Manual
Body Oriented Psychological Therapy for Medically Unexplained Syndromes (BOPT-MUS)

(Shortened version for Primary Care; updated April 2017)

"STRATEGIES FOR BETTER LIVING GROUP"

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1. Introduction

By Frank Röhricht

1.1. Body oriented psychological therapy / BOPT

BOPT refers back to a long tradition of body-oriented interventions in psychiatry. Loew et al. (2006) distinguished clearly between body-oriented psychological therapies and body therapy. They emphasised that BOPT always refers to a therapeutic framework, aiming at enhanced self-awareness, behaviour modification or insight-oriented psychological problem solving. Wikipedia refers to umbrella terms such as 'body psychotherapy (BPT), 'body oriented psychotherapy,' 'somatic psychology' and 'body oriented psychological therapy.' General principles, relevant for all psychotherapies, apply to BOPT: Psychotherapy relies on trustful therapeutic relationships and is directed towards the improvement of a range of identifiable mental and behavioural disorders regarded as requiring specific treatment (based on theories of normal/abnormal behaviour), it mostly uses verbal but also non-verbal psychological techniques, it is a standardised procedure, defined and taught within a framework of academic institutions, responsible for quality assurance and supervision.

The European (EABP; www.eabp.org) and the American (USABP; www.usabp.org) Association of Body Psychotherapy address the question: "What is body psychotherapy" on their respective websites. They state that it is "...a distinct branch of psychotherapy with a long history... involves a different and explicit theory of mind-body functioning (complex interaction)...The body does not merely mean the 'soma' and that this is separate from the mind, the 'psyche'. Many other approaches in psychotherapy touch on this area. Body-Psychotherapy considers this fundamental." Similarly, the Association of Dance Movement Psychotherapy (DMP) in the UK states: "Dance Movement Psychotherapy is the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration" (ADMT-UK; www.admt.org.uk). Body oriented psychological therapy / BOPT is now commonly used as umbrella term in the scientific literature. This is aiming to widen the perspective in order to include all available evidence from clinical trials in the wider field of body-mind work.

1.2. Theoretical foundation

A review (Röhricht 2009) summarised the underlying shared theoretical foundation and commonalities between various BOPT schools in respect of their intervention strategies as well as the emerging empirical evidence for efficacy and effectiveness of different body oriented intervention strategies. Other overarching themes are outlined in: Staunton, 2002; Totton, 2003 and 2005; Corrigall, Payne, & Wilkinson, 2006; Marlock & Weiss, 2006.

It is important to note that a number of associated fields of cognitive/neuropsychological sciences are relevant for the theoretical foundation of the main therapeutic assumptions and principles as well the mode of action in BOPT. Developmental psychology (early body-ego/self development and habitual/attachment schemata) and phenomenology of body experiences, affective neuroscience (e.g. affect regulation), ethological research (non-verbal interaction and movement behaviour), body memory systems and lately particularly 'embodied cognition' are listed as the most important basic science backgrounds in the literature (Röhricht 2009, Geuter 2015).

Staunton (2002) introduced the basic principle in BOPT as follows: 'It is demonstrated...that the fundamental premise in body psychotherapy is that core beliefs are embodied, and that until we begin to experience the pain held in them directly through our bodies they will continue to run our lives, even if we mentally understand them' (p. 4). This quote, even though never intended, explicitly refers to new models in cognitive (neuro)sciences captured under the umbrella term "embodied cognition". These concepts are aiming to describe cognitive processes as intrinsically embedded in bodily processes, emphasizing the role that the body plays in shaping the mind (ideas, thoughts, concepts, etc.) but also the behavioural responses to emotionally significant events. Embodiment has always been a core theme in phenomenology, exemplified in Merleau-Ponty's concept of "ambiguity" which outlines the complex and integrated nature of the human existence as both subject and object: the objective physical body, which we 'own/have' and the subjectively experienced phenomenal body, which is the representative of selfhood. The importance of embodied cognition for the development of the self has hence been emphasized (see above regarding the importance of findings from developmental psychology). Gallagher (2000) describes the importance of episodic memory for the

development of a ‘narrative self’ and refers to the complexity of the neural basis of the self: “…this means that there are extremely complex demands made on the processes that link early sensory cortexes that hold information on the minimal or core self, and convergence or dispositional zones that contribute to the generation of the narrative self” (p. 11). Through constant updating of body memory systems individuals maintain the basic experience of familiarity and continuity.

Neuropsychological research distinguishes explicit/declarative memory from implicit memory systems with different types such as procedural, situative and particularly ‘intercorporeal’ memory: “…early social interactions are stored of the body as behavioral schemata, as body micropractices and dispositions in the memory (Fuchs 2004, pp. 4-5). The body stores relevant biographic/narrative information with particular emphasis and intensified through emotionally salient experiences, “Our basic attitudes, our typical reactions and relational patterns, in one word: our personality itself based on the memory of the body (Fuchs 2004, pp. 4-5). The importance of basic emotions for attention, motivation and behavior has been emphasized in the context of findings from affective neuroscience. On a basic level of primary embodiment, these emotions regulate internal/physiological states in order to regulate drives and fulfill needs in close cooperation with perceptual processes. Therefore mental processes traditionally captured as (non-emotional) higher order cognitive processes such as attention/concentration, memory, imagery, concept building and learning are essentially embodied cognitions.

1.3. Main mode of action in BOPT

Numerous schools in the field of body oriented psychological therapies developed; an overview of those schools and the analysis of theory and practice revealed a great overlap in respect of the described intervention strategies.

According to its three main roots in BOPT (reformist movements in creative dance, pedagogy and psychoanalysis), we can differentiate three main modes of action – apart from relational body-work – as follows: 1. Concentrative Movement Therapy, Functional Relaxation: explorative and perceptual, functional body-mind work, utilising self-awareness techniques, aiming to mobilize/stimulate autonomous physiological processes; 2. Neo-Reichian psychotherapies: energetic and expressive

body-mind work, utilising tension dynamics/grounding and cathartic processes, aiming to ease/loosen up rigid postures and related pattern of attitudes and conflict resolution or coping mechanism, in order to stimulate and develop affective contents/emotional processes (or in severe neurosis work with suppressed or diverted schemata); 3. Dance Therapies and Dance Movement psychotherapies: creative, explorative body-work utilising movement improvisation, authentic movement and 'body dialogues,' aiming to strengthen self-potentials as well as (non-verbal) expressive abilities and communication.

These three main modalities overlap greatly in practice (in integrated BOPT) and an overarching model can be described as follows: centering around the immediateness of (bodily, emotional and perceptive) experiences and through processes of focusing on self-referential body(self)experiences, shifting the attention and awareness towards the bodily reality, patients develop a position of basic inter-relational embodiment.

When applied in the context of psychodynamic psychotherapies for severe neuroses these BOPT techniques aim to mobilise and make space for processes related to underlying conflicts and deficiencies. The emotional and non/pre-verbal aspects of underlying conflicts can lead to some kind of critical (and partially cathartic) therapeutically intended destabilisation. At this point, altering bodily processes such as instinctive alternative psychomotor responses to conflict or distress are initiated. The subsequent therapeutic process aims to foster an integrative, self-determined and therapeutically guided reorganisation of adaptation pattern and the therapist will support clients to identify and gradually strengthen resourceful solution focused behaviours that emerge during creative movement sequences.

2. The theoretical model and the therapeutic principles/mechanism underpinning BOPT-MUS

2.1. Basic premises

"The connection between emotions and bodily states must be made at the affective and cognitive levels by the patients themselves…Physical therapies may also be effective in helping patients to make the breakthrough to a new level of understanding, without the requirements of verbalization" (McWhiney et al. 1997).

This quotation expresses succinctly the basic rationale of the theoretical model of our approach. This rationale in BOPT is elaborated further by the following points:

- Within an integrated aetiological model, a variety of phenomena result in a functional circuit of interdependent drivers for the somatization process: in this circuit basic characteristics are identified, including a predisposing biological vulnerability with low pain/somatic sensation thresholds and labile physiological systems as well as labile body schemata, leading to hyperarousal and an amplifying somatic style of coping. On that basis and furthermore triggered by negative life events (particularly those involving physical traumata) individuals with MUS get often caught in a vicious circle of focused awareness / attention towards distressing bodily sensations, a (negative) interpretation of these phenomena (body-cathexis), leading to "worrying" cognitive styles concerning the body (body image), which enhances further the self-awareness (self-observation) towards unpleasant bodily sensations and the hyperarousal.
- Different aspects of body experience influence the way individuals perceive, evaluate and handle/move their bodies. (Bodily) Awareness is based on selection processes, assigning meaning to neutral environmental factors and related somatosensory information (i.e. body position in space, muscular tonus, information re the environmental condition (e.g. the temperature), internal physiological states (endocrine and autonomic nerve system). The "decision" as to whether which information comes to awareness depends on 1. the comparative standards of the preformed body schema (attention given to new, unexpected or potentially threatening stimuli), 2. the motivational state (e.g. hunger, thirst, sexual desire) and the comparative notion from cognitive evaluations of the constantly changing body-images (previous exposure to similar stimuli resulting

in positive or negative consequences in the body and hence to body-concepts with specific assignments) and 3. the balance between internal and external stimulation.

- Fundamentally, the body language, the postures, gestures and movements displayed in the context of MUS are understood as nonverbal communication of cognitive processes / psychological states - either symbolizing, expressing or avoiding/deflecting from emotional contents and conflicts; they may also be manifestations of learning processes in terms of unsuccessful conflict resolution, resulting in various forms of malfunctioning; finally, these forms of nonverbal communication may reflect various motives of primary and/or secondary gain from the somatisation process.
- In this therapeutic process, particular attention is paid to difficulties in emotion-recognition in self and others as well as the lack of (suppressed, diverted, symbolised) emotional expressiveness, a restricted ability to communicate negative emotional contents (i.e. anger, frustration, rage, and hate).
- The patients' explanatory model in the context of MUS tends to be dominated by concepts of dysfunctional bodies, the notion of a somatic illness not yet discovered and or sufficiently treated. It is very important to fully accept this and indicate firmly to the patient that the therapist believes that the patient's symptoms and suffering are real (to the patient). The therapist will not aim to replace the patient's existing explanatory model but to enrich, widen and complete it by steering it towards the direction of a bio-psycho-social model.
- The central guiding principle in BOPT-MUS is that the body remains the main focus of the therapeutic work throughout. The therapist will not address directly any psychological processes involved in bodily experiences, unless the patient specifically brings them up first.
- The body represents a most complex ambiguity (subject-object nature of the embodied self) in respect of a remarkable and intriguing paradox that it be experienced as a subject and as an object. On the one hand, the body can be experienced as the most unique signifier of the self (as in 'I am this body' or 'this body is me') and yet, on the other hand, the body may also be experienced as an object (as in 'I have a body', 'I hate my body' – where the body is an object to the 'I'). This complex ambiguity will be addressed indirectly through a range of bodily interventions that aim to bring about a subtle integration of the somatic and

psychological aspects of the bodily sensations and the underlying conflicts. This process will strictly avoid exposure to overwhelmingly threatening memories of traumatic nature unless the patient explicitly wishes to explore these.

- The patients' explanatory model in the context of this somatoform disorder tends to lead to a particular interactional style within the therapeutic relationship that that may result in the patient challenging the therapist's competence ; this tends to take the form of generating suspicion and tension and hence the therapist is required to apply a patient-centred interactional style, empathically noticing, respecting and containing the emotional responses and somatic symptoms of the clients both towards the therapist and among the patients in the group.

2.2. Why BOPT-MUS, the mode of action

BOPT-MUS has been conceptualized in relation to the basic therapeutic principle, that the chosen intervention strategy must match with both the client's expectations and the phenomenology of the symptoms (a range of bodily sensations in this case).

- The therapeutic process can only successfully address the complex phenomena in MUS, if the intervention strategy is designed to address the emotional (worrying, fear, negative cathexis), physiological (hyperarousal, somatic amplification) and cognitive (misinterpretation, negative cognitions) aspects simultaneously; this is not the case with any of the established talking therapies, but intrinsically offered through BOPT, integrating sensory awareness, concentrative movement, bodily enacting and cognitive re-evaluation in one seamless process.
- Activating resources (capabilities, bodily strength and creativity) and setting the scene for (bodily, autonomic) self-regulation is regarded as an important aspect of a non-verbal, body oriented psychotherapy; hereby, individuals suffering from somatoform disorder learn to regain control over some of the most dominating bodily reactions and enhance overall self-regulation, which enables patients to down-regulate hyper-arousal and to re-adjust thresholds for pain and other unpleasant bodily sensations.
- Alexithymia personality traits (difficulties in recognising, understanding and processing as well as expressing feelings) in MUS are directly addressed in the context of non-verbal stimulation of bodily self-expression, improving body-self-

awareness and linking autonomic states, bodily reactions with emotional/affective responses.

- Movement, motor expression and bodily enactment of psychological processes are very potent stimulators of memories and serve as correcting emotional experiences.
- Gradually, a range of alternative motor responses in relation to unpleasant mental states and or psychologically relevant events/conflicts is introduced in therapy, directly addressing (re-configuration) the habituated, amplifying somatic reinforcement styles and shifting the attention away from dysfunctional aspects of the body image (constant checking, stimulus entrapment).

2.3. Therapeutic work in BOPT-MUS

2.3.1 Therapeutic relationship and on rebuilding a fundamental positive body cathexis: focusing on bodily awareness and perceptions and supporting the verbalising of these experiences: The aim here is to shift the focus of attention away from the problematic (symptomatic/dysfunctional) areas of the body towards the body as a whole, including those regions not negatively affected and those representing competencies.

Concurrent with the body-oriented exercises is the creation of a safe and trusting space for patients. Here it is important to focus on the therapeutic alliance and the relationship among all group members.

The first sessions aimto reduce the levels of general and health specific anxiety and distress resulting from the symptoms and their associated impact through fostering (partial) control over bodily, non-autonomous, reactions.

2.3.2: Emphasising the contextual factors in relation to perceived bodily sensations: the patients will gradually be supported in understanding the situational nature of bodily sensations and how these change according to external and internal stimuli. Moreover, patients may also remember and explore contextual factors for their symptoms through bodily experiences. Invariably, this occurs when reconstructing memory through expressive behaviour, movement, mimic, and the various aspects of nonverbal communication (e.g. voice intonation) and utilisation of creative medica, i.e. colours, light and musical tones.

This also involves the further intensive exploration of bodily reality in the context of interpersonal interactions with both participants and therapist/s, aiming to enable the patient to perceive the body as a source of neutrally, positively and negatively evaluated impacts on self-experiences. The role of the therapist here is to help the patients to develop an alternative conceptualization of the body, shifting from a judgemental perspective (body being perceived as a mere hostile object, "causing trouble", being in control) to a more holistic perspective of self-respect and -acceptance. Of special importance is the support that group members offer each other in relation to their difficult bodily experiences; sharing and reflecting on these together enables patients to feel less isolated and consequently it allows patients to feel more accepted and understood.

The therapist supports the integration of physical, perceptual, emotional and cognitive aspects of the physical complaints into a cohesive narrative, emphasising how the body itself can help to regulate the impact of symptoms and achieve better coping.

3. The basic therapeutic framework in BOPT

3.1 Format:

Body oriented group psychotherapy with up to 10 participants, one body oriented psychotherapist, 1-2 co-therapist/s.

3.2 Time and duration:

Individual intake interview/introductory session of 60mins with therapist followed by one weekly group session of 90 minutes, 20 sessions over a period of approximately four months.

Each 90 minute group will be divided into five distinct parts: a check-in, warm-up, exploration of objectives, warm-down, closure and homework.

3.3 Equipment/Materials:

A big mirror; Soft balls (between 8 and 13.5 diameter); 24 foot lengths of rope; parachute (3.7metres diameter); co-oper buddy band, coloured clothes and stretch cloths, coloured ribbons, a selection of hand held percussion instruments, beanbags, balloons, CD player and range of music with different rhythmical qualities; natural materials such as stones, feathers, pine cones, shells, soft toys. Felt tips and oil pastels in a range of colours. A1 sugar paper in assorted colours.

3.4 Physical Setting:

A bright, friendly room, preferably with a wooden floor. A space of at least 30 square metres in size is necessary.

3.5 Therapist's professional background:

Knowledge of and experience in working with patients suffering from mental health problems; qualified therapist in one of the main body oriented psychotherapy modalities (Dance Movement Psychotherapy / DMP with ADMP accreditation or according to European Association of Body Psychotherapy / EABP with UKCP registration).

Experience in offering body oriented psychotherapy in groups.

4. Specific therapeutic objectives and examples for their corresponding interventions and processes

4.1. Therapeutic alliance:

Central to the therapeutic effectiveness in the treatment of patients with MUS conditions is the therapist's non-judgemental interactional approach creating a solid therapeutic alliance, i.e. the therapist "picks up the patient where she/he is", without questioning either qualitative characteristics of complaints or explanatory model.

Specific activities include:

- Giving plenty of time and listening empathically. Building up a therapeutic relationship via communicating about and with the body. From the very beginning the therapist will not only passively listen to the complaints but offer comments as well as verbal and emotional reactions.
- The therapist uses mirroring and imitation techniques in order to explore the patients' bodily states in his own body (using the full range of expressive behaviour including movements/breathing pattern, gestures, postures, , etc.).

4.2. Empathic exploration, enhancing complex awareness of the body:

Widening the perspective and de-focussing: exploring the areas associated with the problem areas and the muscular responses to the identified problems (gentle, directed movements in different dimensions); supporting differentiation of somatic sensations and intensifying overall bodily awareness as well as supporting movements of control.

Specific activities include:

- Scoring how the body feels from (1 (very tired or in pain, etc.) to 10 (lively or free of pain, etc.). This at the beginning and end of the session; comparing this to how you feel in term of emotions/mood (using the same scoring scale from 1-10).
- Self-massage (gentle stroking of the body with hands to release tension); working individually, participants are asked to massage themselves in two ways. Firstly, using their hands they sequentially massage their hands, arms, legs, feet, shoulders and back, then addressing specifically those areas of concern. Then they do the same but instead of using their bare hands, they use a small rubber ball to massage the same parts of their body.

- Self-massage can be developed to more vigorous stimulating or ‘waking up’ of tissues by using both hands formed in a loose fist and patting quickly and lightly all the wide body surfaces.
- Massaging with the ball is further developed by firstly manoeuvring the ball over the body parts with the hands.
- Checking changes in body states, e.g. shoulder rotation with one shoulder, reflecting on how it feels before and after exercise and comparing it to how the other shoulder feels which has not yet been warmed-up
- Other exercises concentrate on intensifying of breathing and pulsation. Of particular importance is training in deep breathing [full diaphragm breathing, building up to it by practising expansion of the diaphragm, (up/down dimensions), of the rib cage (side to side dimension) and clavicle breathing (forward and backwards)] for two reasons: to offer patients an experience of having control over their body in a tangible manner and also to reduce anxiety, tension and stress which often accompanies the somatoform pain/symptoms.
- Grounding and centring exercises; Body part warm-up exercises with clear reflections before and after each one so that patients can sense subtle changes in joints (flexibility/fluidity), in temperature, in heart beat aqnd the impact of these exercises on feelings.
- Gaining more awareness of the way the force of gravity affects our bodies and consequently of our constant subtle and more pronounced adjustments to keep ourselves balanced and erect when standing; learning to trust the ‘body intelligence and kinaesthetic awareness’, i.e. that our bodies take care of us and don’t let us fall over even if we try to go off balance.
- Using imagery and symbolism to encourage self expression through postures and gestures like ‘reach for the stars’ and ‘melt like a candle’ or ‘drop like a floppy puppet doll’. Furthermore exploring emotional/thematic self-expression with appropriate movement phrases (e.g. stretching up and bending chest outwards as well as walking on toes suggestive of proud feelings/high self-esteem, opposite gesture with inwardly bended and drooping shoulders suggestive of feelings of defeat and low self-esteem, etc.).
- Further use of visual imagery in relation to anatomical structures to enhance kinaesthetic awareness of the body.

4.3. Learning to recognize and express emotions; recognizing the connection between emotional and bodily changes; affect regulation:

Experiencing the bodily complaints in terms of quality and localisation , gradually moving on towards exploring how the bodily complaints change (nature, degree and quality) in relation to changes in movement pattern or muscular tension/relaxation as well as in response to internal and external stimuli (situational factors). Learning how to induce and tolerate changes in bodily states and their corresponding emotional states and how to obtain partial control over both emotional expression and bodily functions such as breathing and movement (particular emphasis on fear and aggression).

Specific interventions include:

- Drawing analogies of bodily states to qualities of external objects (offering a range of different items to choose from, e.g. balls, natural materials like shells/feathers/stones/wood, dolls, play-mobile figures etc.).
- Identifying and expressing emotional states with different colours: choosing and moving/dancing with cloth that most reflects own feeling/attitude to body and self; deliberate alterations of bodily states (exercising, walking with different qualities and paces such as "fear, pride, anger, happiness").
- Creating/inducing emotional states in a controlled manner via a range of creative arts techniques (drawings, sculpturing of body image figures with clay and sculpturing of emotional expressions in ones own body).
- Supporting alternative expressive behaviours in relation to emotional states, e.g. expression of anger/aggression in safe symbolic way (throwing balls against a wall or a bag/cushion on to the floor, hitting a cushion, making noises, stamping feet, etc.).
- Using drawing or clay sculptures to give form to sensory and emotional states which arise during movement to facilitate concretisation and verbalisation of non-verbal experience.
- Shaping the body according to the symptom/pain and moving around the room in order to demonstrate "how the symptom/pain moves the body".
- "Finding your place in the room"-exercise (a place that will reflect inner states/feelings); intentional movements; interactional "body dialogues":

- patients engage in a verbal dialogue between the ‘symptom and ‘themselves’ expressing feelings and thoughts, such as anger, distress, or a determination to overcome problems with the symptom/s.;
- patients ‘dance’ their symptom, i.e. move their whole bodies in the way that the symptom makes them feel/move e.g. bound flow, small steps, limited use of personal space. This is contrasted with how they actually move and how they would like to move.
- Supporting alternative expressive behaviours; using parachute as a vehicle for expressing emotions, i.e. shaking it fiercely to express anger, gently undulating it to express calmness etc.
- Using props, such as ribbons, symbolically to create a narrative about the symptoms as well as alternative possibilities/capabilities
- Working with negative emotions with particular emphasis on anger, gradually integrating those initially untargeted movements and expressive behaviours with personal themes (e.g. names of people that you may be angry with, situations that frustrate or annoy you, conflicts, etc.): grounding and vocal exercises, “stamping feet”, kicking backwards, throwing balls, beanbags or other appropriate materials towards the floor or walls, making gestures with fists and/or grimacing, hitting soft cushions
- Using body shape as starting point (e.g. closed shape with focus down in contrast to open shape with focus out) as a means of understanding the relationship between and influence of body posture and gesture on mood.
- Finding one’s voice – physically and metaphorically – open sound (created by open voice box) projected from base of stomach to other side of room – e.g. a long ‘ah’ sound’ in contrast to the vocalisation of the discomfort from the base of the stomach – voice box tightens.
- Experiencing one’s own strength or lack of strength by pressing a soft ball firmly with both hands at once. This enhances an awareness of resistance, strength, and also will result in changes in breathing.
- Reflections on these exercises after each one to encourage verbalisation of connections between feelings and bodily sensations and movement.

4.4. Emphasizing the impact of bodily complaints/symptoms on quality of life and overall functioning,

Identifying areas of disabling nature of the condition; drawing connection between psychosocial restrictions and bodily complaints; exploring bodily changes that might impact positively on the symptoms. Using symbolic movement to interact with the pain: the pain in the body is experienced as overwhelming and taking up all emotional and physical energy; introducing the idea of symbolically pushing the pain away using strong sustained movements so that we can experience that the pain was not entirely us, but that we can separate it out and work with it.; contrasting this with pulling positive feelings into ourselves, i.e. happiness, peace etc.

Specific interventions include:

- Scenic (psycho-dramatic, role-play) reacting of conflicts with the help of other group members; performing and overemphasising / exaggerating symptoms. Enacting/improvising/creating stories through group movement and free play, e.g. feeling body is destroying quality of life and unable to do anything and feeling hopeless and meaningless – example: together group creates a story of being under the sea, each group member takes on role of different sea creature and together the group aims at finding a treasure chest at the bottom of the ocean, choosing different roles and responsibilities for the group.
- Impact of symptoms on relationships: focusing on the boundary of the personal space; exploring distance, separating and merging with an opposite partner, giving attention to the general shared space, (e.g. in pairs: partners keep a soft ball between their hands and push/yield stepping forwards or back; one person moves and the other mirrors the movement, keeping eye contact at all times, gradually they move apart, steadily increasing the distance between them, they come back opposite each other and swap roles).
- Explore anger/aggression towards symptoms and how much 'energy' this costs (e.g. "fighting" with the symptoms symbolically); Reflections afterwards.
- Connecting with an animal quality that embodies an aspect of us and it's opposite (e.g. a hippo out of water that is very immobile and heavy in contrast to a giraffe that has a lot of mobility and is able to see far). Embodying the animal quality and/or movement.

4.5. Emphasizing and exploring the competencies and abilities of the body

Introducing attention shifts towards bodily competencies and how these competencies can be used in addressing the identified restrictions/disabilities; at the same time these exercises enable experiences of pleasurable bodily states (relaxation, feeling at ease, “letting-go”, warmth/flow, learn to “listen” to bodily needs).

Specific interventions include:

- Exploring personal rhythm, pace and attempting to connect these with positive evaluations about the self; playfulness-exercises with balls, ropes, parachutes, buddy band, balloons, stretch cloths etc.; walking/moving and dancing in relation to bodily rhythm, using percussion instruments to express feelings, using music.
- Experience the bodily states as sources of pleasure, vitality, lust (e.g. tension-relaxation exercises, discover body warmth, the pleasure of exhaustion etc).
- Exercises to enable bodily strengths (e.g. working with another participant and pushing or pulling each other through the therapy room).
- Name game: saying your own name with a bodily movement that others echo; then creating the opposite movement with your name – evokes contrasting moods/feeling and supports sense of personal identity.

4.6. Drawing analogies, helping to understand the connection between difficulties and physical reactions; feelings, bodily reactions and symptoms:

Specific interventions include:

1. “Does this remind you of similar situations in day to day life”; exploring lust/pleasure/joy as opposed to anger/reluctance/sadness.
2. “Breaking the ice” and “Trust me” exercises such as in pairs with one person closing eyes, being led by the other; this evokes very powerful emotional as well as bodily sensations, which will be addressed verbally and integrated therapeutically (psychodynamic); Family sculpts.
3. Coming together: sensing bodily sensations and corresponding feelings of dis/comfort as one person moves towards the other and comes into his/her space (changing perspectives from being the more active or more passive partner).

4.7. Maintain achieved improvements/relapse prevention:

Continue with homework exercises; follow up individual sessions a month, three months, 6 months and one year after group finishes are optional (outside the research settings); this will allow for further consolidation and helps with prevention of deterioration.

Appendix: Symptom and Mood diary

Date	Physical symptoms / complaints	Does this evoke any feelings, please describe	What situation does this relate to in your life? Alternatively: do these evoke feelings connect to other situations in your life?	In which situations do you feel better e.g. when having a relaxing bath, when playing with your children?