

**Change in the moving bodymind: Quantitative results from a pilot
study on the use of the bodymind approach (BMA) to
psychotherapeutic groupwork with patients with medically
unexplained symptoms (MUS)**

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Abstract

This paper reports quantitative results from a pilot study in primary care (PC) undertaken from 2004-2007. The intervention programme, derived from movement psychotherapy was termed ‘Learning groups: the bodymind approach,’ and emphasized a verbal and non-verbal integrated model, awareness of the inter-relationship between body and mind and a self-managing framework. Founded on the principle that bodily experience can be an avenue for meaning-making it uses metaphor and symbolism.

Aim: To systematically evaluate the outcomes of a 12-week group BMA intervention programme with patients suffering from anxiety/depression with at least one chronic (over two years) MUS.

Methodology: To answer the research questions a mixed methodology in a single case design was employed. Outcome measures completed at baseline, mid, post intervention and three month follow up were: ‘Measure Yourself Medical Outcome Profile’ (MYMOP) and ‘Counselling Outcome Routine Evaluation’ (CORE). T tests (two sided) were used to analyse and compare the two measures.

Results: These were surprising: increased activity levels and wellbeing, more effective coping/functioning strategies, reduction in anxiety/depression, GP

consultation and medication usage and in symptom distress. All maintained at three month follow up.

Keywords: quantitative results, pilot study, medically unexplained symptoms, bodymind approach, wellbeing, anxiety/depression.

Background

At least half of all primary care (PC) mental health consultations are for MUS (Hague 2005a and b). Similarly, in the USA half of all GP consultations concern bodily symptoms (Schapper 1992), and at least one third of these somatic symptoms are medically unexplained (Hartz et al 2000).

Kroenke et al (2002:258) define somatization as ‘the association of medically unexplained somatic symptoms with psychological distress and health-seeking behavior’. These symptoms are present in at least 10% to 15% of primary care patients (Escobar 1998; Hartz et al 2000; Kroenke et al 2002).

MUS, together with depression and anxiety constitute the three most common mental health problems seen in PC (Spitzer et al 1994; Ormel et al 1994; Kroenke 2000). However, Spitzer found that one third of these patients present with solely a bodily medically unexplained symptom. Studies of MUS show that between 20% and 30% of those seen in PC have no clear diagnosis. In secondary care, this rises to an average of 52% (Nimnuan, Hotopf & Wessely 2001). Some estimates place the cost of these cases at an average of £955 (Reid et al 2002) per annum.

The Department of Health (2008:6) states:

Despite the prevalence of depression and anxiety disorders and the fact that mental health problems account for nearly 40% of people on incapacity benefit and a third of

all GPs' time, only a third of people with diagnosable depression and less than a quarter of those with anxiety disorders are in treatment.

Those with mental illness experience a severe lack of quality of life which is closely linked to self-esteem, self-efficacy and social interacting (Murphy & Murphy 2006). A Dutch study showed patients with MUS had significant psychological distress, high levels of medication and poor quality of life (Koch et al, 2007). General wellbeing (which this pilot study evaluated), as a manifestation of satisfaction with quality of life is an essential outcome measurement to monitor with this patient group.

It is important that health professionals recognise that mental health influences physical disease since the two are intimately related. Yet there is a separate mental health and a physical health system within the NHS perpetuating the split in the person between mind and body. Many patients with anxiety or depression problems present only physical symptoms to their GPs (referred to as MUS, psychosomatic or somatoform symptoms), often due to the stigma of disclosing a mental health problem and/or their explanation of an organic cause.

Regarding the efficacy of treatment for somatoform disorders, Kroenke (2007) stated in his review of randomized controlled trials that CBT seemed to be the best established treatment for somatoform disorders. Sumathipala et al (2007) agreed, although mentions most trials assessed had only short-term outcomes. Morley et al (1999) made a meta-analysis of 25 randomized controlled trials of CBT for chronic pain in adults and concluded that CBT was very effective in the short term. For the treatment of chronic, generalised MUSs there are few studies, although for specific

syndromes CBT was found to be successful for fatigue, irritable bowel syndrome, and fibromyalgia (Kroenke 2000). In the same systematic review CBT for somatoform disorders mostly demonstrate the success of those treatments, but effects are often smaller than for the superior evaluated, specific disorders. In 20/28 studies reviewed physical symptoms significantly improved, although just 10 reported noteworthy improvement in psychological distress and only 9 in function.

RCTs (N=34) reviewed on psychosocial treatments of somatisation disorder were unable to draw clear conclusions (Allen et al 2002). Kroenke (2007) however, identified two non-CBT psychotherapy trials which showed methodological problems, such as selection bias and noting “many such patients seen in clinical practice may refuse referral...may be less likely to enrol in studies” (p. 887). In a recent meta-review (Ruddy and House 2007) aiming to discover high-quality systematic reviews for all interventions in three distinct areas of liaison psychiatry concluded that the practice in MUS is not based on high quality evidence.

Chronic (i.e. more than six months) MUS conditions are difficult to treat although most patients have a relatively good prognosis (Khan et al 2003). The chronic population often display rigid conceptualizations of their illness as fundamentally physical but yet to be diagnosed. Consequently, despite availability of effective treatments for some specific disorders, most authors refer to a need for the development of new and more effective intervention strategies for the treatment of chronic/persistent somatoform disorders and corresponding research initiatives.

Body oriented psychotherapies have been effective in different populations and settings (Loew et al 2006; Rohricht 2000). Their proof of concept in treating psychosomatic and specific somatoform disorders has been established in a number of clinical trials. Nickel et al (2006) in an RCT using bioenergetics for in-patients with chronic somatoform disorder, demonstrated its effectiveness on somatisation, depression and anxiety scores. Functional relaxation was found to be effective in the treatment of asthma, IBS and fibromyalgia, compared with treatment as usual and pretence conditions (e.g. isotonic exercises) in several summarised RCT trials (Loew et al 2006, Rohricht 2009). A positive effect was demonstrated on subjective functional impairment scores and somatic symptoms such as somatoform pain.

The lack of long term evidence-based studies on DMP/body oriented psychotherapy, which could be compared to the unquestioned positive short term outcomes of CBT trials, results in a marginalization when patients could clearly benefit from choice between CBT and integrative approaches such as BMA within the NHS.

In a different but related DMT 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, it was found that the treatment group cohort perceived an improvement in life energy, mobility and movement pain.

In other studies Yoga appeared promising for depression (Shapiro et al., 2007), Tai Chi reduced mental and emotional stress (Jin, 1991) and Qigong ameliorated symptoms of chronic fatigue (Craske et al., 2007). Movement therapy/exercise used in

treatments with depressed inpatients had a positive effect on mood (Stewart et al., 2004; Blumenthal et al, 2007). Mindfulness meditation appears to decrease levels of depression, anxiety and overall psychological distress (Kostanski & Hassed, 2008).

Individual drama and movement therapy showed positive effects in a case study of two adolescent girls suffering from medically unexplained chronic pain (Christie et al., 2006). Case studies of DMT and psychosomatic symptoms describe the clients' journey (Silberman-Deihl and Komisaruk, 1985; Hoer 1988; Horwitz et al 2003).

These articles suggest outcomes such as: decrease in anxiety and use of medication; increase in psychological insight; decrease in bodily symptoms; improvement in the perception of the symptom in the healing process, all which have clinical implications for practice.

Body-based combined approaches to groupwork have been used as well, with encouraging results. Jin (1992) combined cognitive and mindful practice with exercise; Mueller-Braunschweig (1998) used body-related psychotherapy, Keel et al (1998) integrative group therapy with body relaxation and Creamer (1999) combined exercise, drugs and CBT to some effect.

Hadhazy et al (2000) systematically examined studies of mind-body therapies for the treatment of fibromyalgia with positive outcomes. Massage (Browlee and Dattilo, 2002); meditation (Majumdar et al 2002 and Bonadonna, 2003); and Tai Chi (Taggart et al 2003) all make claims to relieve MUS and warrant further investigationⁱ.

Group DMT/P has been used successfully for treating patients with psychosomatic disorders in Sweden (Thulin 1997). The study presented here is, however, to the authors' knowledge, the first systematic one of its kind in the UK although builds on an earlier UK qualitative pilot study (Chrysou 1999) using DMT with six patients in a 27 week supportive group in PC with a different but closely related population (those with medically explained physical pain).

The BMA intervention

The BMA intervention derives from movement psychotherapy (MP), also known globally as dance movement therapy (DMT) and more recently in the UK as dance movement psychotherapy (DMP). This form of psychotherapy is founded on an inter-relationship between feeling, body and mind (Winnicott 1984; Csordas 1994; Sachse 1998; Cozolino 2003; Eisentein 2004; Damasio 1994 and 2003; Gallese 2004; Panskepp 2006a and 2006b; Zalidis 2007; Pies 2007). Sometimes considered as a form of body oriented psychotherapy, DMT/P is waiting for parliamentary time to confirm state regulation with the Health Professions Council in 2010, in line with the other arts psychotherapies (music, drama and art).

DMT/P is a hybrid. It uses natural gestural/postural body language combined with words in a psychotherapeutic relationship. As such it may have an implicit advantage over solely talking or non verbal/body-based interventions. It can approach 'dys-ease' from a unique holistic bodymind perspective (Berrol 1992; Stanton-Jones 1992). The emphasis here is on the connectivity between physicality, feelings, thoughts, beliefs, symbolic non-verbal, verbal and imaginative aspects of the psychotherapeutic process. As an integrated approach, it is unlike therapies with a symptom-eradicating

focus. Instead it works with, and through, the distress/dys-ease of the symptom to encourage re-association with the body through the client therapist relationship.

BMA explores physical symptomatology through symbolic movement using aspects of Authentic Movement from the spectrum of approaches within DMT/P (Whitehouse 1979; Bernstein 1983; Chodorow 1991; Adler 2002; Pallero 2003, 2006; Payne 2006).

Hence, in considering the literature it was thought that BMA, which emphasises the therapeutic relationship as central, values body and mind unity and stresses the use of words and non verbal bodily language in a supportive group, might be beneficial to this population. That is, working with reflection/storytelling and action/ physicality in somatic awareness/spontaneous movement from natural body language as a symbolic process (with the symptom in mind) within a therapeutic relationship. Feelings and thoughts are integrated in an imaginative/creative framework located in the body first and foremost to give individual meaning-making leading to understanding and behavioural change.

The therapeutic goals of this BMA study included promoting change in perception of bodily symptoms; meaning-making/self-understanding (for example, making links between feelings, re-connecting with the body-self, lifestyle and symptoms); reduction in anxiety/depression, increased wellbeing and capacity to self-heal with a focus on self-management rather than over reliance on medical cures/medication.

Thus the psychotherapeutic theory underpinning the BMA is integrative (i.e. drawing upon behavioural, humanistic and analytical psychologies together with group

analysis). Behavioural since the prescribed exercises and processes, directed by a highly trained facilitator with specific aptitudes and skills, aim to promote a change in perception, which in turn, it is hoped, will lead to a change in thinking and resultant behaviour. Humanistic experiential psychotherapy puts the patient at the centre of the therapeutic process (as the experts on the experience of their own symptoms), emphasising empathy, congruence and non judgemental attitudes of mind and intersubjectivity. Although psychodynamic interpretations might be made by the facilitator they are stated as owned by her and taken on board, or not, by the participant. The safety and cohesion derived from interpretations, as in group analytic practice, is crucial for developing a containing, trusting, supportive ethos whereby each participant can learn from/be challenged by each other and place their own stories in the context of others. Themes evolve and are commented upon as though the group were an individual. Enacting roles of ‘witness’ and ‘mover’ from the discipline of Authentic Movement in a dyad as well as in a collective would not be possible without safety. Groups provide support and interaction between facilitator and participants, and between participants themselves. When skilfully facilitated groups can be another source of healing. Somatic awareness, relaxation, breathing and massage techniques aimed to increase connection with, and change, the perception of the body-felt sense. A journal was provided to each participant in order to facilitate reflections on their narrative during and between sessions.

In order to give the message sessions were concerned with personal learning/understanding through, and of, their symptoms the programme was termed ‘Learning groups – the bodymind approach’ and stressed valuing the body symptom rather than dismissing it as ‘all in the mind’. This, and the venue being in a

community centre, helped participants to self refer and access the intervention especially for those resistant to mental health explanations, psychological therapies and/or the associated stigma.

BMA appears to be cost effective, when assessing costs against outcomes (Payne and Fordham 2009). And delivered as a group rather than individual format such as with Cognitive Behavioural Therapy (CBT) (one to four sessions), individual focused psychological interventions (six sessions of counselling) or brief (12-20 sessions) psychodynamic psychotherapy for chronic pain sufferers (Bassett 1985) it may be more supportive for patients and cost saving for the NHS.

Methodology

Ethical considerations were central from the outset. These included, for example, aims and plan of investigation, evidence of relevance and benefits to service delivery, informed consent, avoidance of harm, recruitment/referral, allocation procedures, confidentiality/annonymisation personal details, data capture tools, patient information sheet/flyers, adverse effects, roles of facilitator/research assistant/principal investigator, briefing procedures for medics and other relevant health professionals (including counsellors), communication of transcriptions/findings to participants, dissemination, justification for sample size, and inclusion/exclusion criteria and any amendments required.

Prior to being undertaken a detailed submission of the study addressing all the above ethical matters was provided to the NHS Local Regulatory and Ethics Committee (LREC) and received full approval. Monitoring took place during and after the study by the Hertfordshire Research, Management and Governance Committee.

This study adopted a mixed methodological approach (Cooper and McLeod 2007) and as described in DMT research by Berrol (2005), using semi-structured interviews (rather than standardised diagnostic interviews) in order to be fully responsive to the participant for the collection of qualitative data. Validated, standardised, outcome measures were employed however for collecting the quantitative data reported here. This research combined aspects from these two approaches adding depth, validity and relevance derived from the subjective experience of participants, and breadth and objectivity harvested from the validated outcome measures. Thus a small number of participants was most appropriate for such an in-depth methodology. Accordingly it was a within-subjects repeated design, triangulating the analysis from outcome measures, semi structured interview themes and facilitator's process recordings. As well as baseline, mid and post intervention measurements it is also useful to include a follow-up to see what, if any, longer-term effects of the intervention are experienced. Three months from week 13 is not too long for the clients to forget the experience nor too short for the symptom/dys-ease to have returned (if it has disappeared/reduced) to pre-intervention state.

Recruitment of research participants

Participants were recruited using a flyer distributed by health professionals (such as GPs, practice nurses, psychologists or counsellors) in PC practices and by community pharmacists. In line with the ethics procedures all professionals were provided with a detailed overview of the project in a presentation and the referral criteria handout. They then selected appropriate patients to whom to give a flyer. Some participants may have seen notices in the community health centres or GP surgery. All participants self referred, being a first step in taking responsibility for their own health. GPs were

not contacted unless the participant requested. Follow up individual interviews discussed closure, any need to return to their GP and information on supportive avenues for the future.

Out of total 31 referrals, seven withdrew before the programme even started (could not commit due to work (N=3) and caring responsibilities (N=4), six withdrew (N=3 moved away; N=3 ill) after the commencement and 18 completed the programme. In the current study model, instead of one group of six for 27 weeks (Chrysou 1999) there were four groups with four to seven participants for 12 weeks since the intervention is designed in four parts comprising four sessions per part (each session was two hours). Groups had participants with varying ailments. A total of 18 participants out of 24 completed the study. This number of participants provided for more breadth and possibility of internal reliability for any changes in scores on the outcome measures at baseline, mid/post-intervention and follow up.

Inclusion/exclusion criteria

Inclusion targetted those with anxiety or depression with an accompanying MUS (such as irritable bowel syndrome (IBS), panic attacks, chest/abdominal pain, headaches, skin problems, breathing difficulties, joint/muscular pain, lack of vitality). Symptoms needed to be present for at least two years duration, (i.e. chronic) with no known organic cause.

Exclusions were those with a recent (within the previous six months) bereavement or trauma, those diagnosed with substance abuse, dementia, severe personality disorder or psychosis/bi polar disorder, who had been under a consultant psychiatrist in the previous six months and those with an eating disorder or a learning disability.

Data collection tools

The participants completed CORE-OMⁱⁱ questionnaire (Barkham, et al 2001) and MYMOPⁱⁱⁱ (Paterson 1996; Evans et al 2002) at baseline, before entering one of four groups. MYMOP is a symptom focussed, patient generated instrument for measuring outcomes. It concentrates and works with the symptom rather than trying to eradicate or medicate it.

The CORE-OM outcome measurements are derived from 34 statements, each measured on a 5-point frequency scale (0 = Not at all, and 4 = Most of the time). In addition to an All-item score the CORE-OM responses are also used to derive four separate scores for the dimensions of Well-being, Social Functioning, Problems/symptoms and Risk. CORE enables researchers to make comparisons to normative data collected from clinical and non-clinical populations. Because it is extensively used in PC and in counselling agencies in the UK, and results fed back to a central database, there is an added facility of being able to use this as a reference point or benchmark when interpreting data.

The MYMOP instrument requires the participant to specify at least one particular Symptom and one particular Activity which this symptom prevents them from undertaking. Participants rate their responses at baseline and subsequent interviews on a 7-point scale where 0 = “As good as it could be” and 6 = “As bad as it could be”. Additional questions on general Wellbeing and Coping strategies are similarly scaled.

These instruments were administered by a research assistant at baseline, mid intervention-week six (MYMOP only), post-intervention and at a three month follow up.

Participants

Participants (N = 18) were predominantly female (15 female, 3 males). Ages ranged from 21 to 81 with a median age of 48 and an inter-quartile range of 34 to 54 years.

The pattern of symptoms presented through MYMOP at the outset was as follows: Anxiety and/or depression with accompanying bodily symptoms such as headaches; IBS; chest/abdominal/back pain; balance problem; lack of concentration; nausea; tinnitus; vertigo; ‘frozen’ breath (held-in, unable to breath out); prostate pain; lack of vitality; chronic fatigue; joint/muscular aches

Activities participants thought were limited due to these symptoms included being unable to: cope with stressful situations (get anxious, aggressive); work/study; leave the house (no motivation, lethargy); sit comfortably; drive; do household chores; sleep; keep to a balanced diet; maintain a relationship; socialise.

Participants’ individual strategies to cope with the symptoms included: resting/sleeping; receiving massage; ‘distraction’ activities; quilting; TV; making cards; horse riding; play-station; patch-work; listening to music; dancing; osteopathy; taking a hot bath; acupuncture; medication; using special chairs to cope with pain.

Statistical Methods

The data derived from the CORE-OM questionnaire were analysed using published CORE-OM methods. Mean values were calculated for each of the four subscales (Wellbeing; Problems; Function; Risk) and also for “All non-risk” and “All items” at baseline, post intervention and three months follow up. Means were calculated for the three MYMOP scales (Symptom 1, Activity and Wellbeing) for all patients at baseline, mid-intervention, post intervention and follow up. Only participants who completed the intervention are included in the analysis. The significance of change from baseline to follow up is assessed using paired t tests. Correlation between the various CORE-OM and MYMOP scales at baseline are assessed with Pearson’s correlation. Correlation between changes from baseline to follow up across the various scales was similarly assessed. Data was entered in EXCEL and analysis undertaken using SPSS Version 14.

Results

Mean change (95% CI) from baseline to follow up for CORE-OM and MYMOP subscales from baseline to follow up are stated in Table 1. The results of the paired t tests and estimates of the effect size r (Rosnow & Rosenthal 2005) are also stated.

Table 1 here

CORE-OM

The trends in mean values for the four CORE-OM subscales (Wellbeing; Problems; Function; Risk) are presented in Figure 1. Across the Wellbeing, Problems and Function subscales there was a consistent fall in mean scores of around 0.5 to 0.75 points from baseline to three month follow up. The corresponding values for Risk changed little, but that is a reflection of the low level of CORE-OM baseline scores

for this dimension (mean of 0.27 at baseline). With the exception of Risk, the effect sizes are all greater than the accepted benchmark of 0.5 for large effects (Table 1).

Figues 1 here

In Table 2 the six severity levels used by the CORE-OM indicators to categorise initial and subsequent severity have been reduced to three broad bands given the small size of the sample ($n = 17$ at follow up). It is clear that only one of the 17 moved to a higher “broad” severity band compared with seven who shifted into a lower band. The trends evident in mean change for the whole group of participants are reflected at the individual scale.

Table 2 here

MYMOP

The results of the MYMOP monitoring over four time periods reveal the same evidence of consistent falls in the mean scores for each MYMOP scale (Figure 2). Mean scores for Symptom 1, Activity and Wellbeing fell by between 1.7 to 2.1 points on a six point scale from baseline score to follow-up (Table 1). The results for the smaller numbers who reported a Symptom 2 are also consistent. The results of paired t tests were highly significant and all effect sizes exceeded the benchmark of 0.5 for large effects (Table 1).

Figure 2 here

The trends in MYMOP scores from baseline to follow up for each participant are indicated in Figure 3.

Figure 3 here

Potential confounding: age and gender

We examined the data for evidence of age/gender effects. We noted that the rank correlation between age in years and change in selected key outcomes measurements (CORE all non-risk, and the three MYMOP scales) were consistently weak with r coefficients between 0.26 and -0.26. With only three males in the study it is a problem to assess any gender effect but again we noted that the mean reduction in CORE all non-risk was 0.75 for males and 0.61 for females, while the mean fall in the three principal MYMOP scales ranged from 1.7 to 2.7 among the males and 1.7 to 2.0 among the females.

Correlation within and between CORE-OM and MYMOP scales

The four subscales of the CORE-OM assessment correlated to a high level at baseline. Inter-correlation at baseline between the three elements of the MYMOP assessment (Symptom 1, Activity and Wellbeing) is much lower and not significant. Nor is there much evidence among this sample of correlation at baseline between MYMOP and CORE-OM scores (Table 3).

Changes from baseline to follow-up correlate quite strongly and significantly within the CORE-OM subscales while this does not appear to be the case among the MYMOP elements (Table 4). Changes in elements of the CORE-OM scale do not appear to be strongly associated with any changes in the MYMOP elements.

Table 3 here

Table 4 here

Discussion

In both MYMOP and CORE-OM it seems evident that significant mean changes for the whole sample reflect downward trends for the majority of participants. These results suggest that there was significant reduction in perceived symptom distress for the total cohort from baseline to follow up. It can be inferred from this that participants had relief from their symptoms and an increased sense of wellbeing, supported by the qualitative data analysis (Payne 2009a; 2009b; 2009c; 2009d).

Changes in elements of the CORE-OM scales did not appear to be strongly associated with any changes in the MYMOP elements. It is worth noting that our study cohort appears somewhat atypical compared with other clinical groups among whom CORE-OM has been used as an outcome measure. Six out of 18 (33%) patients had “All Item” mean scores of less than 1 at baseline compared with 12.5% in the CORE National Research Database 2007. At follow up 10 out of 17 recorded “All Item” mean scores <1. Nine of the 18 scores for “Risk” at baseline were zero rising to 12 out of 17 at follow up. Thus while CORE-OM addresses important variation in psychological distress it may be less appropriate for use among a ‘mild to moderately anxious/depressed population’. The research team will evaluate the suitability the CORE-OM for the second phase of the research.

It would seem reasonable, given the sensitivity of MYMOP, to employ this tool again for gathering data in phase two of the research. This instrument seems to offer a multi-dimensional enquiry into patients changing response to their medical condition over time. Moreover changes in Symptoms do not necessarily correlate with changes in

Activity or Wellbeing scores. MYMOP seems to be capable of reflecting different dimensions of change.

This study bears out the indication in the literature that integrating non verbal and verbal approaches in therapeutic interventions for this population might be effective. By emphasising the body-felt sense from an experiential bodymind perspective, within a safe, supportive skilfully facilitated group, participants with MUS can benefit in terms of wellbeing and reduction in symptom perception^{iv}.

Patients with MUS in PC have been well researched. Jackson & Kroenke (2008) state these patients are less likely to experience symptom improvement, have higher utilization rates, significant functional impairment, are very difficult to treat and do not easily access psychological therapies often due to the associated stigma of mental health medical settings. The BMA conducted within a non stigmatizing environment appears to give easier access to benefits for patients with chronic bodily symptoms and accompanying mental health needs. As a result it may be this hard to reach group with MUS would consider participating in this sort of groupwork.

IBS, non-ulcer dyspepsia, fibromyalgia and chronic fatigue syndrome are often found to be related to depression and anxiety (Henningsen et al, 2000). Childhood sexual abuse links with chronic pain and gastrointestinal disorders (Nelson et al, 2006). Since it has been found that these patients have co-morbid mental health needs perhaps it is more socially acceptable to present with a variety of bodily symptoms than mental health ones. The BMA values the bodily symptom and enables understanding of symptoms by encouraging participation in a programme which does not solely

address mental health or physical health but a combination of both. The make-up of the bodymind groups in the study were generic i.e. patients in each group had numerous different symptoms yet feelings of stress, loss, fear etc were encountered by all. Once identified there was an opportunity to integrate these feelings to feel better in themselves. Participants learned about the body-mind connection and meaning-making (Kirmayer et al., 2004) such how a possible trigger manifested their breathing difficulties etc. Furthermore, it became evident that patients benefitted enormously from strong group cohesion, relationships with each other and the facilitator.

Consequently, there is definitely a clear need to support people to manage mental health needs which are stress-related medically unexplained conditions. BMA may go some way to fulfilling this need since it was found to have a significant impact on increasing wellbeing and reducing symptom distress, anxiety/depression, medication and GP visits. Participants felt that their quality of life was enhanced as a result^{iv}. There has since been a training course for experienced group facilitators as the local GPs and PCT have indicated they are interested to develop the approach for chronic patients at the primary-community interface.

Conclusions

It is concluded that from the analysis of the quantitative data that this intervention has much to offer this often termed ‘hard to reach’ patient population. The contribution to the field emphasises that an integrated approach using both verbal and non verbal psychotherapeutic techniques within a safe, learning group in a non stigmatising setting can be particularly helpful to this population. In the current climate in the NHS where the government’s emphasis is on ‘Improving Accessibility to Psychological

Therapies' (IAPT) within the UK Primary Care Enhanced Mental Health Teams, the BMA might be an appropriate treatment for consideration at the High Intensity level. Both the physical dys-tress and the mental dys-ease are addressed holistically in a treatment of choice for patients with mild to moderate anxiety or depression where there is a chronic medically unexplained bodily symptom presented. The participants' reported outcomes found it to have been helpful in a number of ways leading to the approach being considered for further research in a randomised control trial (RCT), with a larger sample, longer follow up and in a wider locality.

Limitations include the relatively small sample size, heterogeneity of the sample and lack of precision in terms standardized diagnostic interviews. A RCT would resolve some of these: a larger sample (N=120), a screening diagnostic questionnaire (such as Primary Health Questionnaire Revised 15) to ensure similar scores on referral, treatment as usual control and/or support group arms.

There is also a possibility that the Hawthorne effect (Adair, 1984; Gillespie 1991) might have been present, 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. Although there was a three month follow up, to reduce Hawthorne effects in the shorter term it is advisable to increase the frequency and duration of the follow up to perhaps six months from the end of the programme. This would provide even more substantially significant data validating even longer term outcomes in comparison with a non intervention 'control' cohort treated as usual.

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ENDNOTES

ⁱ A full literature review is available in Payne (2009b).

ⁱⁱ Counselling Outcomes Routine Evaluation (CORE) is the first standardised public-domain approach to audit, evaluation and outcome measurement for UK psychological therapy and counselling services. It was developed by the Psychological Therapies Research Centre, University of Leeds which co-ordinated it from 1995-1998 through a multi-disciplinary team of researchers and practitioners representing the major psychological therapy professions. <http://www.coreims.co.uk>

ⁱⁱⁱ Measure Your own Medical Profile (MYMOP) is a patient generated instrument for measuring outcomes developed by the Department of Social Medicine, University of Bristol and evaluated in NHS and complementary health care settings. Read on <http://www.coreims.co.uk/outcomecore.htm>, 7/10/04.

^{iv} Further findings from the qualitative data analysis can be found in Payne (2009a); Payne (2009b)and Payne (2009d) and a summary of the outcomes from both the quantitative and qualitative analyses can be found in Payne (2009c).