
Total score	12.8 (6.9)	11 (6.3)	12.6 (6.5)	10.6* (6.2)	12.3 (5.7)	11.5 (5.4)

Note. SD = standard deviation.

*Comparison pre- versus postassessment, $p < .05$.

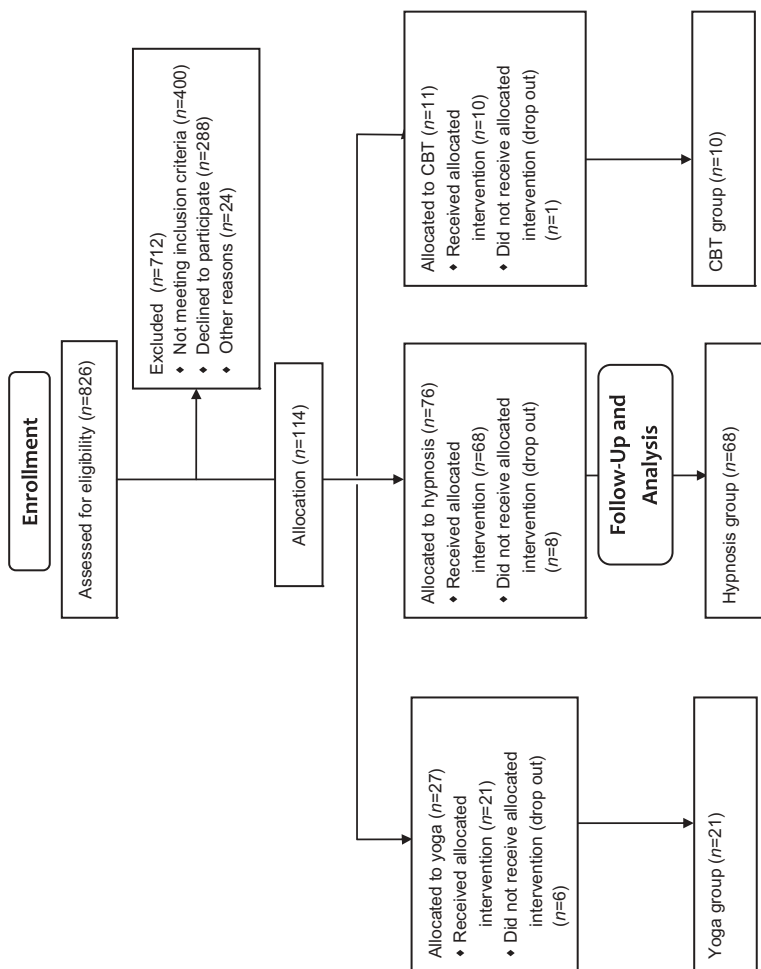


Figure 1. Flow of study participants.

Table 3
Frequency of Practice

	Yoga (<i>n</i> = 21)	Self-Hypnosis (<i>n</i> = 68)	CBT (<i>n</i> = 10)
Frequency of practice (%)			
At least once a day	23.8	31.1	30
Every two days	14.3	8.2	30
Three times per week	42.9	27.9	30
Once a week	9.5	23	0
Once a month	0	6.6	10
Not at all	9.5	3.3	0

(during or after CT/RT), and no significant interaction effect, but there was a significant effect for time, $F(14) = 2.44$, $p = .006$. Specific analysis revealed an effect for time for HADS-anxiety, $F(1) = 19.93$, $p < .001$, HADS-depression, $F(1) = 9.89$, $p = .002$, EORTC-emotional functioning, $F(1) = 17.99$, $p < .001$, EORTC-fatigue, $F(1) = 4.97$, $p = .028$, EORTC-global QoL, $F(1) = 4.30$, $p = .041$, MAC negative adjustment, $F(1) = 3.70$, $p = .058$, and ISI, $F(1) = 8.77$, $p = .004$.

Pre- and postintervention changes in each group separately. In Table 2, significant improvements in anxiety and depression (HADS: $Z = -2.70$, $p = .007$; $Z = -2.33$, $p = .020$, respectively), in emotional functioning (EORTC: $Z = -3.46$, $p = .001$), and on the impact of sleep difficulties (ISI: $Z = -1.94$, $p = .052$) can be observed in response to yoga. For self-hypnosis, there were significant improvements in anxiety and depression (HADS: $Z = -3.97$, $p < .001$; $Z = -3.71$, $p < .001$, respectively). For EORTC-QLCQ30, there were significant improvements in emotional functioning ($Z = -3.44$, $p = .001$), fatigue ($Z = -3.01$, $p = .003$), insomnia ($Z = -2.65$, $p = .008$), and global QoL ($Z = -3.11$, $p = .002$). For MAC, there were significant improvements in anxious preoccupation ($Z = -2.73$, $p = .006$) and total negative adjustment ($Z = -2.61$, $p = .009$). For ISI, there were significant improvements in the impact of sleep difficulties ($Z = -2.37$, $p = .018$) and in the severity of sleep difficulties and the ISI total score ($Z = -3.37$, $p = .001$; $Z = -3.10$, $p = .002$, respectively) as a result of self-hypnosis. There was no significant improvement in any item in the CBT group.

Table 4 shows changes from pre- to postintervention in HADS, EORTC-QLCQ30, and ISI scores in our groups and time changes in scores on the same questionnaires of breast cancer patients who had not received a psychosocial intervention in two other studies (Boesen et al., 2011; Trudel-Fitzgerald, Savard, & Ivers, 2013). In Trudel-Fitzgerald et al., 409 breast cancer patients completed the HADS and

Table 4

Changes Due to Intervention Compared to Time Changes in Patients Who Had Not Received an Intervention

	Our study			Trudel-Fitzgerald et al.*	Boesen et al.**
	Yoga	Self-hypnosis	CBT	Control	Control
	Change Mean (SD)	Change Mean (SD)	Mean (SD) Change	Mean Change	Mean Change
HADS					
Anxiety	-2.7 (3.6)	-1.8 (3.1)	-1.3 (2.4)	-0.2	-
Depression	-1.3 (2.5)	-1.2 (2.5)	-0.7 (3.1)	-0.4	-
EORTC QLC Q30					
Global health status/QoL	2.4 (16.3)	6.4 (16.3)	5.8 (16.7)	-	5
Functional scales					
Physical functioning	4.1 (16.1)	0.1 (12.7)	-2.0 (11.4)	-	0.3
Role functioning	7.1 (32.7)	3.7 (24.4)	7.4 (14.7)	-	32.6
Emotional functioning	19.4 (18.3)	10.7 (22.6)	8.3 (21.5)	-	12.7
Cognitive functioning	4.8 (28.9)	4.4 (27.3)	0 (16.7)	-	13.3
Symptom scales/items					
Fatigue	-2.1 (23.2)	-8.2 (20.4)	-4.4 (18.3)	-	-2.4
Nausea and vomiting	-2.4 (14.2)	-1.5 (12.1)	-1.7 (5.3)	-	-1.5
Pain	-2.4 (24.9)	3.6 (26.1)	13.0 (21.7)	-	-9.7
ISI					
Total score	-1.7 (5.1)	-2.0 (5.1)	-0.8 (5.9)	-1.1	-

*Trudel-Fitzgerald, Savard, Ivers (2013). **Boesenet al. (2011).

ISI twice at an interval of 4 months. In Boesen et al., 97 breast cancer patients completed the EORTC-QLCQ30 twice at an interval of 6 months. For HADS, changes seemed more important after our interventions (e.g., anxiety change = -2.7 in the yoga group) compared to time effect (e.g., anxiety change = -0.2 in Trudel-Fitzgerald et al.). For ISI, changes seemed more important after our interventions (e.g.,

Table 5
Effect Size of Psychological Outcomes

	Yoga		Self-Hypnosis		CBT	
	Cohen's <i>d</i>	Effect size	Cohen's <i>d</i>	Effect size	Cohen's <i>d</i>	Effect size
HADS anxiety	0.77	Medium	0.59	Medium	0.57	Medium
HADS depression	0.55	Medium	0.48	Medium	0.22	Small
EORTC emotional functioning	1	High	0.48	Medium	0.39	Medium
MAC negative adjustment	0.41	Medium	0.31	Medium	0.08	Small
ISI total	0.35	Medium	0.39	Medium	0.13	Small

change = -2 in the hypnosis group) compared to time effect (change = -1.1 in Trudel-Fitzgerald et al.). Improvements in several subscales of the EORTC-QLCQ30 were not greater because of our interventions (e.g., emotional functioning) compared with that in Boesen et al. However, in the yoga group, physical functioning seemed to improve more (change = 4.1) than in Boesen et al. (change = 0.3); in the hypnosis group, fatigue seemed to decrease more (change = -8.2) than in Boesen et al. (change = -2.4).

Effect sizes. Effect sizes were calculated on five relevant psychological outcomes (see Table 5). The results showed five medium effect sizes (anxiety, depression, emotional functioning, negative mental adjustment, and sleep quality) in the hypnosis group; four medium effect sizes (anxiety, depression, sleep quality, and negative adjustment) and one high effect size (emotional functioning) in the yoga group; and two medium effect sizes (anxiety and emotional functioning) in the CBT group.

DISCUSSION

The aim of this nonrandomized study was to measure the interest of breast cancer patients in participating in one of three group interventions (yoga, self-hypnosis, or CBT) and to evaluate the efficacy of these on emotional distress, QoL, sleep quality, and mental adjustment to cancer.

The study showed that only one third of eligible patients were interested in participating in a group. This is consistent with other studies such as Clover, Mitchell, Britton, and Carter (2015), which showed that 221 of 311 cancer patients (71%) who reported emotional

distress declined help. In their study, the most common reasons for declining help were "I prefer to manage myself," "already receiving help," and "my distress is not severe enough," which are different from our study where patients mainly declined help because of a lack of interest. However, some of our patients were also fine and preferred to self-manage, which is similar to Clover et al. (2014). Bramsen et al. (2008) reported another reason for declining help: "not liking the help offered," which is closer to our results. In the future, it would be relevant to propose response options on the issue of desire for help, based on the literature (Australian Bureau of Statistics, 1999). Patient retention in our study was high (only 14 patients dropped out). It seemed that an open trial design (compared to a randomized trial) may enhance participant retention (Avenell et al., 2004).

Most of our participants chose the self-hypnosis group (68.7%). Regardless of the selected group, "managing the negative side effects" was the main reason to participate, which is consistent with other studies (King et al., 2015). However, for hypnosis, another reason given was "having heard about the work of the trainer." The success of the hypnosis group could be explained by the greater availability of yoga or individual psychological counseling compared to self-hypnosis. In the three groups, there was good adherence to the intervention with the majority of participants attending all sessions, despite undergoing sometimes-daily radiation therapy or chemotherapy. There was high compliance to the home practice of each training intervention.

Patients' demographic, medical, and psychological characteristics were homogenous in the intervention group. At baseline, our patients showed a presence of anxiety/depressive disorder, a poor QoL, sleep difficulties and low scores on negative adjustment to cancer, confirming that breast cancer patients experienced concomitant psychological reactions (Tojal & Costa, 2015). Moreover, the average level of distress suggests that we have reached patients who potentially have an adjustment disorder.

Our results indicated a positive effect between pre- and postassessment for anxiety, depression, emotional functioning, fatigue, global QoL, negative mental adjustment to cancer, and sleep difficulties, although there was no significant interaction effect of time and group. These intervention changes seemed to be more important than time changes in breast cancer patients who did not receive a psychosocial intervention (Boesen et al., 2011; Trudel-Fitzgerald et al., 2013).

After CBT, patients showed no improvement, which is in contrast with previous studies that showed a positive impact of CBT (e.g., on anxiety, Groarke et al., 2013). Our low number of participants could explain these conflicting results. In terms of clinical significance, results showed two medium effect sizes (anxiety and emotional functioning), suggesting that significant differences could appear with a larger sample size.

Yoga improved anxiety, depression, emotional functioning, and impact of sleep difficulties, which was consistent with other studies (Chandwani et al., 2014; Kiecolt-Glaser et al., 2014; Moadel et al., 2007). These improvements were clinically significant if we also looked at the effect sizes. We did not confirm observations highlighting a positive impact on cognitive functioning (Derry et al., 2015) or sleep quality (Mustian et al., 2013). This could be explained by methodological factors such as the lower number of yoga classes (e.g., 6 instead of 12 classes in Moadel et al., 2007).

The most significant results were observed in the self-hypnosis group. This group had improved emotional distress, several aspects of QoL (global QoL, emotional functioning, fatigue, and insomnia), and negative mental adjustment to cancer and sleep difficulties. Distress decreased to a less critical level clinically according to Zigmond and Snaith (1983). Results were consistent with a reported beneficial effect of self-hypnosis on distress (Cramer et al., 2015), fatigue (Montgomery et al., 2007), and sleep disturbances (Kwekkeboom et al., 2010). We did not confirm the positive impact on pain (Kwekkeboom et al., 2010), which could be explained by the low pain score at baseline. Our results support the relevance of combining hypnosis with a psychological self-care intervention in the modulation of emotional distress in breast cancer patients (Montgomery et al., 2014).

There are some limitations of this study. First, the small number of participants in the yoga and CBT groups requires caution in interpreting the findings. Second, our study was not randomized. However, it is likely that patient interest, which drives the intensity of practice and its enjoyment, plays a large positive role (Carlson & Bultz, 2008). Carlson et al. (2014) showed in a randomized study that patient preference was a strong predictor of outcomes. In their study comparing two active psychosocial interventions to a control group, breast cancer patients who were assigned to their preferred intervention reported significantly greater improvement in QoL compared to women who received their nonpreferred intervention. Third, there was no control group. However, when we compare with studies describing time changes in breast cancer patients' distress without interventions, our results still showed benefits. Future research might compare mind-body interventions and also compare them to other active interventions. Larger sample sizes and populations of patients other than women with breast cancer, who remain the target of most mind-body research, may be used with longer follow-up periods (Carlson & Bultz, 2008).

CONCLUSION

In conclusion, this study showed the relevance of mind-body interventions combined with psychosocial approaches in the reduction of

emotional distress in breast cancer patients. Future studies should consider comparing self-hypnosis to a control group in a randomized design using a larger sample size to confirm these promising results.

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IB participated in the conception and design of the study, in the acquisition and interpretation of data, and in drafting the manuscript. AM, MEF, PC, EL, GD, and GJ participated in the conception and design of the study, in the interpretation of data, and in revising the manuscript critically for important intellectual content. HS and AW participated in the acquisition and the interpretation of data and in drafting the manuscript. All authors read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Eine nicht-randomisierte Vergleichsstudie von Selbsthypnose, Yoga und Kognitiv Behavioralen Therapie in der Anwendung zur Reduktion emotionalen Stresses bei Brustkrebspatienten

Isabelle Bragard, Anne-Marie Etienne, Marie-Elisabeth Faymonville, Philippe Coucke, Eric Lifrange, H el ene Schroeder, Aur elie Wagener, Gilles Dupuis, und Guy Jerusalem

Abstract: Die Autoren baten Brustkrebspatienten (BC) an einer von drei K orper-Seele Interventionen (cognitive-behavioral therapy (CBT), Yoga, Selbsthypnose) teilzunehmen, um die Durchf uhrbarkeit, leichte Handhabung der Compliance und den Einfluss auf den Stre  der Patienten, die Lebensqualit t (QoL), den Schlaf und die mentale Anpassungsf higkeit zu erforschen. 99 Patienten vollendeten eine Intervention (CBT: n = 10, Yoga: n = 21 und Selbsthypnose: n = 68). Die Ergebnisse zeigten hohe Durchf uhrbarkeit und hohe Compliance. Nach den Interventionen gab es keinen signifikanten Effekt in der CBT-Gruppe, aber signifikante positive Effekte auf den Stre  in der Yoga- und der Selbsthypnose-Gruppe und auch auf die Lebensqualit t, den Schlaf und die mentale Anpassungsf higkeit in der Selbsthypnose-Gruppe. Abschlie end l sst sich sagen, da  K rper-Seele-Interventionen den Stre  in Brustkrebs-Patienten reduzieren kann. Es werden aber randomisierte kontrollierte Studien ben tigt, um diese Ergebnisse zu best tigen.

STEPHANIE RIEGEL, MD

Une  tude comparative non randomis e de l'utilisation de l'autohypnose, du yoga et de la th rapie cognitivo-comportementale visant   r duire la d tresse  motionnelle chez des patientes atteintes du cancer du sein

Isabelle Bragard, Anne-Marie Etienne, Marie-Elisabeth Faymonville, Philippe Coucke, Eric Lifrange, H el ene Schroeder, Aur elie Wagener, Gilles Dupuis et Guy Jerusalem

R sum : Les auteurs ont demand    des patientes atteintes du cancer du sein (CS) de participer   une de trois interventions touchant le corps et l'esprit (th rapie cognitivo-comportementale (TCC), yoga ou autohypnose), afin d' tudier la faisabilit  de ces interventions, la facilit    y adh rer et leur incidence sur la d tresse, la qualit  de vie (QV), le sommeil et l'adaptation mentale des participantes. Quatre-vingt dix-neuf patientes ont b n fici  d'une intervention (TCC: n = 10; yoga: n = 21; et autohypnose: n = 68). Les r sultats ont indiqu  un taux  lev  de faisabilit  et d'adh sion. Apr s les interventions, il n'a  t  relev  aucun effet significatif de la TCC au sein du groupe de TCC, mais on a not  des effets positifs significatifs au sein des groupes utilisant le yoga et l'autohypnose sur la d tresse. On a  galement

relevé des effets positifs sur la QV, le sommeil et l'adaptation mentale au sein du groupe de l'autohypnose. En conclusion, les interventions touchant l'esprit et le corps peuvent diminuer la détresse chez les patientes atteintes du CS, mais des essais cliniques randomisés sont nécessaires pour confirmer ces résultats.

JOHANNE REYNAULT

C. Tr. (STIBC)

Un estudio comparativo no aleatorio sobre la autohipnosis, la yoga y la terapia cognitivo-conductual para reducir la aflicción emocional en pacientes con cáncer de mama.

Isabelle Bragard, Anne-Marie Etienne, Marie-Elisabeth Faymonville, Philippe Coucke, Eric Lifrange, Hélène Schroeder, Aurélie Wagener, Gilles Dupuis y Guy Jerusalem

Resumen: Los autores le pidieron a pacientes con cáncer de mama (CaMa) participar en una de tres intervenciones mente-cuerpo (terapia cognitivo-conductual (TCC), yoga, o autohipnosis) para explorar la viabilidad, facilidad de cumplimiento, y el impacto en la tensión de los participantes, calidad de vida (CV), sueño, y ajuste mental. Noventa y nueve pacientes completaron la intervención (TCC: n=10; yoga: n=21; autohipnosis: n=68). Los resultados muestran una alta viabilidad y buen cumplimiento. Después de las intervenciones no hubo efectos significativos en el grupo de TCC pero se encontraron efectos significativos positivos para la tensión en los grupos de yoga y autohipnosis. En conclusión, las intervenciones mente-cuerpo pueden reducir la tensión en pacientes con CaMa, pero se necesitan más ensayos clínicos aleatorios para confirmar estos hallazgos.

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