

The BodyMind Approach to support people with medically unexplained symptoms to learn to self-manage

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2 OVERVIEW

- Definition, prevalence, costs
- Patient mind-set, profile and experience
- Learning to self-manage
- The BodyMind Approach™
- Reliable change clinical outcomes
- Questions

3 MUS Definition

- MUS -Previously known as psychosomatic conditions/MUPS- recently known as somatic symptom disorder (SSD) DSM-5
- Persistent, physical symptoms which do not appear to have an organic cause or respond to treatment
- Clinical & social predicament, includes broad spectrum of presentations, difficulty accounting for symptoms based on known pathology (Edwards et al 2010)

4 Scale of the problem

- 26-35% GP consultations with patients suffering MUS (Barsky; Borus, 1995)
- Comprise 50% of medical outpatient appointments and 5–10% of in-patient care, with limited evidence of benefit
- 10 of most common problems account for 40% of all visits, but GPs can identify a biological cause for the concern in only **26%** (i.e. 14% of the 10 most common symptoms MUS) (Nimnuan, 2001)
- Therefore we know MUS are very common world-wide, accounting for as many as **1 in 5** new GP consultations in primary care (Bridges; Goldberg, 1985)

5 PROFILE OF PATIENTS WITH MUS

- 70% suffer from depression (Malhi 2013)
- Fewer years in formal education (Creed, Barsky 2004)
- Parental neglect/illness in childhood (for women) (Craig, Cox, Klein 2002)
- 50% more consultations; 50% more healthcare costs; 33% more hospitalisations
- Generally high levels of health anxiety/anxiety
- More women than men, YP and non-native speakers
- Uncertainty whether it is a physical problem or if symptoms are stress related
- Unnecessary procedures/surgery - can create new health problems/increase anxiety

6 PROFILE OF PATIENTS WITH MUS

- The symptoms are just the tip of the iceberg!
- More sick leave & more likely to be unemployed
- Comparable to MES in impairment of physical function/considerably poorer quality of life than MES
- Poorer general health & worse mental health
- Poor affect regulation / needy of emotional support
- Past/current family dysfunction and/or a history of trauma, neglect or abuse
- Insecure attachment (Adshead & Guthrie 2015)
- Frequently multiple physical symptoms

7 WHY LEARN TO SELF MANAGE SYMPTOMS?

- To promote wellbeing - emotional, physical, social and spiritual
- If can manage stress effectively - bad days not so bad.
- Learning stress responses as occur in the bodymind helps in controlling bodily reactions
- Self-regulation (Barlow, 2001) crucial to resilience, life generates stresses - so symptoms experienced more
- Reinforces the patient's crucial role in managing their condition, sense of agency, developing goals, identifying barriers, designing a plan to carry out actions to reach goals
- Supportive reminders reinforce the plan (Woolf et al. 1999).
- Over-stretched NHS, ageing population, fewer resources, lack of GP capacity
- Self-management may be one of the main ways of closing the gap between patient needs and health service capacity (Barlow et al. 2002).

8 LEARNING TO SELF MANAGE: THE RESEARCH

- Patient-oriented educational interventions successful in self management (Renders et al. 2001).
- Educational interventions commonly to improve health outcomes of patients with low health literacy (Schaefer, 2008).
- Health education improves patients' knowledge and treatment of a disease = better treatment adherence / a more positive role in managing their health (Meyer, Leventhal & Gutmann, 1985).
- Group interventions with peer contribution, patient empowerment, acquisition of self-management skills effective in diabetes, asthma, etc. (Gibson et al. 2001).
- Interactive education workshops effective in community-based health promotion programmes for hypertensive patients (Chu-Hong et al. 2015).
- Interventions for chronic disease positively affect wellbeing -(von Korff et al. 1997).
- Traditional patient education emphasized knowledge acquisition/didactic classroom teaching- unsuccessful in changing behaviour/improving disease control (Clement, Clark & Gong, 2000).
- Improving knowledge of condition/confidence/skills in managing it (Norris, Engelgau & Narayan, 2001).
- Changes to lifestyle/ increased adherence to antihypertensive medications to improve effective blood pressure control in hypertensive patients (Shaw & Bosworth, 2012).

9 A DIFFERENT SOLUTION TO THE PROBLEM

- The interactive facilitated group
- Engage by a focus on their pre-occupation 'learning about symptoms' e.g. stress responses
- Physical symptom acts as gateway to the mind
- Work with lived body - a perspective informed by experience, non-linear and unpredictable
- 'Playing with the symptom so it does not play on you'
- Promote wellbeing, self regulation and resilience leading towards 'Recovery' – always in recovery

10 TBMA AS A RESEARCH-INFORMED APPROACH FOR LEARNING SELF-MANAGEMENT

- A similar interactive workshop model may be helpful in supporting patients with chronic MUS to learn self-manage their condition.
- TBMA as a research-informed approach offers just such a model derived from practices in the arts therapies, embodied psychotherapy, mindfulness and group work- an integrated, unique model
- Lived experience of bodily symptoms, from which needs arise, lead to goals for change being identified
- Self-responsibility and self-directedness inherent in the setting of these relevant goals
- Patients actively involved in identifying goals and problem-solving to reach them via an individualised action plan for self-management
- Nudges to support action plan adherence post workshops (phase 1) for six months (phase 2)
- People take the initiative in making meaning from symptoms (understanding selves through their symptoms) and in deciding goals/ arriving at methods/strategies to fulfil those goals.
- Learning how to manage /control symptoms is a result of the learning arising from the various facilitated and home practices
- Reflect in group/with facilitator/ reflective learning journal - self-direction stimulated supporting transformational (Mezirow, 1997).
- Pathway is individual, life experiences, beliefs and lifestyle in relation to perceptions of the symptoms are evaluated together
- Focus is on problem-solving in the context of the real, body-felt inner world

11 THE BODYMIND APPROACH (TBMA)

- TBMA explores the experience of symptom by working from the body to the mind
(Varela et al., 1991; Lakoff & Johnson, 2003)
- honours both conscious and unconscious processes
- sensation, perception, emotion, cognition are integrated
- facilitated group workshop which employs creative, embodied practices
- relationships within the group emphasized - learning with and from others
- body-based practices 'bear the symptom in mind' e.g. body awareness, mindful movement, dialoguing with the symptom through dancing from it, drawing and speaking from it, progressive relaxation, breathing
- people gain an understanding of their symptom and make meaning of its nature, characteristics, purpose and the role it plays in their lives
- seem to be more able to make decisions about how they change their lives to manage their symptoms.

12 COMMUNITY SERVICE FOR PRIMARY CARE PATIENTS

Termed:

- The Symptoms Clinic/MUS Clinic to GPs
- Living Well Groups/Symptoms Groups/Learning Groups to patients

13 WHAT DO LEARNERS LEARN in TBMA COURSES?

- to be openly communicative, creative, flexible, incorporate more positive values
- home practices each session to support them once group ended
- to feel more in control- empowerment encourages resilience to sustain self-management
- to change habits/ build new habits
- the significant features of symptom are explored, effects on feelings, functioning, relationship to behaviour/ thinking
- to explore the symptom/s (and the self) through creative expression
- to set realistic goals, design action/s to achieve them in an action plan for phase 2
- an attitude that change is needed
- to engage as an equal partner in the desire for change -raising this awareness is central to the process
- to acquire new skills, understanding and knowledge on how to change the way they behave towards, feel, perceive and experience their symptoms

14 STRUCTURE OF TBMA COURSES

- Up to 12 patients per group, 12 workshops, x 2 per week for first two weeks, 2 hours, non-clinical location
- Inclusion /exclusion criteria
- Triage/assessment/monitoring
- Recruitment
- Facilitator
- 9 months duration from referral
- Two phases (phase 1 workshops, phase 2 six months action plan and nudges)

15 PRINCIPLES FOR PRACTICE I

- A bio-psychosocial approach
- Cultivate a different perception of symptoms and valuing of the body and sensory experience
- Reflect a relatively positive adaptation despite significant symptom phenomena as stressors
- Foster protective factors which buffer the negative effects of stress and bodily symptoms
- Avoid psychological explanations and interpretations, particularly early on, clients have been sensitised to 'its all in the mind'

16 PRINCIPLES FOR PRACTICE II

- Establish safety/honour the client's symptoms - this is very important
- Allow body to express its distress and bear witness to it
- Language important, differs for GPs/patients
- Aim is to go towards the symptom AND expand consciousness/identity beyond it –'I have my symptom but **I am not** my symptom'
- Offer a 'both' - 'and' not an 'either' / 'or' for referral to secondary care
- De-medicalise the body - normalise

17 PRINCIPLES FOR PRACTICE III

- The lived body experience as the focus for all practices i.e. the subjective body is emphasised.
- Exploring the sensory experience of the symptom helps patients learn more about themselves, their symptoms and new coping strategies to live well.
- The importance of the facilitated group format for cultivating a sense of belonging, the motivation for change, peer support, reduction in isolation and making new and long-lasting friends.
- Providing opportunities for meaning-making through symbolic and metaphoric expression during embodied artistic practices.

18 MEASURING OUTCOMES - Practice-Based Evidence

- Standardised measurements: MYMOP, PHQ9, GAD, GAF, in-house questionnaire
- Pre group, post group and 6 months follow up
- Quantitative and Qualitative evaluation from patients
- Participant Experience Form- 97% completion

19 CLINICAL SERVICE

- Based on research study of TBMA (Payne & Stott 2010) (N=21)
- Taking account of conversion and dissociation present in MUS (Lin & Payne 2014)
- Practice-based evidence (QIPP project) (N=16) (Payne 2015; Payne & Brooks 2016)
- Practice-based evidence (N=18)
- Practice-based evidence (N=30)

Over 70 patients mirror research outcomes

RCT pilot in the corporate world with managers (N=6) showed similar outcomes when compared to matching cohort not receiving the intervention

20 CLINICAL OUTCOMES

pre to post course reliable change

- Depression 35% (11/31) improvement **alone**
- Anxiety 42% (13/31) improvement **alone**

To avoid double counting it is necessary to exclude 4 people who improved on **both** measures.

Thus, figures used to calculate the % are less than combining the two figures giving:

- Depression + Anxiety - overlap 65% (20/31)

Many medicated for depression and/or anxiety - do not show major changes on PhQ9.
Most MUS patients mild to moderate depression/anxiety so PhQ9 /GAD7 may not be the most appropriate tool.

Depression and/or anxiety not the presenting problem nor what they appear to be most concerned about which is their symptom/s.

Very little reliable deterioration.

21 PRACTICE BASED EVIDENCE: CLINICAL OUTCOMES

Table 1-To show pre to post course reliable change

	Reliable Improvement	Reliable Deterioration	No Reliable Change
PHQ9 Depression	35% (11/31)	3% (1/31)	61% (19/31)
GAF General Functioning	35% (11/31)	0% (0/31)	65% (20/31)
Overall Profile MYMOP2	55% (17/31)	0% (0/31)	45% (14/31)
GAD7 Anxiety	42% (13/31)	3% (1/31)	55% (17/31)
MYMOP2 Symptom Distress	63% (39/62)	8% (5/62)	29% (18/62)
MYMOP2 General Wellbeing	55% (17/31)	19% (6/31)	26% (8/31)
MYMOP2 Activity	58% (18/31)	23% (7/31)	19% (6/31)
Either PHQ9 or GAD7 combined	65% (20/31)	3% (1/31)	32% (10/31)

22 CLINICAL OUTCOMES

Table 2: To show PhQ-9 and GAD-7 Reliability

N.B. Lower scores indicates improvement.

Measure	Diagnosis	Reliable Change Index
PhQ-9	Depression	≥ 6
GAD-7	Generalised Anxiety Disorders	≥ 4

23 PARTICIPANT EVALUATION 1

Table 3: To show the percentage of participants' expressing satisfaction with:

Overall Service	75% (18/24)
Telephone Monitoring	75% (18/24)
Venue	83% (19/23)
Facilitator's Listening Skills	100% (23/23)
Overall Facilitation	88% (21/24)
Course Administration	71% (17/24)
Waiting Time to Intake Meeting	79% (19/24)
Type of Treatment	74% (17/23)
Overall Experience	75% (18/24)

24 PARTICIPANT EVALUATION 2

The initial contact, assessment telephone monitoring process, group experience/content, facilitator and overall service were rated as **'satisfactory' to 'very satisfactory'** (i.e. 4s and 5s on a scale of 0-5)

Other Highlights

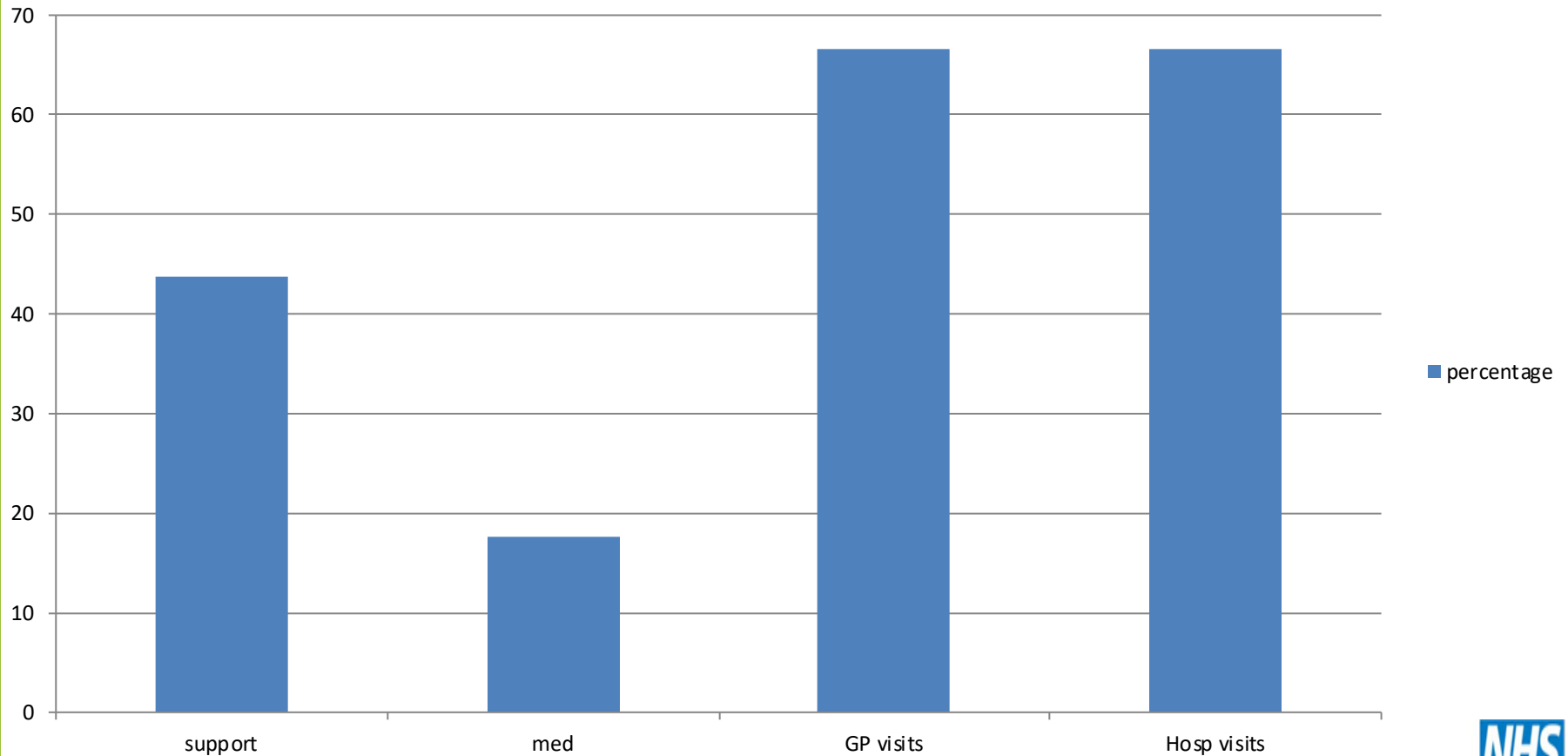
- 88% (21/24) received a resource list at the exit meeting
- 70% (16/23) felt they had enough help to go forward
- 79% (19/24) would use the service again without hesitation
- 97% (20/21) would recommend the service to friends and family without hesitation

25 Table 4: To show the effect of participants' symptoms on ability to work

	Before Course	After Course
Coping well with symptoms	4% (1/24)	52% (12/23)
Coping well at work	14% (3/22)	50% (11/22)

TABLE 5: An example of percentage improvement in social support, medication, GP & hospital visits

percentage improvement



27 PATIENT FEEDBACK

“It was helpful to be in a group of people sharing similar problems”

“Achieved a return to work and overcoming of fibromyalgia”

“There was a freedom of expression and an alternative way to consider coping with my problems”

“The focus was on the MUS issues”

“The group was good in that we spoke and listened to each other “

“I wish it had been available 5 years ago when the symptoms started”

28 FOLLOW UP OUTCOMES

The 6 month follow up analysis compared to **post group**:

- Improvements not only sustained at 3 months post group (as in pilot) but maintained/improved further at the 6 month stage in:

functioning

wellbeing

anxiety

depression

symptom distress

The 6 month follow up compared to **pre-group** analysis showed:

- Improvement or maintenance of **activity** levels (50% of people becoming more active /50% remaining the same when compared to pre-group)
- Improved **well-being** maintained in 50% of people at post-group when compared to pre group
- Improvement in **social, occupational and overall functioning** in 75% of people when compared to pre group

29 CAUTIOUS CONCLUSIONS FROM THE EVIDENCE

- MYMOP2 (symptoms) 63% (39/62) reduction in symptom distress likely to result in consequent improvements in anxiety and depression -may reduce symptom distress still further - an iterative process - a virtuous circle of general improvement and sense of wellbeing.
- Overall MYMOP2 score- 55% (17/31) improvement;
- 55% improvement **general wellbeing**
- 58% (18/31) in **activity**.
- Most patients report important improvements in their **perception** of their symptoms which helps them to self-manage their conditions and consequently cope better day to day (and see quantitative and qualitative data from the PEF).
- GAF (general assessment of functioning) needs 'a 20% increase in pre-treatment scores for clinical significance' (reliable change) (Dugas and Robichaud, 2007p182)
35% (11/31) had undergone clinically significant improvements in **functioning** post intervention.

30 RECOVERY AS SELF MANAGED CARE

- Patients demonstrate their capacity for resilience post TBMA intervention
- Patient self management becomes habitual
- Feelings of wellbeing are sustained giving greater inner resources to cope when symptoms are felt
- Feelings of empowerment cultivated to control symptoms over time leading to self managed care
- Reduced dependence on the NHS, thus saving resources and increasing GP capacity

31 COMMENTS FROM GPs

“ I am grateful to this service which has helped my patient enormously to cope better with her symptoms”

“What an excellent service, my patient has never returned and he was coming every week and writing long letters to me”

“This service should be the first port of call”

32 QUOTATIONS FROM COMMISSIONERS

- ‘We are very impressed with not only the quality of the service being delivered but also the thoroughness and professionalism of the organisation behind delivering this service’
- ‘I can unreservedly endorse and recommend them as an organisation which will deliver their services to the highest professional and ethical standards’
- ‘They have the benefit of having national leading expertise in the treatment of MUS and have proven themselves as extremely capable of running learning/treatment groups for patients and training staff’

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Questions

Over to you!

