



Searching for existential security: A prospective qualitative study on the influence of mindfulness therapy on experienced stress and coping strategies among patients with somatoform disorders



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ABSTRACT

Objective: The aim was to explore how mindfulness group therapy for somatoform disorders influenced the patients' stress experiences, coping strategies and contextual psychosocial processes.

Methods: A longitudinal pre- and post-treatment design, using 22 semi-structured individual pre- and post-treatment interviews. Data-analysis was based on a thematic methodology.

Results: Pre-treatment patients were struggling in an existential crisis, feeling existentially insecure about their social identity, the causes, consequences and management of their illness; experiencing difficulties identifying and expressing stress-related cognitions, emotions and feelings, and low bodily and emotional self-contact; often leading to avoidant coping, making these individuals highly stress-vulnerable. Post-treatment, the overall change was conceptualized as increased existential security, defined by patients being more self-confident; more clarified with their social identity, the nature, management and future prospects of their illness; generally using more flexible coping strategies to reduce their daily stress experiences. Four related subthemes were identified contributing to increased existential security: 1) more secure illness perceptions – feeling existentially recognized as “really” ill, 2) enhanced relaxation ability – using mindfulness techniques, 3) increased awareness – connecting differently to mind and body 4) improved ability to identify and express needs and feelings of distress – more active communicating. Patients suggested that mindfulness therapy could be expanded with more time for group-discussions followed by additional individual therapy.

Conclusion: Generally, treatment positively influenced the patients' illness perceptions, stress-experiences, body- and self-awareness, coping strategies, self-image, social identity and social functioning. However, patients identified potentials for treatment improvements, and they needed further treatment to fully recover.

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Introduction

Physical complaints not attributable to conventionally defined diseases are prevalent in all medical settings [1], when the symptoms become chronic they could be diagnosed as somatoform disorders (SD). The interactions between stress, maladaptive coping patterns and bodily reactions involved in SD-pathology have been unclear [2–8]. However, recent research shows that patients with SD are stress-vulnerable [9] having difficulties coping with psychosocial challenges and illness-related stress [10]. Exploring life-history patterns, SD-patients narrated how the communication of stressful circumstances with significant adults in their childhood was experienced as

insufficient, conflicting or dismissive, generally involving avoidant coping strategies [9]. Patients adapted to this “emotional avoidance culture” by becoming emotionally avoidant themselves [2]. Findings also associates SD with alexithymia [11–15], affect dysregulation [16–18], insecure attachment [19–21], poor expression abilities and avoidant coping [22]. In their adult lives, SD-patients feel a deep longing for existential recognition from others, while experiencing difficulties with self-recognition of concerns, needs, vulnerability and distress, which negatively frame their ability in expressing these essential aspects; as a consequence patients generally hide their concerns [10]. Hence, SD-patients do not achieve the stress-reducing effects normally gained when feelings are verbalized [16,23–26]. Additionally, in keeping their concerns secret, they receive no social support, which makes people more resilient to chronic pain [27,28]. Suffering from a contested psychosomatic illness is found to be stressful, involving stigmatizing processes, diminished self-confidence and disrupted self-biography, leading to identity-crisis [10,29–32] aggravated by insecure illness perceptions [30,33,34] and

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insufficient treatment [2–8]. Thus specialized treatments for these conditions are often lacking [35].

Treatments with mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) reduce SD-related symptoms of stress, anxiety, fatigue and depression [36–40]. Mindfulness-based treatments for fibromyalgia have shown inconclusive results [41–45]. A study of chronic pain-patients reported pain reduction as well as improved attention, sleep, mood and wellbeing [46]. Cognitive behavioral therapy (CBT) is shown to be the best established treatment for varying somatoform disorders [47,48]. Mindfulness therapy (MT) is a new manual-based group-treatment for people suffering from SD, combining MBSR-elements with CBT-elements [35,49]. Mindfulness is the awareness that emerges through nonjudgmentally paying attention to purpose and bodily sensations in the present moment [50], aiming for altering the stress-response from affective alarm – reacting automatically with fight-, flight- and freeze-reactions – to mindful pro-action by cognitive reappraisal and bodily contact [36]. The aim of this study is to gain new in-depth knowledge on how MT influenced the patients' stress experiences, coping strategies and the contextual psychosocial processes including their self-image and social identity.

Methods

Design and data collection

This study employed a qualitative pre- and post-treatment longitudinal design using semi-structured, individual interviews, 1–3 month pre-treatment and 9–14 months after end of treatment. The same interview-method and the same approach to data-analysis were used upon the follow-up interview. Data were based on 24 purposefully sampled cases participating in MT in two groups, recruited from The Research Clinic for Functional Disorders and Psychosomatics, Aarhus University Hospital, Denmark. The patients were referred from both urban and rural areas covering a population of approximately three million people. Inclusion-criteria: Newly diagnosed with F45.0-somatoform disorders following the ICD-10 criteria, clinically conceptualized as bodily distress syndrome, affecting at least three out of four bodily systems with functional somatic symptoms (cardiopulmonary, gastrointestinal, musculoskeletal, or general symptoms) [1], moderate to severe impairment for at least 6 months, 20–50 years, and any comorbid mental- or medical disease, e.g. depression/anxiety or asthma/diabetes, should be clearly differentiated from the SD-symptoms. Exclusion-criteria: current alcohol or drug abuse, pregnancy and not fluent in the Danish language. All patients invited to participate in the study agreed.

MT was offered in eight weekly 3 1/2 hour group-sessions and one follow-up at week 12. Individual treatment goals were excluded [49]. A detailed overview of the MT-program is presented as supplemental data: Appendix 1. Treatment was completed by 22 patients (at least six out of nine sessions). The two none-completers were excluded from the analysis. The researcher ABL was a participating observer of MT, whereas treatment was conducted by a psychiatrist who specialized in mindfulness [49]. Post-treatment, nineteen patients were interviewed in their homes and one at The Research Clinic. Two patients were, for personal reasons, not motivated for the post-treatment interview, but they agreed to participate in a telephone-interview. The design was chosen to make the results post-treatment more valid and give the study a prospective dimension. The patients were purposefully sampled obtaining demographic variations in age, employment status and location [51]. After 16 interviews, a point of saturation was reached, which is the point in data-collection when data become redundant, and no significant new information emerges related to the patterns constituting the theory [51]. Post-treatment interviews lasted two to three hours, covering diverse aspects related to the patient's experiences of how the group-treatment with MT had influenced their experience of stress, coping with stressful conditions, self-image, social identity and

the psychosocial context (see topics explored in supplemental data: Appendix 2). Questions addressing the patients' experiences with MT were raised as open as possible, supplemented with questions of how MT had influenced the most essential challenges experienced by the patients, which they narrated in the pre-treatment interviews. The interviews were recorded digitally and subsequently transcribed verbatim.

Thematic analysis

The data-analysis was based on thematic methodology, which identifies central themes; meanings and patterns chosen in order to capture the patients' perceptions and experiences [52,53]. The analysis was performed consistently following thematic analytic procedures: becoming familiar with data involving transcription and reflective reading, generating initial codes, searching for themes, reviewing and refining themes, identifying coherent patterns, defining and naming themes and producing the report [52]. The coding was done using Nvivo 10 by the first author (ABL) systematically supervised by the senior researchers. Thus, the coding of the most central patient-narratives was discussed within the research-group to ensure reliability and to achieve consensus on the essential codes, covering distinct, coherent and consistent patterns in the patient-narratives. The interrelation between the coded narratives, the related developed theories and the conceptualizations of the findings were developed by procedures of constant comparison, meaning that the research process perpetually involved transactions of data-analysis and theoretical reflections on the interrelatedness of the data [52]. The study was carried out in accordance with the Declaration of Helsinki, and presented to the local Ethics Committee which decided that it should not be notified because no human biological material was involved. All patients gave informed consent.

Results

All patients were influenced by psychosomatic symptoms negatively affecting their private and professional daily lives. Twenty patients had been ill for at least one year, and two had been ill for more than five years; the average duration of illness was 2.7 years (SD 2.3). After MT, six patients were engaged in individual therapy, and two were in group-interventions for stress-management. For a detailed overview of the characteristics of the sample, see Table 1. Four processes of change were identified based on the patients' narrations of how MT influenced their daily lives.

More secure illness perceptions – feeling existentially recognized as ill

A major goal for MT was psycho-education, teaching the patients SD-psychopathology, stress-theories, CBT-models and how prolonged stress could lead to SD. One of the most significant changes was the patients' experience of being existentially recognized as “really” ill. MT enhanced their ability to understand and explain their illness as a stress-related disorder, which relieved patients because they perceived stress to be a legitimate and meaningful explanation. Patients used different illness-idioms, e.g. “stress-hypersensitivity”, “stress-intolerance”, “allergic to stress” and “nervous-system dysfunction”. Thus liberated from the stigmatizing and self-stigmatizing processes that the patients experienced pre-treatment, they felt enhanced security about their social identity as “legitimately ill”. Patients experienced reduced anxiety; worry, shame, guilt and uncertainty, which motivated them to become more socially active (see citations by, e.g. Anna in supplemental data: Appendix 3). Being able to calm themselves, instead of feeling stuck by frightening or shameful catastrophic-thoughts, meant that patients related differently to their symptoms, developed a more positive self-image and social identity, feeling more self-confident and existentially secure, as they were recognized as “really ill”.

Enhanced relaxation ability – using mindfulness techniques

Post-treatment, the ability to be more present, letting go of worries and related tensions (e.g. by using breathing-techniques), was narrated to be another significant change experienced by the patients, reducing their daily anxiety levels and enhancing their abilities to enter a more relaxed physical and mental state. Patients narrated using meditation-skills to relax, e.g. for reducing pain/anxiety/catastrophic-thinking, letting go of muscle-tensions and pain – breathing deeply – paying more attention to the present moment and worrying less. These improvements were experienced to increase their social functioning with their partners, friends, colleagues or children; for example, Ida brought a chair, sitting down meditating while watching her son play football, happy she could now take part in her son's activities. She cited her son as saying: “I have got my mum back” (see citation by Ida in supplemental data: Appendix 3). Her self-confidence became enhanced: now feeling she was back in the role as a good mother, now taking

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