An investigation into the application and processes of manualised group body psychotherapy for depressive disorder in a clinical trial

Nina L.R. Papadopoulos\textsuperscript{a} & Frank Röhricht\textsuperscript{b}

\textsuperscript{a} East London NHS Foundation Trust (ELFT), London, UK
\textsuperscript{b} Centre for Psychoanalytical Studies, University of Essex, Colchester, UK

Published online: 18 Oct 2013.

\textbf{To cite this article:} Nina L.R. Papadopoulos & Frank Röhricht, Body, Movement and Dance in Psychotherapy (2013): An investigation into the application and processes of manualised group body psychotherapy for depressive disorder in a clinical trial, Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice, DOI: 10.1080/17432979.2013.847499

\textbf{To link to this article:} http://dx.doi.org/10.1080/17432979.2013.847499
An investigation into the application and processes of manualised group body psychotherapy for depressive disorder in a clinical trial

Nina L.R. Papadopoulosa* and Frank Röhrictb

aEast London NHS Foundation Trust (ELFT), London, UK; bCentre for Psychoanalytical Studies, University of Essex, Colchester, UK

(Received 3 May 2013; final version received 7 September 2013)

Background: Body-oriented psychological therapy (BOPT) has been described as effective in addressing depressive symptoms. There is, however, a paucity of research into the processes leading to change and the actual experience of the patients and the therapist in delivering BOPT interventions. Method: Secondary qualitative analysis of data obtained within an exploratory randomised controlled trial of manualised body psychotherapy (BPT) for patients with chronic depression, analysing qualitative aspects of change processes during therapy, was conducted. Results: At the beginning of therapy, most patients presented with a restricted, emotionally dissociated and inwardly directed range of expressive behaviours, associated with isolation of emotions from self-awareness. Clinically relevant changes in body postures and gestures were associated with feelings of empowerment; connecting repressed anger with feelings of sadness appears to have resulted in enhanced levels of self-confidence and improvements of depressed mood. Body satisfaction scores improved slightly. Conclusion: Patients with chronic depression may benefit from specific BPT interventions. These interventions appear to be particularly effective in assisting patients to identify and express a wide range of feelings.

Keywords: body psychotherapy; depression; embodiment

Introduction
Depression is one of the highest prevalent mental disorders and is experienced by one in six people in the UK (National Institute for Health and Clinical Excellence [NICE], 2009), i.e. 16% of the population. Symptoms of depression are often associated with a corresponding set of bodily symptoms/somatic complaints including severe fatigue, motor weakness, back and chest pain, headaches and gastrointestinal problems. Phenomenological research identified specific patterns of body image aberration in depressive disorder (DD) and anxiety disorder, i.e. patients displayed significantly higher body dissatisfaction scores, negative body images with boundary loss and somatic depersonalisation and a higher number of physical complaints than other groups of patients (e.g. Marsella, Shizuru, Brennan, & Kameoka, 1981; Röhrict,* Corresponding author. Email: ninadmt@yahoo.com

© 2013 Taylor & Francis
Beyer, & Priebe, 2002). In relation to Laban’s conceptual analysis of movement framework (North, 1972), anecdotal evidence in the literature suggests that there tends to be either a lack of engagement with the Efforts in depression, resulting in passivity in relation to flow, time, weight and space, or a predominance of the ‘yielding’ Efforts (free flow, sustained time, indirect space and light weight) rather than the ‘fighting’ Efforts (bound flow, sudden time, direct space and strong weight; Stanton-Jones, 1992). Other research with a specific focus on the analysis of gait pattern and body posture in depressed patients similarly identified reduced gait velocity, increased standing phases and slumped posture with reduced vertical movement of upper body (Michalak, Burg, & Heidenreich, 2009; Wendorff, Linnemann, & Lemke, 2002).

There is no one unified theory to explain depressive symptoms and their aetiology; in fact, there are a number of different contributory or precipitating factors identified, ranging from organic/biological and genetic to psychological/evolutionary and social influences. The theoretical models describing psychological processes leading to depression do not explicitly or systematically refer to the body–mind nature of depressive syndromes and with the exception of mindfulness-based cognitive behaviour therapy (CBT), the treatments focus either entirely on verbal interventions or on physical interventions, i.e. exercising. This is contrary to the theoretical notion and empirical findings of embodied cognitive science, emphasising the bidirectional and environmentally embedded nature of mental and somatic phenomena (e.g. Niedenthal, 2007). The most recent NICE (2009) guidelines for the treatment of clinical depression recommended treatments such as computerised CBT, psychoanalytical psychodynamic therapy, general exercise programmes as well as drug therapy, all of which have proved to have short-term benefits. Exercising was found to improve depressive symptoms in people with a diagnosis of depression, but the effect sizes are only moderate (Mead et al., 2009). More recent studies such as Chalder et al. (2012) have found no long-term positive effect of exercise on depression. Body-oriented psychological therapies (BOPTs) were found to be effective in single case studies, small case series and non-randomised treatment trials (e.g. see reviews of Loew, Tritt, Lahmann, & Röhrich, 2006; Röhrich, 2000, 2009; Stewart, McMullen, & Rubin, 2004; Steckler & Young, 2009). The results suggested that the interventions were effective in the reduction of overall depressive symptoms and, more specifically, the reduction of general and somatic complaints. Equally, alternative forms of body-oriented interventions such as in dance or mindfulness (e.g. Barnhofer et al., 2009; Koch, Morlinghaus, & Fuchs, 2007) facilitated an improvement of depressive symptoms. To date, there is, however, a paucity of research into the exact nature of the interventions, the processes leading to change in body-oriented interventions and the actual experience of the patients and the therapist in delivering BOPT tailored for specific mental illnesses.

BOPT covers a wide range of psychotherapeutic interventions and schools that focus on the inter-relationship between the body and psyche. All these psychotherapeutic approaches such as neo-Reichian body psychotherapies (BPTs; e.g. Staunton, 2002; Totton, 2003) or Dance Movement Psychotherapies (Stanton-Jones, 1992; Payne, 2006) share certain basic principles, i.e. that the psychological or mental state is intricately interconnected with the body and that, through work with the body, significant changes can take place within psyche. Theoretically, these approaches lean towards different theories of psyche including psychodynamic
theory, developmental theory, embodied cognitive theory and humanistic person-centred theories to mention but a few. The methods that each school uses differ in some respect from each other but do otherwise overlap to such an extent that the validity of the vast multitude of separate schools has been questioned (e.g. Röhrich, 2000). The main differences can be reduced to three, i.e. (1) the extent and purpose of the use of direct body work and touch (e.g. actual hands on work by the therapist on the patient’s/client’s body to facilitate the release of body armour and emotional blocks in neo-Reichian work), (2) the techniques used for accessing the unconscious feelings and mental processes (e.g. by engaging symbolically with movement using techniques such as ‘active imagination in movement’ or ‘authentic movement’ in Dance Movement Psychotherapy) and (3) the degree of body and sensory awareness interventions in dealing with specific syndromes/problems.

From theory to practice: manualised group BOPT for DD

Röhrich (2000) suggested targeting core symptoms and bodily phenomena of depression systematically with a BPT intervention strategy that encompasses the following main components:

1. A range of exercises, movement strategies and sensory awareness procedures to address reduced self-awareness and psychomotor activity levels (lack of drive/initiative).
2. Techniques derived from neo-Reichian BPT, movement psychotherapy, sensory motor awareness training and drama psychotherapy, revitalising and working through (exploring, enacting and transforming) particularly suppressed negative/aggressive impulses especially those featuring as auto-destructive/suicidal tendencies, enhancing patients’ affective modulation, psychomotor expressiveness and fostering healthy affective self-regulation.
3. A range of interventions focusing on bodily strength and capabilities, aiming at rebalancing patients’ negative self-evaluation and strengthening self-demarcation; working against gravity (both physically and metaphorically) as a means of counteracting the feeling of heaviness and the unbearable weight of the mental pain.
4. Body-oriented psychological work directed towards individual biographic backgrounds with a specific focus towards unmet (physical and emotional) needs, nourishment and traumata (i.e. separation/loss); enabling patients to identify how self-destructive tendencies are diverted from external targets and enabling the patient to identify a range of more constructive psychomotor responses and solutions.

The manualised treatment has been developed accordingly by the authors of this paper and was evaluated in a pilot RCT (Röhrich, Papadopoulos, & Priebe, 2013). The therapy in the trial was delivered by an experienced Dance Movement Psychotherapist, trained in the use of the BPT manual, who ran four groups of 20 sessions each (frequency: twice a week), over a period of 18 months. The manual was developed as a tool to guide the therapist’s interventions based on the four components listed above, including examples of the specific kinds of body-oriented activities, interventions and exercises that should be included in each of three therapeutic phases with specific therapeutic objectives. In addition, each session is
structured so that it includes four different parts which support the process of development of the three phases.

**Therapeutic phases of body psychotherapy for severe depressive disorders**

Although it is impossible to strictly divide ongoing psychotherapeutic work into distinct stages, it is nevertheless possible to differentiate at least three relatively discrete phases of body psychotherapy for severe depressive disorders (BPT-DD) that are characterised by certain processes that are typical to each one of them.

**Phase 1**

The first phase of the therapy (sessions 1–5) concentrates on the specific (enacted and embodied) therapeutic relationship in BPT. General principles of group therapy apply as follows: the therapeutic objectives are to create a safe and containing environment in which the patients are met with respect, empathy and are valued as important members of the group. In many instances, patients suffering from depression present with very low self-esteem and often convey that they are a failure in life and ‘useless’ in their attempts at achieving the basic level of coping. The aim here is to widen the patients’ experience of themselves through the embodied and enacted therapeutic relationship, to offer acceptance and support and to work towards a position of perceiving themselves not as ‘failures’, but as complex individuals with self-potentials, strength and motivation. Even though patients may be feeling very distressed and negative, they have demonstrated resilient features such as the basic act of attending the group, engaging with their bodies despite predominantly negative bodily sensations and images, and relating to others even though experiencing an urge to withdraw as well as symptoms of motor retardation.

During this first phase, gentle body-oriented exercises are introduced to widen the range of movement in relation to the Efforts with special emphasis on the ‘fighting’ Efforts; in addition, the exercises focus on and strengthen the experience/awareness of the centre of the body, the spine, chest and the breath as a means of engaging with aspects of personal stability and vitality. Furthermore, in this phase, patients are guided towards exploring the bodily based sense of self, grounding and containing oneself within physical reality, accessing the body as a potential source of creativity and pleasure. By the end of the first phase of therapy, the patients should feel safe and contained with a greater level of self-confidence and respect.

**Phase 2**

The middle phase in therapy (sessions 6–12) lays emphasis on recognition, widening and diversifying the experience of emotion through movement and body experience as well as introducing creative activities in which the patients can begin to express their emotions and aspects of their internal worlds symbolically. The intention is to support emotional processing for those patients who experience ‘affective numbness’/lack of emotions. Second, this phase concentrates on fostering the recognition and expression of a wider range of emotional responses and basic feelings for those patients who are
entrapped in vicious cycles of negative cognitions and emotions. Another process that tends to develop during the middle phase of BPT is the recognition of the embodied and situational inter-relatedness of the patient in the context of interpersonal interactions with both participants and therapists. This aims to enable the patients to perceive themselves and their bodily existence as a diverse source of neutrally, positively and negatively evaluated influences on self-experiences. The role of the therapist here is helping patients to develop alternative conceptualisation of themselves and their social environment, shifting from a negative and judgmental perspective (e.g. as failure) to a more holistic perspective of self-respect and acceptance.

Phase 3
The third phase (sessions 12–18) of therapy is characterised by a complex physical and cognitive re-evaluation in respect of individual conflicts, developmental needs and/or traumatic experiences. Here, patients begin to explore in more depth the range of expressive emotions, creative potentials and alternative coping strategies, both through body-oriented exercises and verbal interactions and reflections. In this way, their capacity to deal with the more negative and overwhelming emotions that emerge is strengthened. Relationships are explored in creative ways through exercises such as role plays, body sculpting and movement mirroring. In this way, patients gradually shift to a state in which feelings can be activated, addressed and experienced, both in the context of their own internal worlds and in relationship to others. The differentiation of a wide range of feelings and movement patterns assists the development of a more complex understanding of self as resourceful, resilient, energetic and able to ‘fight back’, defend or generally speaking being ‘empowered’.

The last two sessions (19–20) take care of the processes of ‘endings’ and concentrate on integration of the perceptive, emotional and cognitive aspects of the DD into a cohesive narrative.

The steps describe the overall therapeutic process and are underpinned by a repetitive structure in each individual session: opening circle/body exploration and awareness, structured tasks of emotional stimulation in relation to bodily states, integrative and creative scenic body work, and closure of session with narrative development.

Methods
In this study, we conducted a secondary analysis of data from an exploratory RCT (Röhricht et al., 2013) in a sample of chronically and severely depressed sample of \( N = 31 \) patients (minimum duration of DD: 2 years). The empirical findings of the trial point towards good efficacy of BPT in reducing the severity of chronic depressive symptoms (main outcome criterion, as assessed using the Hamilton Depression Scale).

This paper examines in some detail the changes that occurred during therapy in body experiences/body image, movement pattern/motor behaviour and emotional processing of the patients. We furthermore investigated the utilisation of the manual and the therapist’s perspective in delivering manualised BPT-DD. This mode of
inquiry attempts to illuminate the complexity of the body experiences and the emotional responses of the patients in the process of using the specialised BPT-manualised intervention. The method relies on the interpretive sensitivity of the authors making use of principles from Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009).

The authors investigated the therapeutic processes at the individual level, from the therapist’s recordings and her impressions of the work, enriched by phenomenological data in respect of patient’s body image, emotional and behavioural expression.

The data for this qualitative research are obtained from three sources:

(1) **Session record forms.** These were filled in by the therapist at the end of every session and include the structured reflections about the sessions. The form was devised by the researchers to serve a number of functions: to assist the therapist with the planning and delivery of the sessions; to assist the therapist with keeping track of events, experiences, changes in body states, emotions and expressive behaviour of the patients over the treatment programme, and finally to assist the researchers in gathering data in a uniform manner. This source of data offers an immediate impression and somewhat undigested reflections on the group and its processes. These are the main structured themes: events/activities included in various parts of each session, Laban Movement Analysis (LMA) observations for individual patients, general evaluation and predominant psychological themes emerging in the group, inter-relational features (e.g. transference and counter transference), therapist’s feelings before during and after the session and future session planning.

(2) **Post-therapy individual patient reports.** This was a structured report devised entirely for research purposes to gather data from the therapist about the changes noticed and documented in body experiences, emotions and expressive behaviour of the patients. This source of data collated the material from the session record forms as well as adding some of the therapist’s own thoughts, feelings and responses in relation to the patients’ physical and emotional states and how they fluctuated and changed over time. At the end of the 20-session treatment programme, the therapist examined carefully all her notes and produced a report for each patient distilling her reflections under the following headings: body experiences, LMA observations behaviour, expressive behaviour and changes in depressive symptoms and emotional responsiveness.

(3) **Final evaluative semi-structured interview of therapist.** This piece of data was specifically designed to gather more general information about the therapy process from the therapist with a time gap between completing the trial and writing the specific reports. A systematic, semi-structured 2-hour interview with the therapist was conducted after all the research groups had ended.

The questions were as follows:

(A) **The body and depression.** How did the patients embody their depressive syndrome? What was the (embodied) counter-transference? What characteristic movement pattern did you particularly notice and how did you relate to those as therapist?
Working with and through the body in therapy. How did you engage body experiences and movement in therapy? How did you work with the patients’ emotional experiences/expressiveness? Can you identify significant events leading to change in the therapy process?

(C) Manual. Give me examples of how the manual facilitated and made a positive difference to patients’ depressive symptoms and interpersonal dynamics within the groups. How did the manual assist and/or hinder you with decisions regarding the session preparation/interventions utilised in the group?

The Likert scale (a visual analogue scale ranging from 0, ‘totally dissatisfied’ to 10, ‘totally satisfied’) and two subscales of the Body Distortion Questionnaire (Fisher, 1970) were used in addition to the qualitative methods of evaluation in order to record patient’s rating in respect of the severity of specific areas of body experiences relevant for this disorder, namely ‘boundary loss’, ‘somatic depersonalisation’ and body satisfaction.

The findings of the research are grouped into three main themes, following the way the qualitative data collection was structured. The content of the key themes was derived from a systematic examination of all three sources of qualitative data and phenomenological findings from which the authors made careful and comprehensive notes. From these notes, the authors consolidated a number of key themes that occurred repeatedly throughout the research data.

In addition, the responses of the therapist in working with the manual are also detailed here and reflected on in terms of whether the manual hindered or aided the therapeutic process.

Results
Demographic and clinical data on participants who entered the trial are presented in Table 1.

Body experiences and body image

Pain and fatigue

All three sources of research data point towards predominant experiences of body pain, fatigue and weakness, specifically back, leg and shoulder pain, headaches and tiredness as well as feelings of heaviness. These problems are usually described at the beginning of sessions, and patients also refer to them when they are asked to do certain exercises that they feel they cannot do such as walking quickly. Often,

| Table 1. Demographic and clinical data on participants who entered the trial. |
|---------------------------------|-----------------|------------------|
|                                 | BPT ($N = 16$) | ($N = 15$)       |
| Gender f/m                      | 6/10            | 7/8              |
| Age (mean/SD)                   | 46.9/11.7       | 48.5/9.1         |
| Duration of illness, years (mean/SD) | 16.3/11.3       | 12.1/9.2         |
| Number of previous hospitalisations (mean/SD) | 1.3/1.5       | 0.4/0.6         |

Notes: BPT, body psychotherapy; WG, waiting group.
symptoms are furthermore characterised in respect of their disabling consequences. For some patients, there is no significant reduction in their reported symptom levels through the course of treatment, whereas with other patients pain experiences tend to improve over the course of the sessions in response to specific body attention and gentle warm-up exercises or massage.

Body cathexis/body satisfaction and somatic depersonalisation/boundary loss
Patients talked about different parts of their bodies that they disliked such as face, nose and thighs. No significant changes were reported by the therapist over the course of the treatment in relation to body cathexis. Patient’s body satisfaction scores were particularly low on admission. No significant changes were observed from baseline to post-therapy assessments, even though the body satisfaction scores improved slightly at the end of the treatment. Equally, the questionnaire scores regarding feelings of being detached and distant from own body as well as weakened and easily penetrated body boundaries improved over the course of treatment without reaching a level of statistical significance (see Table 2).

Body energy levels (subjective feeling of bodily strength)
At the beginning and end of every session, patients were asked by the therapist to identify their perceived energy levels. The vast majority of responses showed that there was a significant positive improvement in energy levels during the course of each session. However, this was not sustained once patients left the therapy room; sometimes it would drop immediately after the session and sometimes a while later and consistently when patients got to the next session their energy level would be low again. In response to the progressive range of activities over the course of the session, patients experienced enhanced levels of activation and motivation, resulting in positive engagement in the sessions. It seems that the patients did not have the capacity or supporting systems to maintain this level of engagement without the careful activation by the therapist within the context of the group programme.

Body language: posture and gestures
The therapist reported that body postures of patients particularly at the beginning of the sessions invariably included a sunken chest, hunched shoulders, narrow body

Table 2. Clinical outcome measures for treatment compared with waiting group (analyses of covariance, adjusted for baseline score).

<table>
<thead>
<tr>
<th></th>
<th>BPT group</th>
<th>Waiting group</th>
<th>Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Body image (boundary loss and desomatization)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At baseline</td>
<td>15</td>
<td>8.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>11</td>
<td>6.2</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>Body cathexis/satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At baseline</td>
<td>16</td>
<td>1.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>11</td>
<td>3.5</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Notes: BPT, body psychological therapy; n.s., not significant.
stance and eye line gaze looking downwards with an internal, withdrawn focus. This changed remarkably over the course of the 20-session treatment as the majority of patients widened their base, opened their chests, lengthened in the spine and began to make good eye contact. The therapist would draw attention to these body postures and offer alternative postures. Often patients commented specifically on this change in body posture saying that ‘I didn’t realise that by changing my posture I would feel better in myself.’

**Movement pattern/behaviour**

**Breathing pattern**

At the beginning of the sessions, the therapist noticed consistently that the breath was very shallow and mainly involving the upper chest region. Also the therapist reported that the flow of the breath was ‘stuck’ and, at times, some patients were even ‘breathless’. During treatment, the patients were encouraged to engage in full three-dimensional abdominal breathing which brought more fluidity and deepening of the breath.

The holding and blocking of the breath were identified by the therapist as being related to an emotional rather than a physical difficulty; the emotional and symbolic psychological theme of ‘being stuck or held back’ was associated with the corresponding shallow breath and understood as a somatisation of emotional content (i.e. blocked or unexpressed emotions, a holding back of oneself emotionally and physically and not being able to release or let go). Furthermore, the therapist identified that this kind of restricted and disconnected breathing was related to a disconnection in the flow of movement between the head and body and/or top and bottom halves of the body and described as a disconnection from emotional states.

**Movement pattern**

There were a significant number of nervous repetitive body movements such as clicking of nails, rubbing of face and neck, shifting from one foot to the other and rocking behaviours. These kinds of ‘shadow’ body movements, which the patients were usually unaware of, seemed to reflect emotional irritability, restlessness and tension.

The use of personal space by the patients was dominated by shrinking, enclosing, shortening and holding movement patterns in only two dimensions. At the beginning of treatment, patients found it challenging to move from a contracted narrow small body shape to a fully extended body posture in the shape of a big X. As with the breath this improved over the course of the sessions. Coupled with this was a sense of patients being ungrounded, finding it difficult, when standing, to ground the body in the floor and to work with gravity in a positive manner. Achieving changes in psychomotor behaviour, i.e. having a ‘lifted and upright walk’, were associated with changes in psychological position, i.e. ‘not to be a victim’ (of depression) any more.

There was a preference for moving on the periphery of the room, close to the furniture and not in the centre of the room. Also, some patients preferred being seated all the way through the session rather than moving out into the general space.

Based on specific criteria applied from LMA and contrary to descriptions in the literature, patients displayed a wide range of Efforts including fighting (strong, bound, direct and sudden) and yielding Efforts (light, sustained, flexible and free), actions
flicking, pushing, floating, etc.), states (mobile, stable, awake, dream, near and remote), and drives (spell, vision, action and passion) and a capacity for patients to broaden and change their Effort profiles. There was, however, one predominant feature which was the over-arching presence of bound flow in the body, expressed in the holding of the breath, in tension in the upper body, in a lack of allowing movement flow to progress through the body, resulting in blocked movement patterns.

The therapist hypothesised that this seemed to be connected with a need to block the feelings from being expressed; one patient said he stored his emotions somewhere in his body and compartmentalised them; the therapist felt that the need for binding occurred so that patients did not get overwhelmed by or lost in their difficult feelings. Again this improved over the course of treatment. As the sessions progressed, the patients were able to engage in playful, energetic and interactive group activities.

**Emotional expression**

The therapist experienced in her embodied counter-transference that the binding/holding back of movement and blocking of energy flow within the body were often associated with frustration and repressed anger (see in section above, ‘Movement pattern/behaviour’). There were dramatic changes in the patients’ capacity to release the tension connected with these emotional states in a safe contained way so that the feelings of distress, sadness, frustration and anger were no longer blocked either physically or metaphorically. This was associated with a major change in depressive symptoms and an enhanced degree of emotional responsiveness. For example, one patient vigorously played the drum on a number of occasions and on one occasion for 15 min non-stop, and although she was unable to verbalise her feelings, it was apparent that she was expressing frustration and anger; one patient flung beanbags down on the floor, voicing swear words in his native tongue reflecting both his sadness and his anger. Another participant commented that he had learnt he could actively contribute to changing his mood through body expression/changing posture rather than feeling overwhelmed or controlled by his fluctuating moods. Towards the end of treatment, another patient, once he had become more open to acknowledging and expressing his anger, commented that he enjoyed verbally challenging people in arguments as a way of making him feel ‘alive’.

A noticeable contradiction often appeared in the movement behaviour experienced in the group and inferred from the therapist’s counter-transference and the patients’ actual verbal reflections on themselves, e.g. patients would engage with high energy, laughter and playfulness but later make statements such as ‘I’m the same, I am/feel flat.’ The therapist noticed that by drawing patients’ attention to noticing where tension is held in the body such as in the jaw or chest and where the eye focus is, changes in expressed emotion occurred. One patient, who after opening/expanding her chest, relaxing her jaw, made more direct eye contact, was described by the therapist as looking bright with a twinkle in her eye; this patient was later able to describe how she enjoyed a movement task.

Some patients began the sessions in a state of being completely cut-off from experiences in their bodies to the extent that they could not even locate their own heart beat or would push their body beyond the limits of movement that were safe
for them. Body and sensory awareness improved over the course of treatment. By the end of treatment, they were able to articulate and express in a much more normative and direct manner a whole range of feelings and were able to comment on how the group helped them, e.g. ‘The group gives hope even though I don’t know why’, ‘I don’t know why it is working, but I’m feeling better’; they appeared more integrated in both verbal and non-verbal communication. Patients expressed the positive effect as well as the challenge of embodying positive emotions and their opposites and overall found this very helpful and useful, and the therapist noted an improved degree of confidence.

However, and although throughout the sessions, personal and often painful biographical information and details emerged, overall it seemed patients did not want to discuss in any detail or depth their past histories or personal inter-relationships except to mention them; e.g. when creating family sculpts one patient referred to incidents of being told off by an angry father or squabbling with siblings; on another occasion early on in the sessions, loss of function and relationship as a result of DD emerged as a powerful theme. But there was a resistance to discussing these dynamic issues and some patients even voiced that it was not helpful talking about things, especially those who had experienced talking therapies in the past and not found them very useful.

The use of props and objects
The use of props was considered very positive and helpful by the patients who engaged well with the balls, beanbags, parachute, buddy band, drawing material, etc. The props facilitated the emergence of a wide range of creative activities, feelings and new body experiences, despite some initial reluctance and hostility amongst participants towards interventions they perceived as ‘playing games’. Some of the structured and creative tasks such as body postures, embodying moods, family sculpts and freeze exercises as well as progressions of body sculpts from one to the opposite mood (e.g. from withdrawal to assertion) were regarded as very helpful as they enabled patients to differentiate these feelings, locate themselves along this continuum and also witness each other. The family narratives that grew out of these body postures were also considered very helpful to assist patients in understanding their present condition and empowering them to take a different stance in relation to interpersonal difficulties, e.g. no longer taking the victim position.

Discussion
Analysing the qualitative data suggests that the main changes during therapy may have occurred in relation to patients becoming more aware of their own bodies through breathing techniques, body awareness/sensory trainings as well as interactive movement and non-verbal communication. According to the session protocols, a process of unblocking and reducing bound flow in movement and, corresponding with that, an unblocking of repressed negative emotions (e.g. anger) took place in the sessions. Patients expressed how they became increasingly aware of the manner in which their depression influenced their embodiment in terms of bodily sensations and their movement patterns. Engaging in inter-relational
movement seems to have allowed patients to experience themselves in a more positive manner and reconnect with a social context. Patients developed the ability to differentiate and express a wider range of emotions, including both positive and negative feelings. It is conceivable that this directly impacted on core depressive symptoms such as low mood, motor retardation, negative cognition and low self-esteem.

The above changes are in line with the therapeutic development as outlined in phases 1 and 2 of the manual, and patients did make positive shifts away from their depressive symptoms and rigidly negatively construed self-images. Most importantly, changes in movement behaviour were associated with shifts in mood-related confidence levels. There is evidence to suggest that BOPT interventions impact directly on the close neuropsychological links between emotional and motor processing systems. More than 20 years ago, the first evidence emerged demonstrating that mood can be changed through manipulation of facial expression, posture and specific movements (Duckworth, Barg, Garcia, & Chaiken, 2002; Riskind, 1984). It is furthermore worth noting that body-oriented interventions seem to be altering plasma serotonin and dopamine concentration associated with psychological distress levels (e.g. Jeong et al., 2005).

However, interestingly, even though the patients significantly improved in terms of core symptoms of their depressive illness, no systematic changes were identified in relation to phase 3, i.e. achieving a re-evaluation of symptoms in respect of individual conflicts, developmental needs and/or traumatic experiences. The therapist offered opportunities to engage in biographical work, but on a number of occasions patients expressed that they did not want to reflect on their personal information. They may have mentioned particular incidents that emerged such as being exposed to violence by parental figures during childhood whilst engaging in symbolic exercise in respect of feelings of anger. Often patients did not want to talk about their past and in particular about traumatic experiences in any depth. In fact, some of them had been in ‘talking’ therapy before and had not found it helpful. Instead, positive changes appeared to be more directly related to the immediacy of the experience and emotional expression when engaging in both structured and semi-structured movement exercises in a contained therapeutic frame. It seemed easier for patients to relate to their experiences of adversity in an enacted and hence more inexplicit manner, i.e. through body sculpts and role play. This may be because the enactments allow for a more positive simultaneous exploration of alternative behaviours, whilst narratives are often dominated by a sense of overwhelming negativity, paired with hopelessness. Enacted engagement in motion widens individuals’ experience of themselves, taking them away from the difficulties they face in everyday life and their core symptoms such as feeling depressed, lonely or even suicidal. Similar to the discussion offered by Maratos, Crawford, and Procter (2011) in relation to music therapy, BOPT might also be effective because of active engagement with a range of creative and interactive exercises.

The findings must be interpreted with caution, given the subjective nature of the therapist’s account utilised here for qualitative analysis. Factors that may have been limiting in relation to achieving envisaged therapeutic milestones of phase 3 of the manual are the limited number of sessions available and the high level of disturbance in some patients who presented with severe, enduring treatment...
refractory syndromes. In many sessions, it took the entire therapist’s skill containing the level of disturbance, keeping patients engaged and able to remain together in the therapy room. One might argue that these patients were not yet at a sufficiently stable state in their recovery process to engage too deeply with their personal history. It is conceivable that more lasting therapeutic effects and an in-depth tackling of those psychological issues of patients with chronic conditions will require longer term therapies, i.e. an extension of the number of sessions to at least 40 sessions according to higher intensity interventions applied elsewhere (e.g. Scogin, Hanson, & Welsh, 2003).

Acknowledgements
The authors thank Layla Smith, Dance Movement Psychotherapist, who committed herself with professionalism and enthusiasm to this research project, and co-therapists, Goretti Barjacoba (Dance Movement Psychotherapist) and Stavros Orfanides (Psychologist), for their very helpful contribution.

Notes on contributors
Nina L.R. Papadopoulos is a Senior Dance Movement Psychotherapist and Clinical Supervisor working in the National Health Service (NHS) and in private practice in the UK. She is involved nationally and internationally in the training of Dance Movement Psychotherapists as well as professionals working in the field of refugees and other displaced persons. Since 1999, she has been involved in research projects in the NHS extending the applications of body-oriented psychotherapy disorder.

Frank Röhrich, Consultant Psychiatrist and Body Psychotherapist, is the Clinical Director of East London NHS Foundation Trust. He is a Honorary Professor at the Centre for Psychoanalytic Studies, University of Essex, and a Honorary Professor of Psychiatry at St. Georges Medical School, University of Nicosia, Cyprus. He is also a Patron of the Association of Dance Movement Psychotherapy UK, and the Chair of German Section of European Association of Body Psychotherapy Scientific Committee. He is a leading research expert in body psychotherapy in mental health.

References


