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Therapeutic processes and personalised care in body oriented psychological therapy for patients with Medically Unexplained Symptoms (MUS)

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Abstract

Background: Body oriented psychological therapy (BOPT) for patients with MUS is a new and innovative intervention offering patients an alternative way to engage with and manage their MUS symptoms as well as their emotional responses.

Methods: This paper is a qualitative report on a pilot study which took place in a primary care setting. Patients were offered 10 weekly sessions of BOPT in small groups.

Results: The qualitative findings suggest that (i) patients responded well to this treatment approach, (ii) they experienced their bodily realities in a more positive way and not just as a source of negativity or pain, (iii) they learnt to manage their symptoms more effectively and (iv) they began to understand the relationship between their bodily symptoms and their emotional state as well as the impact of the one on the other including very poignant themes such as loss and dislocation.

Conclusion: BOPT is a useful therapeutic approach in the person-centered care of MUS.

Keywords

Body-oriented psychological therapy (BOPT), coping tools, healthcare costs, Medically Unexplained Symptoms (MUS), patient preferences, person-centered healthcare

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Introduction

Medically Unexplained Symptoms (MUS) refer to a condition suffered by many patients and the diagnosis is usually arrived at by a process of exclusion of other diagnoses. It is not one unitary disease, such as diabetes or coronary heart disease, but rather a variety of syndromes such as non-cardiac chest pain, headaches, generalised pain, *etc.* for which no specific somatic pathology or medical condition can be identified, hence the term MUS or Body Distress Disorder/Somatic Symptom Disorder in new diagnostic classification systems [1]. In addition to the somatic complaints, MUS sufferers present with complex manifestations of distress, stretching variably across the spectrum of cognition, perception, emotion and interactive movement behaviour.

There is an ongoing debate [2] about the most applicable and patient friendly terms used to describe the disorder, but it is beyond the scope of this paper to enter into this debate and so this particular issue will not be addressed. MUS is associated with high personal, societal and healthcare costs. Fink & Rosendal describe the condition as a significant burden for sufferers, costly for Society and as difficult to treat [3]. The NHS in England is estimated to spend at least £3 billion each year attempting to diagnose and treat MUS [4] and according to the King's Fund report 'Bringing together physical and mental health - A new frontier for integrated care', "Much of this expenditure currently delivers limited value to patients; at worst, it can be counterproductive or even harmful" [5]. One could argue that this is due to a significant mismatch between patient and professional perspectives as set out in Box 1.

Box 1 MUS. A significant mismatch between patient and professional perspectives

Beliefs / explanatory model: "It's all in the body" *versus* "all the mind".

Language / terminology: "Unmet needs" *versus* "Health anxiety, etc."

Emphasis in therapy: "I am in pain" *versus* - "We talk about pain"

Desired location: "Wanting to be in ..." *versus* "Out (of services)"

New, innovative and person-centered approaches are therefore required to overcome such obstacles to providing effective treatment. Following up on previous successful trials of body psychotherapy for specific psychosomatic conditions, a pilot study investigated an innovative manualised treatment approach that offered body oriented psychotherapy to patients with somatoform disorders in secondary care [6]. The results of the pilot suggested that the intervention might be effective in reducing symptoms and reducing service utilisation. The service was, however, under-utilised as many patients did not want to be referred to a secondary care mental health service. Interviews with participants revealed that MUS patients do not regard mental healthcare as an appropriate treatment approach to their problems and this is in line with findings from the wider literature, pointing out that these patients mostly present with somatic explanatory concepts and a corresponding reluctance to engage in psychological therapies [7]. Taking these important barriers to providing clinical and cost-effective treatment into account, a care pathway package was developed that enables provider services to achieve a better match with patient characteristics and to be more person-centered [8].

According to patients' preferences it was decided that it would be more beneficial to offer treatment to MUS patients in enhanced primary care services where they are most frequently seen by their GPs, with whom patients have established and trusted therapeutic relationships. Secondly, the care pathway was offered while changing the language of care systems from a predominant psychological (talking) therapy emphasis (e.g., Cognitive Behaviour Therapy) to one that focuses on empowerment, capabilities and resources to foster coping and creative solutions to dealing with (bodily) distress. Thirdly, a choice of two group interventions was offered to patients: Strategies for Better Living Groups (a Body Oriented Psychotherapy group, BOPT-MUS) and Mindfulness Based Stress Reduction (MBSR).

These two group interventions have one common person-centered denominator in relation to the core difficulties: they both offer an intervention strategy that works with and through body experiences (body awareness, movement, relaxation, *etc.*). Hereby, patients are met at the level of their specific complaints and learn to establish through the intervention that their embodiment is not only dominated by negative features (somatic

symptoms, disabilities), but also characterised by capabilities and a reliable physical vitality. The interventions provide patients with a sense of agency in response to dealing with their medical difficulties and the choice of describing the BOPT-MUS group as a 'Strategies for Better Living group' indicates a more positive perspective on the intervention and on the patients' own ability to engage in their treatment in a pro-active manner.

The central guiding principle of the intervention strategy in both MBSR and BOPT-MUS is that the body remains the main focus of the therapeutic work throughout the sessions. In addition to addressing the painful symptoms and negative experiences of the body, the focus of the therapeutic work always, in parallel and intrinsically, activates the physical capabilities, strengths and creativity to assist in the management of pain and other symptoms. BOPT-MUS also addresses directly emotional responses either in relation to the MUS or to other bodily experiences. More specifically, a differentiation of a range of emotions and emotional expression through psychomotor self-exploration and interaction is included in the therapeutic work. MBSR therapy combines meditation, body-awareness techniques and yoga exercises to enhance coping with distressing bodily symptoms such as pain; techniques taught included body-scan, mindfulness of breath / body / feelings / thoughts / emotions and mindful movement [9].

The focus of this paper is on the therapeutic processes of the BOPT-MUS group intervention in a secondary analysis of qualitative data from the cohort study.

Methods

This paper examines the processes and changes that occurred during BOPT-MUS group intervention for patients with MUS with particular emphasis on body experiences and interactive bodily engagement between patients and therapists as well as between patients themselves. Data collected during a cohort intervention study are utilized [8].

The cohort study "MUS-SHINE" project

A care package was offered in the context of a novel 'One-Stop-Shop' treatment programme (holistic care approach) to MUS patients from a cluster of seven GP practices in East London, UK.

Identification of patients was carried out by means of a specially developed algorithm. The care pathway introduced a specific approach to engaging these patients, taking an active interest in their physical complaints in relation to when, where and how they occur. Patients were assessed with a range of standardised in-depth somatic symptom questionnaires, health-related quality of life measures and treatment satisfaction questionnaires. During the initial individual assessment and engagement sessions, patients received psycho-educational information about the nature of their condition.

The findings of the trial evaluation have been described in a paper summarising the primary analysis, indicating that the care package can be successfully implemented in primary care with potential benefits in symptom reduction, improved health-related quality of life and reductions in service utilisation / cost [8].

Source of data for analysis

This paper describes findings from the perspective of the researchers and psychotherapists, reflecting specifically on the Body Oriented Psychological Therapy intervention in terms of patients' experiences and how they may have changed. The focus of this paper is specifically on the BOPT-MUS because this intervention is a novel addition to the treatment options available for MUS, whereas MBSR is already well known and has become an established and commonly recommended intervention [9].

Therapeutic intervention/ BOPT-MUS

The BOPT-MUS intervention in the Strategies for Better Living group was delivered as a manualised approach of 10 weekly sessions of 1.5 hours each. Each session introduced activities that focused on assisting the patients to experience a new and more complex bodily reality, rather than perceiving their bodies as an objectified, negative and dysfunctional dimension of themselves. Furthermore, the therapist introduced exercises to help patients to identify, to recognise and to express emotions, fostering a process in which patients could draw connections between emotional and bodily states and in response to changes in their immediate vicinity. Patients' personal narratives in relation to their bodily experiences and the impact these have on everyday life were invited and finally exercises to practise at home were introduced to help patients manage their conditions more competently.

The intervention is described in detail in the BOPT-MUS manual (www.mus.elft.nhs.uk).

Results

We report here the main process observations in relation to 4 core somatic processes: breathing and pulsation, body awareness through movement, emotional expressiveness and working metaphorically and symbolically through enactments.

Breathing and pulsation

Learning deep breathing techniques were particularly appreciated and patients would practise these exercises at home once they learnt the techniques. Patients reported that they experienced the benefits physically in their bodies as it helped them to release tension and this impacted on their symptoms, for example, in reducing the severity of the pain they were experiencing. These exercises also helped to improve erratic sleeping patterns, especially when sleep was disturbed by pain. Simultaneously, patients

noticed an emotional and psychological improvement in that they experienced a sense of gaining control of themselves and a sense of their own agency. Breathing exercises enabled more direct engagement with a wider range of somatosensory sensations and patients reported that this helped them to recognise their bodily presence in new ways and to explore the body in its spatial dimensions, for example, when inhaling and exhaling they might lengthen and twist the torso or raise and tense both shoulders and release and drop the shoulders. This, in turn was often associated with themes of personal relevance such as creating or restricting their interpersonal space in interaction with others. Sometimes, experiences of deep relaxation and "letting go" were reported.

Body awareness through movement

During the sessions, participants were encouraged to investigate their range of movement in diverse body parts with, as stated above, the focus on the body always being primary. Patients engaged positively in the mobilization of all the main joints of the body as well as intensifying this exercise into expanding and contracting their whole bodies in movement exercises by introducing visual metaphors such as opening and closing the body. This was sometimes interpreted as a metaphor about their own lives, that is, opening and closing themselves to their specific life experiences. Tension and release exercises, for example, of the shoulders, gave the patients a clearer sense of the level of stress they constantly encountered in their body. Often, patients would reflect that after these exercises they felt relaxed all over and tired. In this situation tiredness featured as a positive consequence of physical activity, contrary to the adynamic exhaustion and tiredness otherwise experienced in the context of somatic symptoms.

Self-massage, either by using hands or small balls, was introduced to assist patients noticing the difference between body parts that had been actively manually explored in self-touch and those that had not. This offered patients another means of re-evaluating their body as a dynamic source of varying sensations.

Shaking, stretching, swinging and grounding exercises further extended a sense of awareness of the body especially in relation to the force of gravity to which one could surrender or resist. Here, patients began to notice the subtle and obvious effects of body movement in space. One patient expressed that moving different body parts in new ways enabled completely new feelings to emerge and exclaimed joyfully "Look, I can move my hips".

Emotional expression

Frequently, therapists found that this group of patients conveyed a sense of not recognising their emotions or displayed an emotional incongruence both in facial expression and in body posture and gesture; for example, a patient may be smiling, but the body would be tense and rigid which suggested that the smile was not reflecting the feelings that the person was experiencing. This was evident because there was a clear inability to reflect on or talk

about emotions and feelings in the initial sessions of the group intervention, which not unexpectedly was particularly prevalent when describing situations with family and friends.

Creating a range of body postures representing emotions was helpful in assisting patients to differentiate and express emotions that either may be held or repressed in the body. Following the identification of emotions, patients made choices about which emotion resonated the most with them and which they would like to work with. In this process there was often a recognition that they were experiencing feelings but were not able to identify and acknowledge them. Movement exercises were introduced to help patients to connect with more challenging feelings. For example, the therapist would introduce bean bags and the patients would explore the sensory qualities of resting these bean bags on different body parts, sometimes two or three at a time, noticing the impact of supporting different weights. Following this bean-bag exercise the therapist would introduce a throwing exercise in which each group participant was encouraged to “take the weight off their bodies” and to throw the beanbags to the ground while simultaneously voicing feelings that they had been unable to express before. This was implicitly understood as a sense of “freeing” themselves from an invisible burden and pent up feelings. Some patients would utter some of the following words: “(I am) fed up, angry, tired of the pain, tired of not being able to share my pain, isolated, lonely”. At this point the therapist would encourage group members to put more emphasis behind those expressive movements, such as stamping or raising their voice, or putting more strength into their bean-bag throwing.

Creating and practising body postures symbolising their feeling states enabled patients to express how they felt at the beginning and end of sessions. Body postures and corresponding gestures were used to develop body awareness as group members mirrored each other's postures and movements, which encouraged kinaesthetic empathy.

Working metaphorically and symbolically through enactments

The work in the groups during the later sessions moved into the realm of metaphor and symbolism, for example, in sharing a dialogue about physical pain or distress, which became the initial foundation of group cohesion for the participants. Once they had moved out of a state of unrecognised emotions or repressed feelings, many patients were able to shift from the preoccupation with physical symptoms to wider realms of communicating their emotional experiences. Feelings were at times expressed through a group metaphor and occasionally patients took bold steps to reflect on their own individual autobiographical and often painful process. This often included life events which they had experienced as traumatic, such as physical violence, miscarriages, childlessness, prolonged periods of unemployment, migration, *etc.*

As many of the patients were from the ethnic minority populations and/or were immigrants to the UK, significant themes that emerged were a sense of loss and separation as a result of their own geographical displacement and consequently also related to their own identity or to their new community in their host country. For these patients the impact of mixed gender groups evoked feelings of fear, shame and even self-censorship, particularly for some of the women taking part in the sessions. In addition to these more difficult and painful themes, the patients were, through symbolic enactments, able to work towards the potential for individual change, growth and empowerment. In the creative process personalised themes and solutions emerged in scenic enactments. One group of women collectively grew “new plants”, taking turns, creatively, to add the light and water to nurture growth. Loss was mourned and even symbolically laid to rest as one patient, in a ritual enactment, symbolically laid to rest a lost child. And group members were even able to imagine and playfully refer to places where they had been feeling well in the past. Mostly, patients left with a new set of coping tools in which there was a greater perceived connection between bodily realities, emotion, cognition and self-awareness and therefore potentially a new way to express their difficulties. This enabled participants to ‘move forward’ in their journey of both managing their bodily distress and opening new, positive avenues of life engagement.

Discussion

The BOPT–MUS intervention was delivered over a short period of 10 weeks. Despite the brief nature of the intervention there were some significant transformations in how patients dealt with and managed their symptoms. Primarily, the patients broadened their bodily awareness and explored implicit possibilities of utilising body experiences to foster their own wellbeing. Working with and through the body is a deeply personalised process as it relates to the unique physiognomy, to autobiographical and implicit memories and consequently to experiencing bodily capabilities, which counteracts the negative body image associated with chronic MUS. Body oriented psychological therapy is an integrative approach utilizing a wide range of interventions responding to the latest research in cognitive neuroscience which emphasise the bidirectional and environmentally embedded nature of mental and somatic phenomena into one unified and seamless state of existence. Indeed, as Niedenthal puts it, “The theories suggest that perceiving and thinking about emotion involve perceptual, somatovisceral, and motoric re-experiencing (collectively referred to as “embodiment”) of the relevant emotion in one's self” [10].

Papadopoulos developed a coherent framework of eight therapeutic characteristics to assist in the understanding of the significance of engaging the body when working with patients who experience psychological difficulties including psychosomatic problems [11]. Two are of relevance here. The bodily processes constantly work

towards maintaining homeostasis and stability; pulsation, breathing, temperature and other autonomic factors adjust to a constantly changing internal and external environment. This factor is referred to as the body providing constancy, stability and continuity. The second characteristic factor is transformational change which “refers to the ability (‘wisdom’) of the body to introduce changes in a rapid way that can then enable one to experience transformational change in oneself. The body does not simply maintain stability. Its remarkable versatility also enables it to be the vehicle of important changes not only at the level of bodily experience but also in the wider psycho-somatic dimensions of the person ... Under one’s conscious direction and control, the body can offer rapid and positive experiences of change which can give one a sense of purpose and agency that can be generalised to wider spheres of one’s being” [11].

This process can be regarded as one of the key factors that initiated change within this group of patients as they learned quickly (and mostly implicitly) to identify both the differentiation and expression of emotion as significantly contributing, precipitating and perpetuating factors of their physical symptoms. They made use of creativity through a primary focus on their bodily responses to changes as the starting point and, as we see in the examples given above, these experiences then evoke personal, interpersonal and social narratives.

Of special note is that the therapist in BOPT-MUS will only directly address any psychological processes such as intra-psyche or inter-personal dynamics if the patient specifically brings them up first. Interpretation as used in psychodynamic therapies will only be used if appropriate and led by the patients. This aspect of a person-centered approach allows patients to gain control over the therapeutic process and offers flexibility and choices in relation to the patients’ desire to engage with body-oriented exercises and corresponding personal themes. Furthermore, patients are encouraged to share their own explanatory models of their MUS condition as well as their experiences in managing their symptoms and other difficulties. It may become apparent to patients that contextual factors trigger symptoms and when led by the patient these may be explored, possibly leading to remembering past traumatic or challenging experiences that can be processed through creative body movement, through verbal discussion or a combination of both.

Conclusion

Offering patients suffering from MUS a body-based therapeutic intervention has positive effects on their ability to manage and contain their symptoms. They learn to relate to their bodily reality and consequently their MUS in a different manner, resulting in them experiencing a new sense of agency in themselves. Profound transformational changes were witnessed in some patients even within this short, compact intervention. This approach to MUS opens a new realm of treatment opportunities that can be effectively embedded in enhanced primary care services.

Further research with the model in a variety of primary care settings and, as part of controlled trials, would be the next step in exploring the efficacy of this new approach.

Acknowledgments and Conflicts of Interest

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