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**Pilot study to evaluate a Dance Movement Psychotherapy (the BodyMind Approach) with patients with medically unexplained symptoms: participant and facilitator perceptions and a summary discussion**

**Helen Payne**

**University of Hertfordshire,  
School of Social, Community and Health Studies, Meridian House  
32 The Common, Hatfield, Herts AL10 0NZ  
01707 285861  
H.L.Payne@herts.ac.uk**

**Biography**

Professor Helen Payne, PhD, is a researcher and supervisor at the University of Hertfordshire leading the Arts, Counselling and Psychotherapy Research Group comprising a visiting professor, post doctoral, PhD candidates and research fellows. She is a UKCP accredited psychotherapist, Fellow of, and Senior Registered movement psychotherapist with, ADMT.UK and group analyst. Research and clinical practice has been concerned with Dance Movement Psychotherapy (DMP) and children with autism, learning disability and emotionally disturbance, young offenders, personal development groups for trainees in the psychological therapies and with patients suffering moderate anxiety and depression in primary care. She has published a number of articles and books including *Creative movement and dance in Groupwork*; *Dance Movement Therapy: Theory and Practice*; *A Handbook of Inquiry in the Arts Therapies*; *Dance Movement Therapy: Theory, Research and Practice*; and *Supervision in Dance Movement Psychotherapy*. She is the founder and editor-in-chief for the international peer reviewed journal *Body, Movement and Dance in Psychotherapy* published by Taylor and Francis. Her clinical work has influenced her approach to DMP and Authentic Movement both of which are also informed by her extensive research. She trained in Laban Dance, Person-Centred Counselling and Group Analysis and has been developing her own form of Authentic Movement with groups and individuals for 25 years. She has a small private practice in group, individual and supervision work. 0044 1438 833440

**Pilot study to evaluate Dance Movement Psychotherapy (the BodyMind Approach) with patients with medically unexplained symptoms: participant and facilitator perceptions and a summary discussion**

**Abstract:** The principle objective of the study was to explore and systematically analyse whether participants with Medically Unexplained Symptoms (MUS) changed their perception of their bodily symptoms, and received any other benefits, from their perspective, following a 12-week group using the BodyMind Approach (BMA) derived from Dance Movement Psychotherapy (DMP) (Payne 1992, 2006). The study recruited patients with chronic (over two years) MUS accompanied by moderate anxiety/depression. This was a cross-over study design in which participants acted as their own control. Quantitative data from standardised instruments, self reports on GP visits and medication as well as qualitative data through semi-structured interviews with participants, were collected pre, post and at three month follow up. Facilitator's process recordings were also raked through in a comparative analysis to elicit similarities and differences in perceptions of the process. Participants were recruited from primary care and the intervention was undertaken in a community setting at the primary-community care interface. Findings demonstrated that this intervention, particularly due to its supportive nature in a group facilitated by a qualified movement psychotherapist enabled participants to increase their activity levels, reduce bodily symptom distress, increase self-management of health, improve overall wellbeing and make positive changes in their lives (Payne and Stott 2008 and Payne 2008a). In addition, medication was reduced or stabilized and further GP visits were rare. All

outcomes were sustained at the three month follow up. This study has demonstrated that patients with MUS can benefit significantly from an approach which intentionally uses the body-mind inter-relationship to promote change in perceptions and behaviour in self managed health care. The BMA approach appears to have been seen as successful when both participants' responses and clinical process recordings are analysed. Recommendations revolve around the need for further research in a phase two type study with an additional control 'treatment as usual' arm.

**Keywords:** medically unexplained symptoms, primary care, anxiety, depression, bodymind, group dance movement psychotherapy.

## **Introduction**

The study was conducted between 2005 and 2007 and received full NHS ethical approval. In previous articles (Payne 2008a and Payne and Stott 2008) a summary of the qualitative and quantitative findings from this pilot study are presented respectively. These examined outcomes from the pilot research study for patients with MUS receiving the intervention termed a Body Mind Approach (BMA) derived from Dance Movement Psychotherapy (DMP). In this sequel paper an overview of the study, its rationale for the intervention, and an analysis comparing the facilitator's clinical notes on sessions with the experiences of the sessions as reported by participants are presented. Finally an in-depth summary discussion incorporating the research literature from the fields of movement psychotherapy and MUS is given as a context for the findings.

## **Background**

People suffering from stress related bodily symptoms (often termed medically unexplained symptoms or somatoform disorder) do not necessarily present with pain and are not the same patient group as those attending pain management sessions. They frequently experience other mental health conditions, are often forced to give up their jobs or studies, experience major problems in finding and keeping work which consequently leads to even more stress, anxiety and depression. These patients, often seen as 'revolving door/heartsink' patients in GP practices, usually end up on increasing doses of medication and endure many secondary care interventions. Once entering and sliding on a downward-spiral they are not able to live their normal lives anymore, they tend to minimize activities and social contacts which can finally lead to complete isolation. It is very hard for them to find ways out of this vicious circle.

The facts and the figures released by the UK Department for Work and Pensions (DWP) (2007:1) underpin the situation in which the, then, Secretary Peter Hain, stated that "...around 40 per cent of people currently receiving incapacity benefits are doing so because of mental ill-health." Health Secretary, Alan Johnson (ibid) calls this "...a terrible waste for British business and a great loss to the individual."

A press release by the DWP states that 30% of GP appointments are used to discuss mental health and stress related problems and Primary Care Trusts spend 11% of their budget on mental ill-health. The high stress-related sick notes do not only have devastating financial consequences to the state and to businesses. Individuals with mental illness experience a severe lack of quality of life which is closely linked to their self-esteem, self-efficacy and social interacting (Murphy & Murphy, 2006).

Hague (2005a; 2005b) states that at least half of all these mental health consultations are for medically unexplained bodily symptoms. For example, skin conditions, bladder/bowel problems, prostate pain, back/joint/muscular pain, gastrointestinal problems, abdominal pain, balance problem, fatigue, headaches, breathing problems, nausea, tinnitus.

A five-year-follow-up study on the prevalence, impact and prognosis of multisomatoform disorder (MSD - another label for MUS) (Jackson and Kroenke, 2008) screened 500 adults with a physical symptom presenting to a primary care clinic. According to Jackson and Kroenke (2008), MSD at baseline was a predictor of MSD at five years. The patients were more likely to have co-morbid mental disorders and seen as “difficult” by their clinicians. Overall, it can be stated that these patients are less likely to experience symptom improvement. They have higher utilization rates and have significant functional impairment. A Dutch study screening 466 patients with MUS measured the quality of life. These patients showed significant psychological distress, had high levels of medication and on average, their quality of life was poor (Koch et al, 2007).

According to a Canadian review by Kirmayer et al. (2004) the most common MUS reported within one year were “musculoskeletal pain, ear, nose and throat symptoms, abdominal pain and gastrointestinal symptoms, fatigue and dizziness” (2004: 663-672).

The functional somatic syndromes such as irritable bowel syndrome, non-ulcer dyspepsia, fibromyalgia and chronic fatigue syndrome are found to be frequently related to depression and anxiety (Henningsen et al, 2000). Furthermore, it can be stated that people with childhood sexual abuse build a risk group for MUS, especially for chronic pain and gastrointestinal disorders (Nelson et al, 2006).

Therefore the evidence appears to suggest a connection between psychological well being (particularly anxiety/depression), some previous traumas and some medically unexplained bodily symptom. Consequently, there is definitely a clear need to support people with stress-related bodily (medically unexplained) symptoms to manage their problems and hence their lives.

A recent paper (Bakal, Coll and Schaeffer 2008) aimed to provide GPs with an experiential framework for understanding patients with body distress symptoms involving somatic awareness to resolve the dualist (physical-psychological) position inherent in conventional multi disciplinary approaches. It stresses the importance of acknowledging the patient's physical symptoms. It utilises, as a meta-skill, the body sensations felt by the patient to identify social, psychological and physiological factors needed for symptom self regulation. They describe psychological influences as psychobiological in nature rather than mental phenomena. They claim it is easier for the patient to accept, experience and alter impacts of trauma, personality, stress and emotions if they see the body as the mediator of these experiences. This is precisely the intention of the BodyMind Approach (BMA) in the treatment and healing of these patients' distress. The term 'BodyMind' used in the research suggests this type of concept to the patient from the outset, without labelling them as needing

‘psychological’ support, which many refuse due to the stigma and a conviction they have solely a bodily condition.

In terms of the efficacy of treatment for somatoform disorders, Kroenke (2007) stated in his review of randomized controlled trials that “although somatoform disorders are among the most common mental disorders presenting in the general medical setting, the strength of evidence for specific treatments has not been well synthesized” (ibid: 881). The result of the review is that Cognitive-Behavioural Therapy (CBT) seems to be the best established treatment for somatoform disorders.

Although Sumathipala et al (2008) came to the same result, he mentions the fact that most CBT trials assessed only short-term outcomes. Morley, Eccleston and Williams (1999) made a meta-analysis of 25 randomized controlled trials of CBT for chronic pain in adults. They concluded that CBT was very effective but also only in the short term. In addition, doubts are further emphasised on the efficacy of CBT in the longer term in a recent study (Sumathipala et al. 2008) of a randomised controlled trial evaluating CBT and comparing it with structured care given by GPs. The conclusion was that CBT was no more efficacious than structured care, although it was unclear precisely of what this ‘structured’ GP care consisted.

Nowadays, CBT is well known and vastly researched. It is acknowledged as the recommended (NICE guidelines) and most used short-term therapy mode for this population. To the authors knowledge there is little on its effectiveness for the MUS population over the long term.

There is still a paucity of evidence-based studies on body-orientated psychotherapy approaches (such as body psychotherapy and dance movement psychotherapy) which could be compared to the unquestioned positive outcome of CBT trials. It is the fact that CBT trials are widespread and numerous studies can be compared and reviewed due to the easily measured behavioural outcomes (within a quantitative methodology akin to drug trials), which underpins the need for similar evidence-based studies on “new” interventions, such as the BMA used in this study.

A number of studies of CBT, group psychotherapy and hypnotherapy as interventions have shown these can be beneficial to those suffering MUS in the short term (Turner & Jensen 1993; Greene & Blanchard, 1994; Speckens et al 1995; Kashner et al 1995; Scoppola, 1996; Temple et al 1996; Warwick et al 1996; Harrison et al 1997; Mayou et al 1997; Grabhorn, 1998; Milch, 1998; Kuechenhoff, 1998; Morley et al 1999; Lupke, 1999; Kroenke & Swindle 2000; Ehlert, Wagner, & Hadhazy et al 2000; Lidbeck, 2003; Bleichhardt, Timmer, & Rief, 2004).

Consequently, it is reasonable to anticipate that, theoretically, an approach which combines elements of cognition and behaviour, altered states with a focus on the body in a group psychotherapy setting might also be helpful to those with MUS, at least in the short term. Indeed, the research findings presented here appear to demonstrate that the structured BMA, deriving from DMP, and which integrates elements from CBT (particularly mindful CBT), group psychotherapy and hypnotherapy leads to significant longer term change in perception and behaviour helping in a fuller recovery of patients with MUS (up to three months).



Other research has shown that so-called 'non verbal' approaches (they all use verbal language as part of the treatment) such as art therapy, music therapy, dance movement psycho/therapy and meditation are helpful for this patient group (Brown et al 1989; Grossman, 1992; Standley 1992; Magill-Levreault, 1993; O'Callaghan, 1996; Theorell et al 1998; Fagen & Wool 1999; Bullington et al 2003).

### **The design**

This study aimed to systematically evaluate the outcomes of a 12-week BMA intervention programme with patients suffering from anxiety/depression with at least one MUS. Eighteen out of 24 participants completed the study. A small number is desirable for such an in-depth, single case design methodology since it provides for a greater richness achieved for the qualitative data resulting in a thick description (Geertz 1969). Withdrawals were due to illness, moving home or no longer being able to commit to the 12 weeks for personal reasons.

The study used a within-case study design whereby participants acted as their own reference point. Pre, post and at three months follow up semi structured interviews were conducted by a research assistant and the principle investigator to elicit views for example of their symptoms, expectations of, and the experience of, the process of the BMA programme. This qualitative approach added depth, validity and relevance derived from the subjective experience of participants. Participants were sent their interview transcriptions to invite approval, amendments or comments and much later a short final report on the study findings.

In order to gain an exhaustive cross sectional study both the semi-structured interviews and validated, standardised, outcome measures (quantitative methods of data collection) were implemented. Only the qualitative findings are presented in this article due to wordage restrictions; the quantitative results are reported elsewhere (Payne and Stott 2008).

For the qualitative analysis a framework for the generation of theory grounded in data was arrived at by using a method described by Glaser and Strauss (1967) as constant comparative analysis - data is collected, coded, and compared with earlier data for the generation of categories, their properties, and the relationships occurring between them.

Facilitator's process recordings were systematically raked through in a similar thematic analysis as a comparison to participant's views. Analysis from these data aimed to evaluate the approach to discover the perceived experiential aspects of the process, adding depth to our knowledge of any pitfalls and benefits (see findings below). As a result the BMA model may be confidently repeated again and training established.

### ***Participants***

#### *Accessed*

Participants were self-referring or referred from primary care trust health professionals such as GPs, primary care counsellors or practice nurses. These professionals were aware of the nature of the research, the intervention and inclusion/exclusion criteria having attended a presentation on the project and received

a handout written specifically for them. They selected appropriate patients to whom to give a flyer i.e. those who fell within the inclusion criteria. Some participants may have seen a flyer/notice in the community or GP surgery and self referred. In all cases, prospective participants made their own phone call to participate in the project (thus, ultimately all self referred) and were subsequently screened for inclusion/exclusion criteria on the telephone. Not going through primary care referrals has been shown to be a valuable access route; for example, many can be as unwell as those who are GP referred and generally have been in distress for longer.

### *Selection*

The telephone screening procedure ensured all were within the **inclusion criteria** of: over 18 years of age; suffering an MUS for more than two years; and that there appeared to be a moderate risk to the person's current or future independence in social, work/study and/or personal care/domestic routines.

**Exclusion criteria** were: those in the care of a consultant psychiatrist in the past six months; those having suffered a trauma or complicated bereavement in the previous six months; those with a learning difficulty or eating disorder; individuals with a primary diagnosis of substance/alcohol misuse or having a diagnosis of dementia, psychosis or severe personality disorder.

Precautions taken to avoid selection bias were: a) ensuring all those referred who were eligible were offered a screening, b) ensuring only the selection criteria were applied in each case, c) alternating the screening meetings between the principal researcher and research assistant, d) all those wishing to participate and meeting the

inclusion criteria were allocated a place in a group on a first come first served basis. We do not know to what extent the participants were representative of the larger population of MUS patients GPs see in daily practice.

A physical illness can have accompanying psychosomatic symptoms and the psychological stress/disorder can have an accompanying physical illness. As a result, referrers required clarity about which part of the problem is thought to be psychological and why it is thought not to be a consequence of diagnosed physical illness. Consequently, presentations on the research were made to six local GP surgeries, a counselling service and two physiotherapy departments at local hospitals outlining the inclusion/exclusion criteria and the project as a whole. GPs were not contacted unless, on invitation, the participant requested we informed them of their participation; most participants did not make this request.

### ***Procedure***

In this study, next to pre and post interviews to elicit participants' experiences of the process, it was useful to also include a three-month follow-up interview with participants. This enabled a view on what, if any, longer-term benefits were experienced in the eyes of the participants, and to clarify overall levels of satisfaction with the programme. Three months from post intervention is not too long for participants to forget the experience, nor too short a time for the symptom/dys-ease to have returned (if it has disappeared/reduced) to the same state as that before the intervention.

After the telephone screening for selection an individual research briefing meeting aimed at explaining the research, assessing suitability answering any questions and issuing informed consent forms and withdrawal procedures. Potential participants were invited to give informed consent prior to their involvement. They could withdraw from the research at any time without adverse consequences. For example, they could choose to remain within the intervention group but withdraw from the study. It was made clear from the outset that the research had gained full NHS ethical approval and all data would be anonymised and confidential, seen only by the research team.

Next, informed consent was checked and a semi-structured interview was conducted to elicit: their motivation to attend; medication levels; frequency of GP visits; a description of symptoms and when they first occurred; current coping strategies; hopes, fears and expectations of the group and the participant's perception of the referral procedures. Outcomes measurements on standardised instruments were also administered at this point.

At the individual pre-intervention meeting with the facilitator the participant's suitability for participation in the next group was assessed, further questions answered and the nature of the group, its boundaries and ground-rules were explained.

The 12 week, two-hourly intervention included the completion of a personal journal by group members, at and in between sessions, to record personal thoughts and feelings. This was also an aide memoire for recalling experiences during the semi-structured interviews to follow.

At the conclusion of the intervention in week 13, an individual meeting was held with the facilitator where questions were answered and information about further resources for support if desired were distributed.

This was followed, also in week 13, with a post intervention semi structured research interview which sought views on the process and benefits of the intervention, visits to GP and medication levels and the administration of outcome measurements. A follow up semi-structured interview date was agreed for three months time which sought the same data again for comparative analysis.

### **The intervention**

The intervention focused on enhancing self-awareness and self-reflection by integrating a verbal mode of expression with the non-verbal. Although called a BodyMind Approach it derived directly from Dance Movement Psycho/Therapy (DMP) (Stanton-Jones, 1992; Meekums 2000; 1992; 2006a; 2006b, Payne 1992 and 2006) and uses one specific aspect of this, Authentic Movement (Chodorow 1999; Pallero 1999 and 2006; Payne 2006a). Spontaneous movement as a source of individual bodily expression as well as relaxation techniques (breathing, massage) were incorporated in the approach. The aim was to change the experience of the body-felt sense to provide for new perceptions on symptoms; in turn leading to new coping strategies. Speaking, drawing and writing were offered as tools for the self-reflective process at the end of each session.

Now established in the NHS, DMP practitioners are currently in the final stages of registration with the Health Professions Council (HPC) (ADMP UK, the professional association for DMP, has successfully applied to HPC and awaits parliamentary time for completion of the process). In the most recent NICE consultation guidelines (2008), DMP was found to be an effective treatment for negative symptoms in patients with chronic schizophrenia. Inclusion of DMP in the NICE guidelines was primarily due to a study by Rohricht (2006).

The pilot study, of which some outcomes are reported here, aimed to change the perception of the bodily symptom to enhance the self-management behaviour of patients suffering from a MUS using the **BodyMind Approach (BMA)**.

Participants in the pilot were all interested to understand and learn more about their symptoms, but not necessarily about any possible emotional connections. The intervention was entitled 'A learning group – the bodymind approach' to embrace this interest on bodily symptoms, understanding and education, rather than stressing the terms psychological or therapy. The focus on understanding bodily symptoms encouraged access and participation. During the intervention they appeared to demonstrate a desire to understand how emotions/thoughts/lifestyle were related to their individual symptoms and what may have triggered them. They were increasingly keen to learn something about the body-mind connection and embarked on a journey of self-discovery.

The author has argued elsewhere the physical and psychological benefits of an intervention such as DMP which uses physicality, the moving bodymind - as in moving the body with mindfulness - for patients with psychosomatic symptoms:

‘there are valid physiological reasons for the place of dance-exercise in [psychological] therapy, emphasizing the unique contribution DMT has to make in, for example the treatment of stress and psychosomatic conditions’ (Payne 1992:6).

DMP, as a hybrid combining the body as in natural, creative, movement and verbal language in its therapeutic process, may have an implicit advantage over solely verbal or non verbal/body-orientated interventions. The BMA can approach ‘dys-ease’ from a unique unity and inter-relationship of a bodymind perspective and a mixing of the verbal with the non verbal.

In authentic movement, used in BMA, eyes are closed engendering increased body awareness and an altered state akin to meditation in movement and stillness. The emphasis here is on the connectivity between symptoms (body), feelings, thoughts, beliefs, symbolic non-verbal and imaginative aspects of the psychotherapeutic process. The experience from this is then verbalised by the patient who can also later request verbal and benign witnessing from another. This combination of verbal and non verbal provides for a greater synthesis at unconscious and conscious levels which is expected to afford a more dependable and deeper anchor for change.

As an integrated approach for this population BMA is consequently unlike the other former distinct approaches which are solely either bodily symptom or psychologically focussed. The major difference lies in the fact that it is working through and with the mind in the body, intergrating body and psychological aspects, concentrating and working with, and through, the distress/dys-ease of the symptom rather than trying to



distract from, or eradicate it, both of which can lead to (further) disassociation from the body.

### **A comparative analysis between the facilitator and participants' perceptions of the BMA approach**

It was essential to ensure the approach offered a consistency of experience between participants themselves and between facilitator and participants. In this way the approach could be relied upon as having been evaluated as a model for future research, training and delivery.

When comparing an analysis of facilitator's reports of the process and participants' statements about sessions it can be stated that overall there are more agreements than differences. This leads to a conclusion that the approach may be duplicated with other facilitators for the same effectiveness.

Concerning the main themes that were addressed in the group, there is absolute congruence. Many sessions dealt with the symptoms of participants. Time and space were given to encourage participants to become aware of what triggered their symptoms, and which feelings and circumstances were linked to individual physical reactions. Participants stated that they had been enabled to understand how their emotions or life situations had an effect on their bodies and how symptoms were triggered, but also how these could be avoided or how they learned new strategies to cope with any new symptoms in a different way. These findings concur with the outcomes from the semi-structured interviews.

Participants became aware of how emotions are closely linked to physical reactions, for example, how stress can affect the body in a negative way. In relation to that learning process different issues emerged and were addressed in body work or movement exercises (body awareness exercises), for example, 'being present in the body', 'emotions and the body', 'body boundaries'. Clearly links between feeling states and the bodily experience were being made in sessions, verified by the participants' own observations in semi structured interviews.

Statements about the role of the facilitator and the facilitator's own views about her role show similarities as well. She (the facilitator) was described by participants as providing safety and guidance for the group, helping people to become aware and facilitating changes in their lives. The importance of safety in group DMT has been shown in previous research (Payne 2001). Group psychotherapy literature (Yalom 1970, Foulkes 1948, 1964, Nitson 1996) too recognizes the importance of trust in the group for change to take place for members. Participants felt understood and comfortable. From the facilitator's reports, we know that she actively worked towards providing safety and comfort for the group (for example, "We spend time getting comfortable"). Her concern was also not to push people into something they were not ready to do and to follow participants' individual paces.

Since she had to deal with very mixed abilities within the groups there were also worries from the facilitator whether participants would get frustrated or be reluctant to move. This insecurity in participants and facilitator was not mentioned in post or follow-up interviews, which leads to the conclusion that overall participants had positive feelings about the group experience.

It seems that certain problematic issues (such as feeling exposed in front of the group) had been resolved over the duration of the learning process. We can assume that due to the facilitator's high awareness and self-reflective process (and support by her clinical supervisor) participants were enabled to overcome their own shyness and boundaries and therefore opened themselves towards the learning process.

Positive aspects of the group (such as joyfulness, reflecting time, feedback) were mainly congruent on both sides, i.e. for participants and the facilitator. It is an interesting fact that, from the facilitator's point of view, aspects that are a lot more difficult arose within the groups. However, once again, supervision helped her to work through and resolve those difficulties. Moreover, sometimes dealing with something that initially had been seen as a problem brought up an issue, which could then be addressed in the group and finally led to a positive outcome. For example: "the two-hour session feels too long, but interestingly it brings up the need for punctuating the time and the need for rest."

When comparing pre and post intervention analysis of data there are a number of changes evident. The main difference in participants' observations of the aims of the group from pre intervention to post was concerned with 'body'. For example it was more differentiated after participation in the intervention. Initial understanding was simply "it is about movement/dance". Afterwards however, they had understood that they explored different aspects of the body which had to do with movement but also with body awareness and self awareness in general. Statements were concerned with feelings, the body/mind connection, symptoms, self-development and an

understanding of the group setting which were consistent in pre/post intervention interviews.

Positive and negative expectations concerning the group (as expressed in fears /hopes pre intervention) were closely linked to the role of the facilitator. Fears, for example, were diminished by her “providing physical and emotional safety”, she made the group members feel comfortable, she was understanding, caring, nurturing. Positive outcomes were definitely supported by the facilitator and therefore hopes had been fulfilled to a high degree.

### **Some outcomes**

In addition to their previous coping strategies pre intervention, participants stated they had gained new strategies and important insights. Apart from finding new resources or re-discovering talents and old hobbies, and other than simply seeking distraction from the symptoms, participants were able to apply learned relaxation techniques or exercises. Furthermore, they were enabled to see individual connections between emotional states (stress, worries, etc) and their symptoms. Having an understanding about cause and effect some participants were able to influence the cause, and, as a consequence, stop the symptom. The coping mechanism of taking medication also changed significantly. For example, most participants did not need medication any more. Those who were still on medication took a diminished dose or remained stable.

Some symptoms completely disappeared (such as the skin condition, bladder problem, prostate pain, back pain, balance problem), attributed by participants directly to the intervention. Further bodily and emotional symptoms diminished in the effects on

lives and amount of distress they caused (such as fatigue, nausea, depression, anxiety) and a few remained the same, however for these participants stated they dealt with them in a more relaxed way (tinnitus).

General physical changes and improvement in overall well-being (more energetic, more active, more relaxed) were reported. Furthermore they emphasized enhanced awareness of themselves and their physical needs as well as improved self-value and self-confidence. All these changes they made clear they thought were as a result of the intervention.

For most participants, in addition, at the three month follow up there had been general changes concerning their life styles. For example they could go back to work/study (at least part-time), they were no longer taking medication, had reduced the frequency of GP visits to nil, gained more quality and joy of life, felt considerable changes in personal relationships/socializing and were taking more responsibility regarding their own health.

According to participants' comments in post intervention interviews they all experienced a relationship between body symptoms and certain inner feelings/thoughts, becoming more aware of meanings as manifested body signals/body language. It became evident that, as Kirmayer et al. (2004) state: 'Having the opportunity to create meaning for symptoms by exploring their characteristics, context, and antecedents, seems to relieve distress for many individuals' (p. 666).

The process helped them to deal with their symptoms more easily or even enabled them to make general changes in their lives such as in work, study, diet, relaxation, massage, physical exercise, activities, split from partner, which then led to the effect that the symptom completely disappeared or reduced dramatically (Payne 2008b).

### **A summary discussion**

It can be seen that the impact of this BMA approach on patient identified symptom distress far outweighed the study's anticipated benefit, which was limited to change in perceptions towards the bodily symptoms possibly leading to new coping strategies.

Additionally there was an increase in wellbeing as well as the predicted general coping strategies together with a decrease in bodily symptoms, anxiety or depression. These findings were validated by the analysis of quantitative data as well. For patients and the primary care service as a whole there were decreased GP visits, referrals to secondary care and prescription medication. A cost benefit analysis based on these outcomes has since been undertaken (Payne and Fordham 2009) which demonstrates the reduced cost of this intervention for primary care (increased access to psychological therapies (IAPT) high intensity in the stepped care approach) when compared to one to one interventions such as counselling or CBT.

A review of body-mind therapies for this population, including relaxation exercises; meditation; hypnosis; guided imagery; biofeedback and autogenic training in the treatment of fibromyalgia, concluded that these discrete therapies should not be favoured over other forms of therapy (Hadhazy et al 2000). In addition, Creamer (1999) claims the combination of different therapies according to the individual's

needs and interests may be most helpful. This study supports these recommendations for patients with MUS in that other therapies, such as DMP, which uniquely promotes an integration between body, mind and self can be useful to recovery for this patient group who are normally quite hard to reach.

A programme in which group exercises (walking, strength training movements and stretching activities) were combined with education and a focus of self-management in women with fibromyalgia (Rooks et al., 2007) demonstrated that the combination of physical activity and education had been most beneficial for the patients. This is similar to the focus on the body/physicality/movement, self management and learning emphasis of the BMA intervention. However, it does not appear to have been physical movement only that had a positive effect on participants. Rather it was more likely a combination of moving and sensing the body and verbal/non-verbal self-reflection which led to meaning-making and enhanced self-management, coping strategies, increased well-being and the overall positive results at the three month follow up.

The placebo effect on outcomes must be considered though since participants are likely to have volunteered to attend sessions with the expectation that that BMA would be beneficial, and were unlikely to have attended otherwise.

Where DMP was used in the treatment of women with breast cancer (Dibbell-Hope, 2000) the objective data differed strikingly from the qualitative data. The quantitative data indicated few changes in mood and distress of patients and none in body image and self-esteem, whereas the subjective data marked improvement in body image and self-esteem but less in mood and distress. In contrast, in the BMA study, the

examination of qualitative data showed coherent results both within that analysis and when compared with the quantitative analysis. Both, post-intervention and follow-up interviews reflected the positive outcome of the objective measures.

A study from China which investigated the effect of DMP on cancer patients (Ho, 2005) did not specifically address the problem of self-esteem. But, very similar to participants' comments in the BMA intervention, all participants reported the program was helpful.

'They felt relaxed, comfortable, happy and released. Some participants claimed to be able to get in touch with their inner world and felt the connections between mind, body and spirit' (Ho, 2005:337-345).

Furthermore, it became evident in the Chinese study that patients could benefit from strong group cohesion and relationships with each other. This, too, is coherent with the current study's result.

Ho had to face patients' reluctance and shyness about dancing and moving freely at the beginning of the programme, since in China dancing and moving in front of others can be seen as culturally inappropriate. Although this was a cultural issue, in the BMA intervention the facilitator was confronted with the same fear and feelings of embarrassment in their participants. Nevertheless, due to a very sensitive proceeding by the facilitators the Chinese and the European patients were able to open themselves. Ho states "by the fifth session, all participants could dance spontaneously and on their own in front of others." (Ho, 2005:337-345).



This example demonstrates the importance of the role of a competent facilitator who has to provide guidance and structure, but also needs to respond sensitively to needs and fears of participants. Security and a sense of feeling comfortable (Payne 2001) are necessary to support a positive group process. Participants from the BMA study clearly stated that exactly that kind of positive support was given by their group facilitator. She was seen by them as a “leader”, “nurturer” and “catalyst” which enabled patients to open to the therapeutic process and helped them to gain relevant insights.

In a different but related DMP study with fibromyalgia patients (Bojner-Horwitz et al., 2003) the investigation focused on changes in stress-related hormones and patients’ perception on their own mobility, movement pain and life energy via video-feedback. In contrast to a control group, it was found that the treatment group showed improvement in life energy, mobility and movement pain. Yet, the fact that the levels of some stress-indicating hormones were slightly increased in the treatment group led researchers to the conclusion that DMP can trigger unconscious processes that may cause anxiety. It seemed that for that particular study six months of treatment and eight months of follow-up had not been enough time to process problematic issues and to develop completely satisfying coping strategies. However, in a shorter duration study, participants from the pilot BMA study reported that they had developed coping strategies. They had learned how to avoid stressful situations which had previously triggered certain symptoms. Some of them had made major shifts in their lives. Also, they were able to apply relaxation techniques which had been introduced to them in the learning group.

## **Conclusions**

Further research is indicated from the outcomes of this study, although it would need to be with a control cohort. The findings so far are considerable though. It appears from this study for this population, that the BMA intervention was responsible for noteworthy change in: lifestyle; symptom and stress management and self understanding manifested in stability, a reduction in, or the complete disappearance of: GP visits; medication; bodily/psychological symptoms and an increase in an overall sense of wellbeing.

In summary, the research systematically evaluated participants' experiences of group BMA as a 12 week intervention for those suffering MUS with anxiety or depression over six months duration. The participants' reported benefits at post intervention and at a three month follow up which were significantly supported by the outcome measurements from the standardised tests used. Both participants and facilitator noted similar experiences of the process, consequently we can be guided by the model used for the intervention approach in this study, implementing a similar model in the planned future research project.

This finding leads to the approach being considered for a double blind, randomised partial control trial (RCT) with a larger sample and in a wider locality. Although there was a three month follow up, in the next study it is recommended to increase the frequency of, and extend the follow up to provide even more substantially significant data.

A RCT would be appropriate as a next step at this stage in the development of the research because there is a possibility that the placebo/Hawthorne effect (Adair, 1984; Gillespie, 1991) might have been present in this within-subject design. This is where the participants gain short term benefits which may be due to being engaged with an interesting, unusual and extra intervention resulting in motivational and self esteem effects. In other words by simply being involved benefits are gained. Therefore, although the seeds of the positive outcomes have been sown in this methodology it is necessary to control for the Hawthorne effect by adopting a treatment as usual cohort to provide unambiguous information about findings.

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