The BodyMind Approach for supporting people with medically unexplained symptoms: Reliable change outcomes

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Pic 2 What's on our Agenda?

- The prevalence of MUS
- The importance of emotional regulation, somatic mindfulness and safety to working with people with MUS
- An overview of this research-informed and research-based intervention called The BodyMind Approach (TBMA)
- Outcomes of reliable change from TBMA

Pic 3 Medically Unexplained Symptoms I

- One definition of MUS is that they are persistent bodily symptoms for which no medical explanation has been found
- MUS is sometimes referred to as a 'somatization disorder' or 'somatic symptom disorder' (SSD/DSM-5) within the MH field for which it is the total number of somatic symptoms and the level of the patient's concerns which are the predictors of health outcome and use.
- MUS is common world-wide. Affects women, young people and non-native speakers mostly –
- Because of the ACE, stressors including disrupted attachment, which may be prevalent in migrant populations fleeing war or political and other trauma. MUS is consequently highly likely to be present
- Just like migrants people with MUS exist in a no-man's land because they have physical symptoms the origin of which cannot be determined
- Just like migrants certainty is elusive since medics cannot find an organic diagnosis, standing on this edge of having no diagnosis can be disempowering and unhealthy
- MUS becomes part of the person's identity- a loss of health identity to unhealthy just like migrants who loose their original identity
- Loss of status in not being able to work etc. just like migrants who loose their status
- Loss of confidence and sense of agency just like migrants
- MUS is associated with chronic stress, anxiety, depression and ACE

Pic 4 MUS II

- Another uncertainty - The **GP does not know** the medical explanation for **75%** of the ten most common symptoms presenting to them (chest pain, fatigue, dizziness, headache, swelling, back pain, shortness of breath, insomnia, abdominal pain and numbness)
- Overall MUS totals **26–35%** in primary care and **50%** in secondary care
- **1 in 5 GP** consultations and **18%** of consecutive attenders are for MUS
- For people with MUS there can be fear that there is a serous condition which has yet to be diagnosed
- When all medical explanations have been ruled out there is even more anxiety - it is stressful, living with uncertainly and doubt - it is not good news!

pic 5 The BodyMind Approach is designed to support people with MUS to self manage based on research in:

- Emotional regulation
- Safety
- Mindfulness

Pic 6 Emotional regulation I

- Emotional regulation is the process that tunes the emotions, up-regulating or down-regulating emotions (Parrott, 1993).
- Emotional regulation strategies may be employed such as suppression and reappraisal (in which a person tries to think about a condition that changes the emotional response).
- The aim of increasing or lowering levels of arousal is to enhance emotional wellbeing.
- Emotional regulation is associated with wellbeing and describes the positive aspect of emotions.

Pic 7 Emotional regulation II

- It attributes to measures of longevity, quality of life, and resilient characteristics (Friedli 2009).
- Research indicates improvement in emotional regulation contributes to improvement in mental and emotional wellbeing.
- This emotional self-regulation framework provides for emotional arousal and vitality but also reduced arousal and calmness.

Pic 8 The importance of safety

- In Maslow's hierarchy of needs for self actualisation the first is physiological then comes safety needs followed by the need for a sense of belonging
- Reliable safety is crucial so there is no threat in order to allow social engagement to occur
- In people with an insecure attachment associated with MUS the need for safety is even more critical
- Safety needs are based in the limbic system, which is responsible for the fight/flight system of defences
- When safety and wellbeing is threatened, as in MUS, there is a greater need for safety to reduce the activation of the stress adaption responses

Pic 9 Mindfulness

- People with MUS often have accompanying depression and/or anxiety.
- There is evidence that mindfulness can reduce depression and anxiety (Hofmann, Sawyer, Witt, & Oh, 2010) and that it can have a moderate effect on some MUS (Grossman, Niemann, Schmid, & Walach, 2004).
- There is an association between lack of mindful self-awareness and depression (Segal, Williams & Teasdale (2002)
- This lack of self-awareness results in poor recognition and reflection on bodily cues or signals such as tension, pain, fatigue, destructive patterns, negative thoughts or feelings.
- It can help a dis-identification with bodily symptoms which as so often tied up with identity for the MUS patient.
- Kabbit-Zinn demonstrated MBSR reduced chronic pain.

- A 'mindful attitude' relates to a state of absolute presence moment to moment achieved through intentionally directed attention which at the same time allows internal and external stimuli to come into awareness and leave it without judgment e.g. body sensations.
- A mindful state is not dissociation but participation as an empathic observer or witness as in 'benignly regarding the self'

Pic 10 Bodymindfulness/somatic mindfulness

- Rather than immobility as in mindfulness TBMA encourages mindful mobility/ mindful movement

- For example ‘being in the movement moment’ as in walking around the space together with an inward focus

Pic 11 TBMA: I

- Unlike mind-body interventions in TBMA the body is emphasised first and foremost
- TBMA works in the space between the known and the not yet known towards a new perception of the symptom and identity
- TBMA honours the symptoms - working from the subjective body experience to the mind and back again
- It privileges the interactive relationship between the body and mind, emphasised in MUS
- It is bio-psychosocial, focussing on the whole person holistically
- It does not rely solely on language, has more of a focus on the right side of the brain
- There is no explicit discussion of psychological, biographic or causal relationship with the symptoms unless the participant makes such connections themselves
- It addresses a range of symptoms for a number of participants in the same group
- Participants become engaged in, for example, a state of inner mindfulness, as they move in the presence of a benign witness/facilitator
- Afterwards responses to these practices are reviewed verbally and then reported in their journals which form the basis of their action plan

Pic 12 TBMA: II

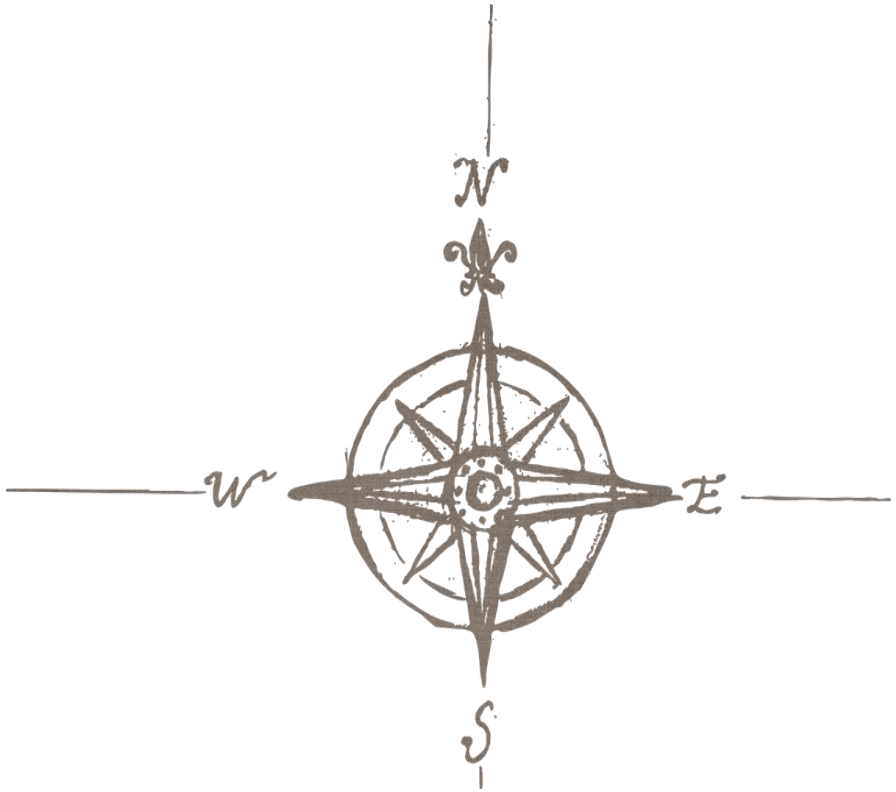
- TBMA is derived from dance movement psychotherapy (DMP).
- Informed by group psychotherapy TBMA is conducted as a facilitated group process which emphasises the lived experience of the symptom as an avenue for transformation
- It is framed as experiential group learning. The facilitator enables access to perceptions of symptoms through coaching enactive, embodied mindful practices involving, for example, body awareness, sensory experiences, symbolism and metaphor
- It aims to shift the experience of the symptom, changing the relationship, perception and mind-set to cultivate the **self management** symptoms to unlock wellbeing to live well
- It transforms seeing symptoms the 'enemy' to embracing them as an 'ally' and that flags up the need for self care and a compassionate acceptance of symptoms
- Caring for the self is initially modelled by the facilitator e.g. how to sit, breathe, use bodymindfullness and listen to the body for signs of stress
- Practices compare symptom sensations with other areas of the body as functioning and positive to create a balance

Pic 13 Exploration

The facilitator coaches participants who are requested to 'suspend their judgements' through exploration practices relating to their symptoms.

TBMA uses a mindful, kinetic practice for this experimentation-exploration

Practices explore the participant's relationship to, and perception of, their bodily symptoms and to their health care use



Any payoffs in having symptoms are explored, participants realise they have a conscious choice to change behaviour.

TBMA uses symbols e.g. drawing, clay, sound and creative movement to provide novel, playful and pleasurable conditions for safe exploration.

Pic 14 TBMA research

Pic 15 RESEARCH AND PRACTICE-BASED EVIDENCE

Based on research study of TBMA (Payne & Stott 2010) (N=21)

Accounting for conversion and dissociation (Lin & Payne 2014)

Women with/without depression (Lin, 2016) (N=24)

Practice-based evidence (QIPP project) (N=16) (Payne 2015; Payne & Brooks 2016)

Practice-based evidence (N=30)

Payne & Brooks (2017)

Practice-based evidence (N=18)

Payne (2018); Payne & Brooks (2018) in review

RCT pilot in the corporate world (N=6) showed similar outcomes

Over 90 patients mirror research outcomes

Pic 16 So what were the Reliable Change Outcomes? N=31

Reliable change outcomes from a recent county-wide delivery

73% of people who engaged in TBMA reported -

Lower levels of:

- symptom distress
- anxiety
- depression

Higher levels of:

- wellbeing
- overall functioning
- activity

EADMT, October, 2018

EADMT, October, 2018

Pic 18

Inclusion criteria includes the presentation of MUS for more than 6 months

Outcomes were evaluated pre, post group and at six months follow up

Measures included PhQ9; GAD7; GAF (same as IAPT) and MYMOP2

An in-house form at pre group collected demographic data

A participant experience form is distributed post group. 97% completed

Scores were calculated using reliable change criteria (as in IAPT)

95% of people **completed** the TBMA groups

Pic 19 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

Pic 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.

Pic 21 PRACTICE BASED EVIDENCE

	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)

Table 1-To show pre to post course reliable change

Pic 22 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

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

Pic 23 PARTICIPANT EVALUATON 1

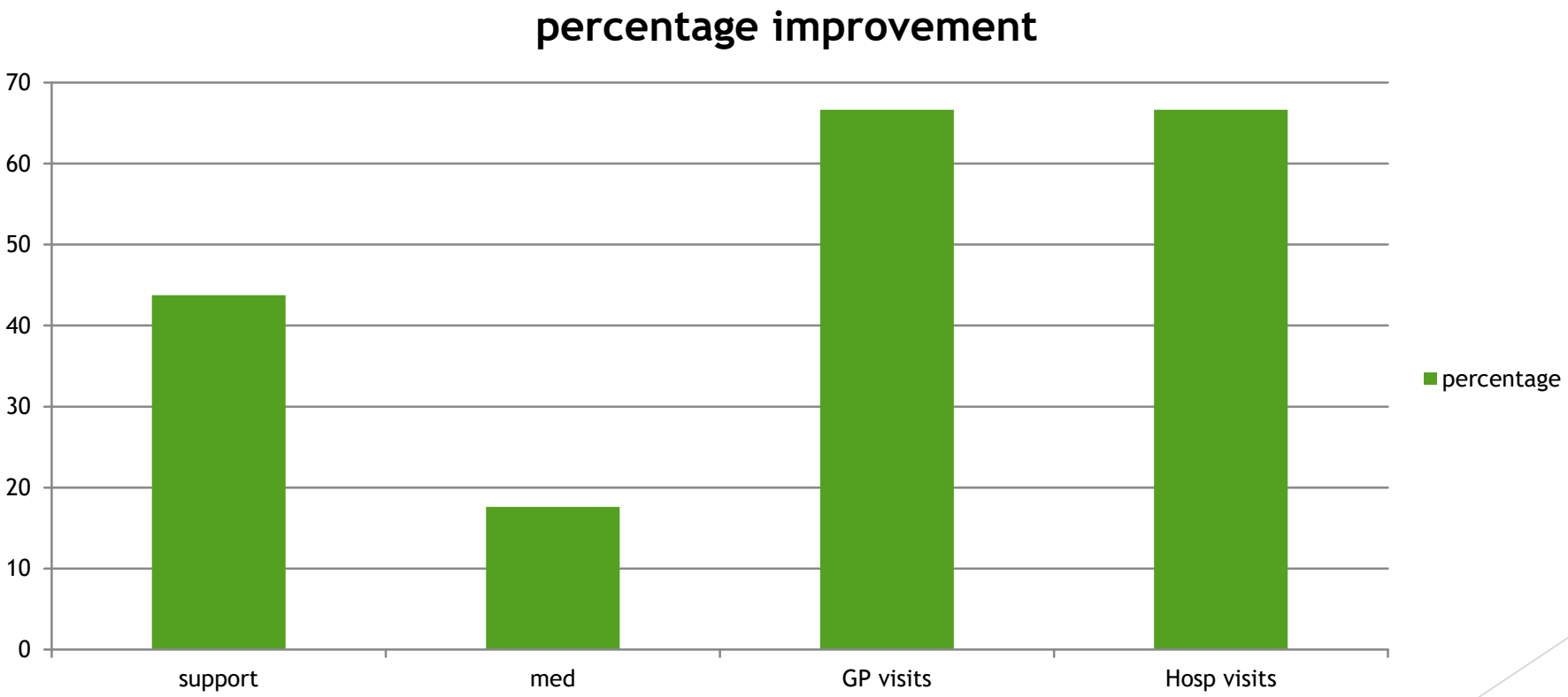
Overall Service	75%	(18/24)
Telephone Monitoring	75%	(18/24)
Venue	83%	(19/23)
Facilitator's Listening Skills	100%	(23/23)
Overall Facilitation	88%	(21/24)
Course Administration	71%	(17/24)
Waiting Time to Intake Meeting	79%	(19/24)
Type of Treatment	74%	(17/23)
Overall Experience	75%	(18/24)

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

Pic 24
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)

Pic 25 TABLE 5: An example of percentage improvement in social support, medication, GP & hospital visits



EADMT, October, 2018

Pic 26 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"

NHS Hertfordshire

Pic 27 FOLLOW UP OUTCOMES

Pic 27

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

- 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

Pic 28 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.

Pic 29/30 BLOSSOMING INTO 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- the economic argument!

Pic 31 Conclusion

- TBMA has been designed for structure and content based on the aforementioned research on mindfulness, safety and self regulation.
- It promotes the self-management of symptoms trough embodied practices.
- It addresses some of the particular anxieties that people with MUS bring, so as to, for example, reduce their fear preventing the repetition of dysfunctional patterns affecting the continuity of care to sustain recovery.
- It honours the symptoms and provides predictable on-going contact even after face to face treatment has concluded, both of which appear to reduce patients' concerns

Thank you for your attention

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