

Submitted to E-Motion (quarterly newsletter ADMPUK)

Psychosomatic Conditions in Primary Care: Change within the Moving Bodymind

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December 2009

Introduction:

This is a short report on the outcomes of a pilot study (2005-2008). Full details of the study can be found in the publications listed below.

Research question:

Do patients from GP surgeries suffering psychosomatic conditions (otherwise termed somatoform disorder/medically unexplained symptoms) perceive an improvement in their quality of life, in relation to the perception and management of their symptoms, following a group intervention termed the BodyMind Approach which traces the connection between physical symptoms and emotional experience?

Achievements in terms of objectives of the investigation:

1. A pilot study, based in primary care, was undertaken within a collaborative approach, in order to examine the experiences of patients living with chronic psychosomatic conditions as reported by them before and following participation in a 12 week, two hourly intervention entitled 'A Learning Group: the BodyMind Approach'. It was thought this title may be more accessible and reflect the nature and purpose of the group in that it might encourage self understanding from a personal development perspective as well as by witnessing others in the group. These patients will rarely access psychological therapies e.g. CBT and counselling which do not seem able to address the bodily nature of their condition sufficiently. In a supportive group environment patients learned alongside their peers where sharing was encouraged. The intervention itself, and its title, was evaluated from both patient and therapist perspectives.
2. The investigation team collaborated with WelHat Counselling Service and primary care practitioners in setting up the research intervention and in particular evaluating the referral procedure. The inquiry embraced user-involvement (the steering committee had one member from PIP) as well as collaboration with the counselling, GP and other referring services. Full LREC and local PCT ethical approval was obtained.
3. The pilot delivered a number of groups to eligible patients (those who met the inclusion/exclusion criteria). The groups had the overall aim of providing a supportive context for patients to explore their experience of their symptoms by focusing on the bodily symptom, the inner natural movement arising from it, and to form links between this unconscious process, life experience, current psychosocial situations and their bodily and emotional experience.

4. The perceived effects of the groups on participants in terms of coping strategies to manage their symptoms within the wider social context included increase in wellbeing, decrease in anxiety/depression and substantially reduced distress from their symptoms.
5. New coping strategies derived from an understanding of their bodily symptom as an expression of an underlying conflict or dys-ease. An increase in body/self awareness led to a reduction in symptoms, and an increase in the capacity to relax appeared to result in the reduction of anxiety and a greater sense of well-being.
6. Patients with generic rather than specific symptoms appeared to benefit across the age ranges without variation.
7. It was seen by patients to be a helpful, supportive model of treatment giving them and their GPs an alternative to traditional approaches, such as medication prescription and frequent visits to the GP and/or secondary care consultations. Many patients thought the Learning Groups might be helpful to patients with explained physical symptoms.
8. An evaluation of the referral process from primary care to the Learning Groups resulted in the patients seeing the intervention as non-stigmatizing and the referrers seeing it as a psycho-educational approach and requiring GPs to be kept in the loop.
9. The identifiable difficulties in the setting up of the Learning Groups in a PCT included GPs failing to refer sufficient chronic patients. As a result pharmacies and counsellors made several referrals. Another difficulty was in motivating GPs to make use of the group approach for patients since they appeared to believe patients would prefer one to one approaches. It was a contrasting experience in fact for the participating patients who seemed to think the group was particularly crucial to the approach and to helping them.

By focussing on the body through natural movement, links were made between the symptoms, unconscious, life experience, psychosocial situations and emotions.

The objectives of the study were therefore fully met and more, both at the end of treatment phase (week 13) and at a three month follow up.

Outcomes:

It is thought patients' cognitive understanding that the bodily symptom may be an expression of an underlying social or emotional conflict led to the following as induced from a thematic analysis of qualitative, semi structured interviews and as measured on self reporting, standardised and validated instruments:

- better coping strategies
- a reduction in symptoms
- a reduction in anxiety
- an increase in well being
- an increase in activity (eg returning to work/study)
- a reduction of GP consultations

- a reduction or stabilisation of medication usage
- a reduction in secondary referral care

Unexpectedly, symptom distress reduced considerably to a moderate –strong effect statistically which may have reflected a change in perception of their medically unexplained symptoms.

Patients gained a better understanding of their symptom and how it related to them intrapsychically and in their social setting. Attitudes towards symptoms changed together with an increased self-confidence resulting in a healthier self-image and re-associating positively with their bodies.

The research's relevance to GP practices in WelHat, and eventually practices throughout Hertfordshire, offers GPs an opportunity to refer these patients, who are known to be difficult to treat and often termed 'heart sink', resulting in less time for GPs working directly with these patients and less prescription medication/secondary care referrals.

The outcomes of the study are therefore very relevant for GP practices which each have to deal with over 30% of patients with intractable problems where there is no organic medical explanation and a resistance to traditional 'talking' psychological therapies due to the associated stigma. The BodyMind Approach has a large potential for not only offering relevant treatment for this group of patients, but also considerable potential savings in GP practice resources.

The addition of a new treatment with an evidence-base for its effectiveness will increase the number and breadth of treatments for this 'difficult to treat', chronic, patient group, bringing a range of opportunities for treatment.

The study is based on small numbers (N=24) and the methodology is not easily generalised to large populations. However, the inclusion of a number of Health Professionals, including GPs in the referral process, and in the study's evaluation/presentation of outcomes will mean that a good understanding of how this kind of intervention can be included within the context of the Health Service has been gained.

There is now sufficient preliminary data to support the cost of a large scale phase II clinical trial for this treatment. Consequently the experience of running this small pilot trail has been valuable in informing the development of a larger two armed trial for which an application to NIHR has been made.

A manual has been developed from the analysis identifying facilitation competencies within the treatment approach, rather than a step-by-step methodology/recipe since every group will interact differently with each facilitator and the approach is not designed to be objective. The facilitator's process recordings from each group were comparatively analysed against the patients' perceptions of the process and very few differences were found. Consequently, we can be confident that, with facilitators holding the correct pre-requisite qualifications, the outcomes for each subsequent group will be similar.

A market research feasibility study provided an excellent indication of the numbers and willingness of GPs, counsellors and psychotherapist in the PCT to become involved in helping to set up the approach across Hertfordshire¹.

In addition, linked to this study a cost effectiveness study was undertaken to generate a model for estimating the savings made in each GP practice based on the quantitative study outcomes².

Benefits to Hertfordshire:

1. The provision of a specialised treatment group for patients with medically unexplained symptoms/functional somatoform disorder/psychosomatic conditions.
2. A more developed evidence-base for the use of the alternative supportive treatment at the primary-community care interface.
3. An enlargement of non-stigmatizing treatment services in WelHat.
4. A specialised, innovative treatment approach using the body as the primary avenue for change which is practice-led and responsive to government guidelines.
5. Savings for treating this patient population in terms of reduced GP consultations/medication usage/secondary referrals allowing for more time to be devoted to patients with organic conditions.

Dissemination:

All GP surgeries and other involved health professionals were invited to attend a presentation of findings and, in addition, offered a presentation at their weekly practice meeting during 2008.

The extent of health professionals involved in the study provides opportunities for them to be directly involved in informing the development of service delivery in this area, and through their own professional bodies.

Commissioners have expressed an interest in taking the treatment forward for patients in early 2010 in North and West/East Herts PCT.

All participants were sent copies of their interview transcriptions to audit and an overview of the findings. Some have indicated they would be willing to sit on a steering committee should funding be granted for a randomized controlled trial.

Short up skilling training courses at the University of Hertfordshire have already been undertaken for those qualified to learn the approach and more are planned for the 2010. Facilitators (and assistants) will be required once the approach is rolled out across the PCT³.

¹ Payne, H; Eskioglou, M and Storey, J (2008) Medically unexplained symptoms: a holistic bodymind approach to group therapy for depression and anxiety in primary care. Unpublished report. Project supported by a grant from the East of England Development Agency.

² Payne, H and Fordham R (2008) **A Group BodyMind Approach to Medically Unexplained Symptoms: Proof of concept and potential cost savings**. Unpublished report. Study funded by University of Hertfordshire and the East of England Development Agency.

Publications:

During 2008-9 there has been collaboration (including with a service user) for the writing of some papers. In particular an article was produced with the statistician involved in the analysis of the quantitative data.

Articles have been produced and accepted for publication in the following journals:

Payne, H (2009) Medically unexplained conditions and the BodyMind Approach. *Counselling in Primary Care Review*. 10, 1, 6-8.

Payne, H (2009) The BodyMind Approach to psychotherapeutic groupwork with patients with medically unexplained symptoms: a review of the literature, description of approach and methodology selected for a pilot study. *European Journal for Counselling & Psychotherapy*. 11, 3.

Payne H. (2009) Pilot study to evaluate Movement Psychotherapy (the BodyMind Approach) with patients with medically unexplained symptoms: participant and facilitator perceptions and a summary discussion. *International Journal for Body, Movement & Dance in Psychotherapy*. 5, 2, 132-157.

Payne H & Stott D. (2009 on line) Change in the moving bodymind: Quantitative results from a pilot study on the BodyMind Approach (BMA) to groupwork for patients with medically unexplained symptoms (MUS). *Counselling and Psychotherapy Research*. In Print March 2010.

It is anticipated a book will be published in 2010 by Taylor and Francis illustrating the findings of the study and a manual for the approach.

Conferences:

Payne, H (2008) **Invited Keynote:** Dance Movement Psychotherapy as an evolving profession: its application in the health service. *Conference proceedings: Fourth International Congress on Psychomotricity, Amsterdam*.

Payne, H (2009) Medically unexplained symptoms and a BodyMind Approach in primary care: results and findings from a pilot study. *Tenth European Consortium on Arts Therapies Education, London*.

Payne, H (2009) **Invited Keynote:** 'Medical Research in Dance Movement Psychotherapy' launch of *International Centre for Research in the Arts Therapies, Imperial College Medical School, London*.

³ For dates of training courses please contact Professor Helen Payne H.L.Payne@herts.ac.uk in the first instance.

*Another **invited keynote** on the findings has been accepted at the European Congress for Body Psychotherapy, Vienna, June, 2010*

Acknowledgements:

Thanks to all the participants in the study and to the Steering Committee - Jeni Boyd, Sabine Fichter, Margot Holmes-Smith, Hannah Murdoch, Dr David Stott and Dr David Wellsted all from the University of Hertfordshire and to Sarah Webb - WelHat Counselling Service. Appreciations for the funding for this project go to the University of Hertfordshire, School of Social, Community and Health Studies.

For further details and dates of training courses please contact Professor Helen Payne, PhD, UKCP, SDMP, Fellow ADMPUK, at: H.L.Payne@herts.ac.uk in the first instance.