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T (Tirannie) Cancer of The Breast

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Keywords: Motor rehabilitation, Nutritional counseling, Psycho-oncology, Humoral rehabilitation, Complementary integrated therapies

First part

I have been working for months with and for my very suffering patients, with that due and studied effort derived from the unconscious pathos that I have been carrying with me for some time. Lately, I've been struggling more with happy patients than my delicate, misunderstood tightrope walkers. I do not know if it is for a natural envy unconfessed with respect to the showcase of the perfect world, or for pity towards pain, however it is in fact that I remain suspended between the factual and the factual counter. I present here my work divided into two parts: the first part diverted to the PDTA and the scientific evidence recorded in the oncological enology department of the Santa Chiara Hospital of Pisa and a second part dedicated to the presentation of the ESBM research protocol with related data outcomes. Aims of psycho-oncology in the mammary route. The patient (i.e. pz) who arrives at the breast unit meets the specialist in psychoncology for the first psychological examination in the clinic upon delivery of the histological report, delicate phase, punctuated by stages listed in Appendix A). If the piece does not manifest obvious fragility, an appointment is fixed that will be scheduled after the intervention and the initial therapy, called the second psychological visit, which coincides with the joint visit with the whole team. At this point, always following the treatment protocol of this PDTA, the pz without particular new and occurred fragility, is invited to a third meeting called the third psychological assessment visit, which coincides with the outpatient examination of follow.

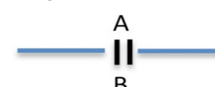
1.1. Milestones for the psycho-oncologist

Oncology, and in particular breast cancer, represents a context in which the assessment of the impact of the disease concerns both the pz and the professionals involved and for this reason there are two therapeutic paths to follow together with the entire team that essentially concern the three topical moments of the encounter with the breast unit, the time of reporting the histology, the time of reviewing the team after surgery and taking stock of the situation and subsequent supportive therapy to promote compliance with the hormone therapy and medications usually prescribed, and the final assessment of the state of overall well-being of women. Objectives of psycho-oncological treatment There are five primary objectives of psycho-oncological assessment, which correspond to the objectives of subsequent follow-ups:

1. evaluating psychosocial stress and the quality of life perceived by the patient;
2. evaluating perceived social support;
3. assess the personality characteristics of the patient;
4. to assess the presence of possible psychopathological past and/or present disorders;
5. to assess the psychological response to treatment.

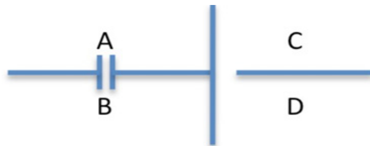
The work of the psycho-oncologist focuses on certain psycho-physiological aspects, which usually present themselves in a more or less evident way, such as shock, denial, frustration, depression, experiment, decision, integration; following a systemic approach we try to relate the specialist with the pz itself and to form - as soon as possible -, the so- called psychological alliance. As an example, the alliance work will start from here:

a) Initial situation: A and B represent graphically the psycho-oncologist (B) in structural relation with the pz (A), whose boundaries will be distinguished as follows



b) State of treatment: A and B establish the right therapeutic alliance and work with the other figures (C and D) that contribute in teams, to the success of drug therapy, rehabilitation and psychological

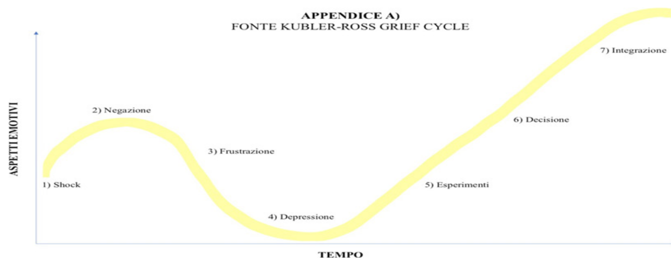
1. Objectives of psycho-oncology in the breast pathway
2. Key moments for psycho-oncology
3. Objectives of psycho-oncological treatment
4. Appendix A: the Kubler - Ross model; Appendix B: Evaluation and treatment test protocols)
5. Summary of my work translated into a graphic
6. Two graphically represented patterns of the psychological path
7. Adaptation of the BPS model with graphical display



The importance of the compatibility of triadic relationships (for example: surgeon - oncologist - psycho-oncologist) deserves to be stressed in view of the good compliance and compatibility of all the protagonists (Caplow, 1968).

Appendix a) The model of acceptance of the new state of health[2]

Every woman who arrives at the Breast Center needs time and specialized support to manage the new health condition, so that denial, anger, plea bargaining, depression, identified as the critical stages to go through, whose elaboration and management is mainly in charge to the figure of the psycho-oncologist. In this phase the psycho- oncologist has the specific task of supporting the medical staff directly involved, to favor the so-called medical humanities, with targeted psychological support.



2 Systemic bio-psycho-social approach, adaptation by Dr Menditto.

Appendix b) Breast Unit cancer PDTA3

Protocol 1: Depressive assessment

1. Ansia - Depressione – Stress PTDS (ADPTDS)
2. MADRS - (Montgomery Albery Depression) misura gravità dei disturbi dell'umore
3. HAD - (Hospital Anxiety Scale)

Stress percepito
Scala di BECK

1. Scala di HAMILTON
2. Sonno
3. Preoccupazione

Protocol 2: Cognitive assessment

Apatia – CBA(H) – Frustrazione 1) PFS - Picture Frustration Study

1. STAI - State-Trait Anxiety Inventory – Forma Y

2. BAI – Beck Anxiety Inventory

3. CBA-H - Cognitive Behavioural Assessment – Forma Hospital

4. SCL-90-r – Symptom Checklist-90-R

Protocol 3: Defense Mechanisms (DMI – PFS – PoMS)

1. DMI–DefenseMechanismsInventory–Forma per Adult

2. PFS – Picture-Frustration Study PoMS – Profile of Mood States

Protocol 4: Psychological Treatment (PTI - PCL-r)

1) PTI – Psychological Treatment Inventory

2) PCL-r – Hare Psychopathy Checklist – Revised: 2nd Edition

Protocol 5: Parenting Stress (PSI - EPQ-r – CBI)

1) PSI – Parenting Stress Index – Forma breve

2) EPQ-r – Eysenck Personality Questionnaire – Riveduto

3) CAREGIVER BURDEN INVENTORY (CBI)

1.2. Tiberia Hospital in Rome

Top The anxiety of naming something soon, talking about what's wrong. T (tirannie)

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First Part

SUPPORTING SCIENTIFIC EVIDENCE

AIOM 2021 Guidelines (updated to 11/11/2021)
NCCN. Clinical Practice Guidelines in OncologyTM. Breast Cancer.

UNITED RESEARCH FORUM (CONNECT WITH RESEARCH WORLD) https://unitedresearchforum.com/neurology-conference/
INTERNATIONAL CONFERENCE ON NEUROSCIENCE AND MENTAL DISORDER JUNE 29-30, 2023 I ROME, ITALY

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We think of empathy as a look at the absolute, an attempt at a relationship, the awareness that outside of us there may be something else from us, with which we can come into contact; empathy is not an external reality, it is not a ghost, a hallucination, but an act of restitution. The perception of the other in the intersubjective dimension does not explain and does not exhaust the dimension of the Einfühlung, which serves as thecontainer of the response. This phenomenological dimension distinguishes empathy well from emotional contagion, observed by Lorenz in 1935 and defined in terms of the inner induction of moods, typical in animals, to the extent that emotions are present in both situations, but with some important differences, one between all the exposed emotional participation and the more or less elicitated awareness of one dimension compared to the other.

T (Thinking) Our DNA is stretched to adapt to longevity; we weren't programmed to live that long, yet research and progress have made epigenetic changes: we are developing in evolutionary terms, we are increasing stages.

The estimated survival of life runs along the line of the ideal lived experience of becoming immortal, but in the situation in which this is presented as a possibility of probability, here appear the fears, second only to the trauma of stress, to survive life. The concept intrinsically linked to fear links the phantasmagoric ritual of the enchantment of living and not living, of memory, of the past that returns in other forms, in the form of more or less present, more or less archaic experiences, and in making this journey, it consumes the moment of the melting point, that

unique moment in which we stopped feeling pain for one event and we begin to have for another.

HB (human brain)

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Diagnostic Therapeutic Care (PDTA)

Cancer of the breast

Dr Lorena Menditto, Ph.D. Human Department University in Rome

Lorena Menditto, Ph.D.

If the woman does not manifest obvious fragility

An appointment is fixed that will be scheduled after the intervention and the initial therapy, called the **second psychological visit**, which coincides with the **joint visit with the whole team.** At this point, always following the treatment protocol of this PDTA, the pz without particular new and occurred fragility, is invited to a third meeting called the **third psychological assessment visit**, which coincides with the outpatient examination of follow-up, in which they are made a battery test of evaluation of the state of well-being of the pz.

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I worked a lot to deepen the synaptogenetic replication of neuronal cells, convincing myself how the adult can increase the production of these special cells even after childhood; and just as I was thinking about aging, I stopped to think about how explosive the issue can be in the child. When thought thinks itself, becoming object of itself, it stimulates the activation of many zones close to the mesial line, zone, the latter, very noble because contiguous to other very important regions, such as the insula and the amygdala, in interconnection with the MPFC, with the precuneus and the cingulate corteThe archeal traces typical of the fear of darkness, for example, are evident in the realization of the hidden dimension of white violence: beating, handling, overturning, shouting, In- quinare the passage from the solitary world to the universal one in the name of life, are violent practices and as such, recognized also inadmissible for the jurisprudential history (art 571 c.p.). From birth the newborn has many of the keys of access to his Self, without possessing concrete awareness; he lives the images, to put it with Jung, in one of his breakaway writings with Freud, on the symbols of transformation, and marks its passage. The frontal area and in particular the pre-frontal area of the medial cortex (MPFC) seem to be activated under certain specific conditions, which in this paragraph are omitted to be taken for more details in the continuation of the discussion. What we find here is that the same data seems to be confirmed by other surveys with detection of potential events - i.e. ERP - that is, the area facing the brain base, what we will say ventral, seems to be more active in sensorimotor tasks, and those relatively higher than the base, the more dorsal areas such as the pre-frontal cortex, work mainly on abstract and metacognitive aspects, considerations that tend to confirm with evidence performance based understandings of neuroscience on a certain prevalence of some areas compared to others in the performance of cognitive activities compared to motor activities. The remarkable neuro-scientific specialization, combined with the revision studies, allows us to hypothesize on this occasion that the hyper-specialized characteristics of the components of empathy, how the ability. That actually there is a seizure of emotions, to use an expression of Goleman, compared to the brain architecture is a known fact, but how this then happens specifically of the various emotional declinations, this requires further analysis and analysis. If left free, our brain wanders and in doing so does not empty itself of the images and of the people met, remembers them, keeps them in mind and undertakes, more or less freely, self-referential activities, typical of the elaborations made during the digressions. The activities of this type activate various areas of the MPFC that contain, for example, the temporo-medial lobe, involved in memory processes, indicated by Raiche in 2015 as an area dedicated to the connection of multiple functions. We can say, in other words, that if required the brain can focus on multiple cognitive activities, but when it comes to regulating emotions, to lower the volume of perceived compared to real experience, they can take over, and in fact this often happens, that the pause of cognitive thinking does not correspond to a pause of the emotional brain. if thought is left free, a so-called system of default is activated that takes us into the dimension of self-referentiality; for the reverse this system is deactivated if we focus on cognitive tasks (for cognitive factors in empathic processes see distract us from loving thinking, for example, or from what we did before the experiment or what we would like to do next. In short, we can conclude that we possess a switch for social thinking, functional to feel the other, which needs categorical regulatory components on the one hand and more universal adaptive dimensions on the other.

The set of proto-narrative images, those of the passage towards the outside and the cohabitation of the child with the spirits in the maternal cave, constitute the deepest layer of the collective unconscious, a legacy potentially existing in every individual. It is the psychic equivalent of the differentiation of the human, neotenic and vital brain that has come so far. The adults who have been subjected to violence as children, statistically, will in turn abuse other children, with a determination perhaps slightly weakened by the events, but surely the children of these parents will receive the same treatment. Breast cancer and trauma exposure for the therapist with related factors contributing to CF management, animate some of the latest research on mirror neurons and affordances, regarding the ability of the subject to use a physical object; these are the elements present in the PDTA treatment plan that I present here. Kubler Ross' curve highlights the classic course of mournful thinking and indicates some very particular phases. The answer to some issues related to imaginative situations and response situations like

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Delicate phase*

In the mammary route the patient (i.e. pz) who arrives at the breast unit meets the specialist in psychoncology for the first psychological examination, in the clinic upon delivery of the histological report.

***Appendix A The Kubler -Ross model**

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"Daydream and fantastic with a certain regularity, about things that could happen to me" (item 1 taken from Interpersonal Reactivity Index IRI - Patient version)have allowed us to measure, in the specific case, the reactivity in front of certain situations, particularly exposure to internal or external emotions. an index was needed that, together with the balancing of the negative effects of acquiescence and social desirability provided by the Balanced Emotional Empathy Scale, with items such as: "I can't feel sorry for people who are directly responsible for their own unhappiness" (item 2 taken from BEES), and the IRI reactivity index was able to give a first indication of empathic behavior. To complete the profile required by the study, it was

decided to combine two scales on psycho-physical well-being with the ISI Sleep Severity Index and the level of awareness of one's own stress with the PSS perceived stress scale.

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2. Second part

The schibbolet of the therapist

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What's about the risk,
when we empathize?

In the unlike hypothesis that we happen to suffer brain trauma, depending on the extent of the affected area and the various modulations of gravity, we could experience to realize that, if properly treated, the brain is able to organize in a plastic way the areas of mutual aid. We imagine the grey matter as a gelatin that contains the cellular life, the neurons, the synapses and at the same time animates the thoughts, the emotions and the mental life of the person; as in a syllogism of Aristotelian memory, it is not bold to postulate the statement, the brain undergoes a trauma, the mind will show the wound. changes in the rhythm of sleep, intensity of emotional reactions, inability to modulate the emotions of depressive traits, raising arousal. The highest secondary stress markers

The analytical findings interesting for our work are that the medical and paramedical staff and psychologists intervened had a significant data of ST, in which the "negative life event" correlates to the extent of . 18 ($p<.01$) with the experience of their traumas; and again: the age of the professional correlates to the extent of -.14 ($p < .05$), data significantly interesting for the impact of the average age of victims relatively low and finally the other statistically significant data was found with the Scale ST with a figure of . 27 ($p < .001$).

2.1. The tyranny of empathy in the clinic

Our psychic experience sometimes coincides with the psychic essence, as if to say that we have arrived where we have always been, a little the read motive of this book.

And the experienced therapist knows that the magic formulation of evolution lies not only in the two A + B1 meetings, but in what we call the therapy hour.

$$T = A+B$$

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This dual overlap between the neurobiological plane and the ideological plane was the leitmotiv of this study, which I encapsulate in this mathema:

$$\Delta = (sinc. + nA + nB + therapyroom + EMPATHY)$$

x

I start by saying that the untranslatable French onomatopoeic term of *schibbolet*, wantsto be an invitation to all therapists not to slip on the smooth and slippery walls of the tyranny of empathy, and to ensure that the synchrony with the patient, is more than ever the best version of a One that is just a crack, a way to look inside the story, an Unbergriff, ie a concept of lack that generates desire, from which X = f (One) and not just a diachrony, ie a concatenation of time in time. Synchrony is not only what happens to us, but what is said together.

The hour evolves, it fills with minutes, and with minutes they arrive in meanings that transform - always a little magically - the A into A1 and the B into B1, that is, the minutes evolve in evolution. But it is not a mathematical syllogism the success of the relationship between the two signifiers, since the transformation of the two codes and modified as follows

$$T = A+B + min. + room + empathy$$

One might argue that in reality signifiers A and B have changed themselves, and in fact my need to get the count back leads me to formulate a new equation

$$T\ 1 = A1+B1\ f\ (min. + room + empathy)$$

It would seem a useless contortion typical of the more mature speeches of Husserl, while in reality it is vital survival at the time of therapy, which then is a way to put it as Bernard Nominè says, later quoted in the paragraph, which summarizes in an almost elementary formula all the fatigue of care

Y = f (?)

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Macrocategorie

		Frequenza	Percentuale	Percentuale valida	Percentuale cumulativa
Valido	Infermieri	24	52,2	52,2	52,2
	Medici	17	37,0	37,0	89,1
	Altro (Amministrativi e Tecnici)	5	10,9	10,9	100,0
	Totale	46	100,0	100,0	

- Doctors
- Nurser
- Tecnic Amministrative

x

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Categorie

		Frequenza	Percentuale	Percentuale valida	Percentuale cumulativa
Valido	Amministrativi	4	8,7	8,7	8,7
	Fisioterapisti	1	2,2	2,2	10,9
	Infermiere	17	37,0	37,0	47,8
	Medici	17	37,0	37,0	84,8
	Operatore Sanitario	6	13,0	13,0	97,8
	Tecnici di laboratorio	1	2,2	2,2	100,0
	Totale	46	100,0	100,0	

- Doctors
- Nurser
- Tecnic Amministrative

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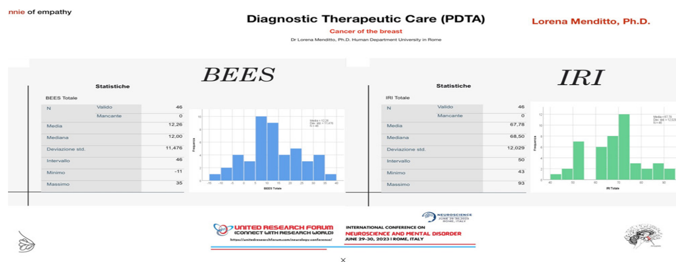
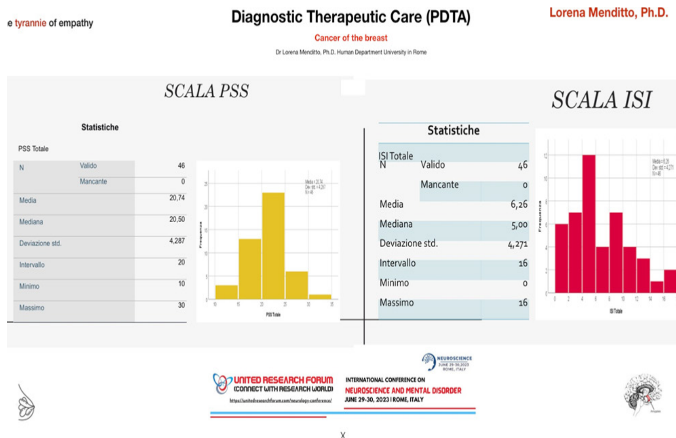
In this section we present the univariate descriptive statistics of all the variables present in the dataset. For qualitative variables (ordinal and non-ordinal) we will present the frequency tables while for the quantitative variables.

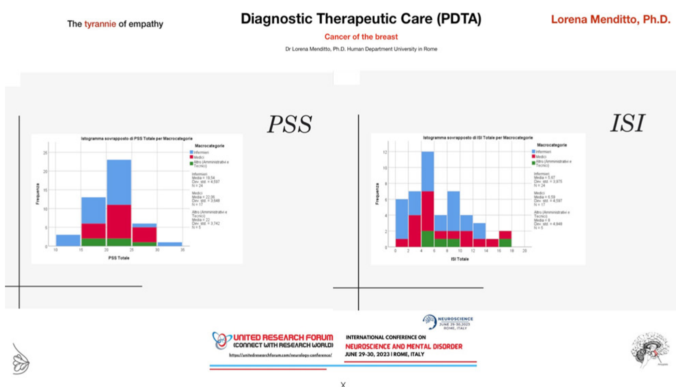


BEES measures the emotional component of empathy defined as a vicarious experience of the emotional experiences of others: feeling what another person feels. Emotional empathy reflects interpersonal positivity, social skills, prosocial orientation, and involvement in altruistic behavior. In addition, people with a high level of emotional



empathy are usually less aggressive, characterized by high levels of moral judgment, more responsive to emotional stimuli and led to help others voluntarily. First, we look at the Pearson correlation scores calculated between the four total scales of interest. Both correlations are fairly modest (about 0.3).

We therefore conclude that as BEES' global score grows, PSS' global score grows and ISI's global score grows as PSS' global score grows. We note that there are two positive and statistically significant correlations at the 0.05 level between the BEES and PSS variables and between PSS and ISI. Both correlations are fairly modest (about 0.3). We therefore conclude that as BEES' global score grows, PSS' global score grows and ISI's global score grows as PSS' global score grows.



What distinguishes a science is to have a factual object, and we are - in power - many objects. Let's start from the setting. First of all there is the psychologist to constitute the place; the place of the meeting that supports science, that knows the rules of the game, that includes the transfer of knowledge and yearns for transfer, institutionalized by long years of study dedicated to the love question of the hour of terapia. We with our proximity make the trajectory. Martine Menés speaks of desire and the trajectory of desire as an act of a supreme good, the patient's ego. We have hidden purposes, we therapists, when we wish and wait for the hour when we will meet for the first time our new patient, and the purposes are hidden in mental formulations similar to mathematical functions. Are we the unknown to find or is the patient the unknown variable? Bernard Nominè in a seminar in March of this year, on one of the first spring afternoons with an unusually hot sun, used words that have illuminated and warmed me, with the idea of a real function of desire, as if it could be expressed in mathematical terms, and it would be an X = f (...), with the variable that remains unknown, among the brackets of the àgiti, of the unspoken, of the unconscious parts, and a therapist who is there in the crucible of his hypothetical embodied thoughts, to fall in love once again with the story he is about to handle. In the hour of therapy there is then the patient.

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Breast cancer refers to an archaic pain, continuous, that in my department lives with therapies. Tiredness and industriousness require an operation of assessment to avoid that we move towards conditions of malaise and burnout, which at present are only slightly declined in some areas such as the personal distress referred to above. For this reason I'm proposing a **Risk Assessment Protocol** functional to the results of ESBM that will be built on the evidence presented.

3. My referee

Dimitrios Varvaras MD, PhD

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