

Medically unexplained symptoms and attachment theory: The BodyMind Approach®

Introduction

This article builds on attachment theory (Bowlby, 1969; Holmes, 1993, 1994; Main, 2000; Holmes & Slade, 2018) and draws the links made between it and medically unexplained symptoms (MUS) by Adshead and Guthrie (2015). Its contribution to knowledge lies in that it describes how a novel group model, using a biopsychosocial perspective, called The BodyMind Approach® (TBMA) (Payne, 2009a, b, 2015) supports people with MUS who also have insecure attachment. The rationale for the use of TBMA as opposed to psychological interventions is that the characteristics of insecure attachment are seen in some people with MUS so TBMA has been specifically designed in content and structure to work with these characteristics. It has been shown to be effective, in rigorous research, at reducing participant's symptoms, anxiety and depression and increasing wellbeing, activity levels and overall functioning (Payne & Stott, 2010; Payne 2017c; Payne & Brooks, 2016, 2017, 2018). The research also employed qualitative (participants comments, Payne & Brooks, 2019) to assess the outcomes in an NHS community setting¹ (Payne, 2014, 2017a). The concept here is that the effectiveness seen in the empirical research derives from the design (explained below in detail) of this novel approach which specifically addresses attachment-related issues for people suffering MUS. TBMA uses a learning treatment methodology with the aim of self-managing symptoms (Payne & Brooks, 2019) rather than offering psychological treatment. We interpret self-management as an outcome due to the fact participants report seeking less external help for symptoms such as visiting General Practitioners (GPs), hospital and/or accident and emergency (A&E) departments. Therefore, TBMA provides a new, different and acceptable pathway for people with MUS and adds to the discourse and understanding of the condition and its management.

Attachment

Attachment is the social connection that a child forms with a primary caregiver for emotional support/ regulation (Munsell, Kilmer, Cook & Reeve, 2012). Attachment happens during a 'critical period' between six and twenty-four months enabling the child to create a working blueprint for future relationships. This forms an attachment style for the adult dependent on those from whom they seek and receive care (Bowlby, 1969), particularly relevant for people suffering MUS and seeking repeated care from the health service. Attachment style is embodied and to a large extent stored in implicit memory (Schachner, Shaver & Mikulincer, 2005; Bentzen, 2015).

When there is a perceived threat (real/imagined) to survival, wellbeing or safety, attachment behaviour kicks-in to reduce distress for example, to increase proximity to, and receive soothing comfort/reassurance from, an identified attachment figure. Thereafter in the long term the adult has self-soothing behaviours for comfort when in distress, with healthy self-care and trust in the adequacy of caregivers.

Medically unexplained symptoms

Medically unexplained symptoms are common world-wide affecting mostly women (Verhaak, Meijer, Visser & Wolters, 2006; Steinbrecher, Koerber, Frieser & Hiller, 2011), young people and non-native speakers (Steinbrecher et al., 2011). Illness is the context from which their experience is

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constructed hence people with MUS tend to overly-identify with their symptoms. Research has found people with MUS have increased social isolation (Dirkzwager & Verhaak, 2007), more functional impairments (Katon & Walker, 1998), poorer quality of life (Smith, Monson & Ray, 1986), associated depression (Mahli, Couston & Fitz, 2013), and anxiety (Lowe, Spitzer, Williams, Mussell, Schellberg & Kroenke, 2008) when compared with non-MUS populations. Although moderate and severe MUS appear comorbidly with common mental disorders, a direct psychological causality to symptoms is too crude to explain most MUS (Henningsen, Zipfel & Hersog 2007).

One definition of MUS is chronic, persistent bodily symptoms for which no medical explanation has been found. MUS can also be termed 'somatic symptom disorder' (SSD) (American Psychiatric Association, DSM-5, 2013) within the mental health field. It is defined as the total number of somatic symptoms and the degree to which the patient is concerned about them both of which are the predictors of health outcome and use.

Of the ten most common symptoms (fatigue, chest pain, headache, dizziness, swelling, back pain, insomnia, shortness of breath, abdominal pain and numbness) GPs cannot find a medical explanation for 75% (Kroenke & Mangelsdorff, 1989). One in five GP consultations and 18% of consecutive attenders are for MUS (Taylor, Mann, White & Goldberg, 2012). Edwards, Stern, Clarke, Ivbijaro & Kasney (2010) found studies from around the world showing MUS totals 26–35% in primary care and 50% in secondary care (Barsky & Borus, 1995).

Treatment studies have been varied with mixed outcomes. Most have been based on one single condition such as fibromyalgia, which has associated symptoms, although in practice patients have more than one additional condition. TBMA is different in that it can include all types of symptoms in one group. Schröder et al., (2012) is the only other approach which found group cognitive behaviour therapy (CBT) to be effective with generic MUS conditions. TBMA is a group approach similar to those for specific symptoms in CBT (Arnold, Speckes, & van Hermert, 2004; Zonneveld et al., 2012) and group psychotherapy (for example Selders, Visser, van Rooij, Delfstra & Koelen, 2015). Treatments are normally found in specialised clinics and mental health centres, limiting accessibility as patients refuse mental health referrals (Raine, et al., 2002; Allen & Woolfolk, 2010). Approaches derived from individual CBT reduce the strength and occurrence of symptoms and improve functioning (den Boeft et al., 2014). Short-term intensive dynamic psychotherapy reduces symptoms and visits to A&E settings (Abbass, Campbell, Magee & Tarzwell, 2009). Mindfulness-based CBT may also be effective (van Ravesteijn, et al., 2014). Training of GPs in reattribution therapy has had little success (Gask, Dowrick, Salmon, Peters, & Morriss, 2011), however physical exercise (graded) and yoga have promising outcomes (Aamland, Werner, Malterud, 2013; Yoshihara, Hiramoto, Oka, Kubo, & Sudo, 2014). None of the above mention insecure attachment styles.

Attachment Issues

Not everyone has a secure attachment. Insecure attachment can derive from adverse child experiences (ACEs) such as neglect, emotional/physical/sexual abuse, separation, loss to create insecure future relationships (Murphy et al., 2014) into adulthood. The result is a vulnerability to manage stress, suppress negative feelings and care for self. Trust in the care-givers' competence is eroded leading to withdrawal from help-seeking behaviour (Ciechanowki, Walker, Katon & Russo, 2002) which may be true for some MUS sufferers, dependant on the insecure attachment style involved.

Links between attachment style and medically unexplained symptoms

Bodily symptoms may be felt as a threat to survival, wellbeing and safety creating a susceptibility to an insecure attachment style. Adshead and Guthrie (2015) reviewed the evidence that insecure attachment is common in people with MUS and with some long-term conditions. They found three studies are relevant to insecure attachment style and MUS. For women in a health maintenance organisation (Ciechanowski et al., 2002) only 34% had secure attachment which was half the expected number for a non-clinical sample. The women exhibited fearful (21%), preoccupied (22%), and dismissing (23%) insecure attachment styles. Furthermore, the number of symptoms reported were significantly associated with these styles. A greater number of somatic symptoms were reported for preoccupied and fearful compared with secure. Attendance costs/call outs were higher for people with insecure attachment styles compared with secure. Patients presenting with MUS were 2.47 times more likely to have insecure attachment according to Taylor, Mann, White and Goldberg (2000) and Taylor et al., (2012) showed frequent attendance at GPs was related to insecure attachment style.

Waller, Scheidt and Hartmann (2004) assessed attachment security in 37 patients with ICD-10 somatoform disorder (without severe physical or mental illness) compared with 20 healthy matched controls. Compared with 60% of controls, only 26% rated as securely attached. The healthy controls demonstrated the expected incidence of insecure attachment, that is 25% were dismissing and 15% were pre-occupied. Patients though had high levels of dismissing (48.6%) and pre-occupied (25.7%) attachment styles in sharp contrast. Other studies showed how early insecure attachment styles are more common in patients with MUS (Taylor, et al., 2000; Ciechanowski et al., 2002; Spertus, Yehuda, Wong, Halligan & Seremetis, 2003; Noyes et al., 2003). It is proposed here that symptoms could be related to threats to attachment and thus to the self, resulting in fragility.

Using the natural stress adaptations e.g. flight, fight, (for mobilisation) freeze, fold or faint (defensive immobilisation) does not appear to resolve the internal perceived threat to wellbeing, survival and safety presented by MUS because the threat is in the body and not the environment. There is a correlation between female survivors of sexual abuse and preoccupied or insecure attachment (Stalker & Davies 1995). Additionally, ACEs and somatisation are linked (Waldinger, Schultz, Barsky & Ahern, 2006), as are ACEs and attachment issues (Sansone, Wiederman & Sansone, 2001). Insecure attachment has also been linked to somatisation (Stuart & Noyes, 1999). Hence, ACEs are linked with both somatisation (of which MUS is a subset) and attachment issues.

We know from research MUS is associated with cumulative ACEs, to include attachment issues (Elbers, Rovnaghi, Golianu & Anand, 2017). We know also that insecure attachment creates stress and stress can result in mental health conditions and/or MUS. Thus, it could be concluded, having unexplained bodily symptoms might be a way for people with some insecure attachment styles to legitimately seek help to meet their physical needs from those expected to be unresponsive to emotional needs. Some insecure attachment styles result in the perception that health professionals are inadequate in reducing arousal levels to relieve stress. That is, the professional is experienced as the mirror of the early inadequate care-giver (i.e. the child's primary care-giver).

Hypothesis

Not everyone with MUS will experience insecure attachment. However, Adshead and Guthrie (2015) showed three insecure attachment styles are associated with MUS: dismissing, pre-occupied and fearful.

It has been demonstrated that TBMA is effective (Payne & Brooks, 2017) in promoting the self-management of symptoms. Building on the work of Adshead and Guthrie (2015), which

demonstrates the link between MUS and some insecure attachment styles, TBMA has been specifically designed to take account of different insecure attachment styles. MUS presents as many and various symptoms. TBMA groups reflect this as they are heterogeneous. As a result, there will be some participants with insecure attachment as an underlying issue within these groups. At every stage, therefore, TBMA addresses issues of insecure attachment in the structure of the programme, facilitation, group content/practices and mind-set of the population. Rather than one-to-one models, or non-interactive class-based methods, such as dance, Tai Chi or yoga, TBMA is a group interactive model. It supports people with MUS to take the risk of interacting with others (facilitator and other group members) within a safe, regulated environment. It may be that this interaction is the element of TBMA which helps address insecure attachment patterns.

We hypothesise to account for the effectiveness of TBMA, that it can address insecure attachment styles, which may be present in some MUS sufferers, leading to their capacity to self-manage. There are considerable benefits from TBMA as a specific type of bodymind approach that differs in that it is a group approach that avoids the stigma of, or aversion to, psychological therapies. In TBMA people learn to live well by self-managing symptoms. All this makes TBMA different from somatic therapies such as somatic experiencing (Levine, 2015), sensorimotor therapy (Ogden, 2006) and contemporary bodymind approaches. Whilst people report TBMA has helped them with their symptoms TBMA does not aim to transform trauma, relieve symptoms, help clients to discover the emotional and physical source of their trauma, discharge the consequences of that trauma from the nervous system, and then support their ability to self-regulate. Therefore, TBMA is unlike these models or any other psychological intervention.

The design of the model is apt for people with MUS because it is accessible and acceptable as a learning treatment methodology rather than a psychological treatment intervention. This population often do not accept or understand psychological methods/therapies due to their physical experiences and explanation for them. Consequently, TBMA can engage this hard-to-reach population.

The three insecure attachment styles

Consequently, the three insecure attachment styles linked to MUS to which TBMA attends are: dismissing and pre-occupied (Bartholomew & Horowitz, 1991; Main, 2000); and fearful (Bartholomew & Horowitz, 1991). Not all participants attending TBMA groups will necessarily be insecurely attached, however the programme supports this population specifically and can be helpful to all.

Dismissing

There may be an expectation that inadequate attention or care from others will be received with a 'dismissing' type of attachment style. There may be anxiety about their symptoms and fear they will not be believed or taken seriously by health professionals. There may also be anxiety that the health professionals may assume there is a mental health condition. Therefore, any form of mental health referral is often rejected and generally the health service is seen as unhelpful. The GP and other health care providers may become, to the patient, 'the inadequate clinician' as they attract the patient's dismissive attitude.

Pre-occupied

In contrast, an individual with a 'pre-occupied' attachment style could become more concerned about losing the relationship with a health care professional after tests and scans etc. are over,

and/or treatment is not indicated. There may be anxiety this relationship will need to end, they may become overly needy and dependent, pre-occupied with the relationship through their symptoms, so returning to the GP frequently. Bodily symptoms engage both parties, the patient visits the GP with more and more symptoms becoming emotionally needy of attention. The GP tries to find a resolution, so sends them again for more tests and scans etc. thus feeding their anxiety. These patients may be referred to by GPs as 'frequent flyers'.

Fearful

Waldinger et al., (2006) showed that fearful insecure attachment style is correlated with childhood ACEs and adult somatisation in women. When a child is abused/neglected by a significant, yet unreliable adult caregiver, fearful attachment ensues. In this style a self-image may develop whereby the child feels unworthy of support from others, and of caregivers as being unreliable, or damaging. The combination of caregiver/GP and patient experience in the consultation may develop frustration and misunderstandings. Consequently, there may be a poor GP-patient relationship, and reduced care. The patient may feel they might drive others away and/or trigger inadequate outcomes due to their emotional neediness. Furthermore, this may develop into a compensatory emphasis on care-seeking for unexplained symptoms, due to an increased attention to bodily sensations.

The BodyMind Approach®

We propose the insecure attachment above affect the sufferers' ability to self-manage. Hence the need to develop a more secure attachment as part of learning to self-manage. TBMA appears to be effective for supporting people with MUS (Payne & Stott, 2010; Payne & Brooks, 2016, 2017, 2018, 2019), and we suggest this as a result of increasing secure attachment, in some participants, enabling the development of self-management. Due to TBMA's purpose-built design (discussed in detail below) insecure attachment may be re-worked. In our experience, working with the symptoms through the body using improvisation, movement play, clay modelling, collage, mark-making, bodymindfulness, creativity and body-mind-emotion connections enable participants to explore and access meaning (Kossak, 2009). Using the imagination and creativity in movement, for example, can tap into sensory-emotional connections allowing embodied tacit knowledge of the symptom (which may otherwise be inaccessible) to surface. In contrast to CBT, TBMA uses the notion of the embodied unconscious (van der Kolk, 2015) by accessing the sensory experience in the body acquired through lived experience of the symptom. Accessing meaning explicitly invites people to make their own interpretations of the symptoms, for example when making marks or moving hands to describe how they feel about/experience their symptom. This symbolises for themselves their unconscious meaning of the symptom which helps to make their previously unconscious experience explicit, similar to how arts therapies work. However, the authors are unaware of any arts therapies being employed for supporting people with MUS to self-manage. Establishing meaning helps the participant to validate the symptom. This is liberating because many MUS sufferers have been disbelieved.

The embodied style of attachment will be symbolised by the relationship to the symptom. Cognitive behaviour therapy comes at the world from thinking about thinking (meta-cognition) i.e. content. TBMA, in contrast, when employing bodymindfulness comes at the world from the awareness of awareness (meta-witness of the experience of sensation and process). The ability to have awareness of awareness enables people to recognise the possibility of non-attachment to the symptom (Wallin, 2017).

Adshead and Guthrie (2015) propose mindfulness-based practices may help with MUS by improving

regulation of negative affect and to alter the awareness of, and relationship to, pain and bodily experience. Additionally, they suggest approaches offering 'here and now' bodily experience connecting with images whereby links can emerge between physical sensations, emotions and relationships. They go on to recommend that 'clinicians need to develop interventions that 'fit' the attachment narratives of individual patients, rather than forcing patients into one size fits all psychological therapeutic techniques' (Adshead & Guthrie, 2015: 8). TBMA satisfies this recommendation because it has been specifically designed to fit the attachment narratives of individuals, additionally in a group setting. Furthermore, TBMA works with the imagination and bodily experiences, and somatic mindfulness practices to help people make connections between emotions, sensations and relationships. TBMA works in the 'present moment' to raise and change awareness of the bodily sensation and the individual's relationship to it (Payne, 2019a). TBMA is framed as experiential learning (Kolb, 1984; Payne & Brooks, 2019) as well as transformative in adult learning (Payne, Jarvis & Roberts, 2019b). The exercises enable access to perceptions of symptoms through the facilitator coaching enactive embodied mindful practices. They aim to shift the experience of the symptom, changing the relationship, perception and mind-set towards the symptom. This leads to the cultivation of self-management of symptoms thereby encouraging wellbeing.

Unlike psychological interventions in TBMA the body is emphasised first and foremost hence bodymind, joined together, rather than 'mind-body' with 'mind' written first and separated from 'body' with a hyphen. TBMA works from the subjective body experience to the mind and back again. It privileges the interactive relationship between the body and mind, which is so emphasised in MUS. TBMA is focussed holistically on the whole person rather than relying solely on language with more of a focus on the right side of the brain (creative side). In TBMA there is no explicit discussion of psychological or causal relationship with the symptoms unless the participant makes such connections themselves.

TBMA transforms seeing symptoms or the body as the 'enemy' in a dismissive attachment style to embracing them as an 'ally' flagging up the need for self-care and compassionate acceptance of symptoms/ self (Payne & Brooks, 2019). Caring for the self (self-soothing normally developed from early attachment experiences) is initially modelled by the facilitator as a proxy caregiver e.g. how to sit, breathe, use bodymindfulness 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 between health and 'dys-ease'. Rather than immobility, as often found in mindfulness, TBMA encourages mindful mobility/ mindful movement which favours agency, and somatic mindfulness, for example, 'being in the movement moment' as in walking around the space together with a focus on what is happening in the body and to the symptom in action.

Group interaction is important to aid different styles of attachment with peers rather than solely with the facilitator, who for some may be a health professional to whom they may have a corresponding negative attitude (dismissive style). This attitude may not be so prominent with the group members. The group gives the opportunity for shared resources, a sense of belonging helps engagement, reduces isolation and promotes hormones to be released, for example, dopamine, oxytocin, serotonin and endorphins (Porges, 2003; van der Kolk, 2014).

Three key concepts

The BodyMind Approach® is designed to support people with MUS and insecure attachment to learn to self-manage through three key concepts pragmatically built into the programme.

- a) Emotional regulation
- b) Safety
- c) Bodymindfulness

a) Emotional regulation

Emotional regulation is how a person manages feelings with cognitive, physiological and behavioural associated processes. It is the process that raises or lowers the degree of emotions (Parrott, 1993) to enhance wellbeing. This emotional self-regulation framework provides for vitality but also reduced arousal for calmness. It is developed through attunement with a reliable caregiver. Attachment is therefore a significant aspect of emotional self-regulation. More securely attached children rate higher in emotional regulation and empathy (Panfile, 2012). TBMA appears to overcome the powerful blueprint of early insecure attachment, using the relationship with the facilitator and the group to cultivate a more secure relationship enabling the development of resilience drawing on neuroplasticity.

Holmes (1993) reporting on Bowlby indicates that attachment is a primary motivational system related to a spatial environment in association with a loved one. When an individual feels safe and securely attached to the loved one they can begin to pursue exploration. When they feel unsafe dysregulated signs of distress appear in behaviour. TBMA engages with individuals to explore their symptoms by providing a safe environment. The facilitator models unconditional positive regard and a non-judgemental attitude. When this is combined with stable closed group membership (few withdrawals), a constant space, predicted dates/times for meetings and a consistent facilitator, safety ensues making for regulated behaviour.

b) The importance of safety in groups

Participants were requested to commit for the first six sessions and thereafter for the following six. The opportunity to withdraw after the first six sessions appeared to add to the safety element for some people but was never used. Paradoxically it seems likely that this structure was less threatening for individuals with a fearful or dismissive style enabling them to complete the 12 sessions. Participants with a pre-occupied style would feel compelled to complete anyway.

In Maslow's (1943) hierarchy of needs for self-actualisation the first is physiological then comes safety needs followed by the need for a sense of belonging. Insecure attachment means that a sense of belonging is missing, maybe because social engagement is too difficult. We know reliable safety is crucial to allow social engagement to occur. When safety and wellbeing is threatened, as in MUS, there is a greater need for safety to reduce the activation of the stress adaption response of mobility (Porges, 2018). In people with both MUS and insecure attachment the need for safety is even more critical. Hence the group needs to be a safe place, non-threatening and social to give a sense of belonging through the shared purpose. Another aspect of safety in TBMA sessions is that no one need disclose their symptom/s which helps enable experimentation and exploration of symptoms.

c) Bodymindfulness

Depression and/or anxiety often accompany MUS (Rosmalen & de Jonge, 2010; Burton, McGorm, Weller & Sharpe, 2011). Mindfulness reduces depression and anxiety (Hofmann, Sawyer, Witt & Oh, 2010) and has a moderate effect on some MUS, such as pain (Grossman, Niemann, Schmidt & Walach, 2004). Segal, Williams and Teasdale (2002) found an association between a lack of mindful

self-awareness and depression, resulting in poor recognition of, and reflection on, bodily cues or signals like tension, pain, fatigue. A 'mindful attitude' can be defined as a state of presence moment to moment, realised through intentionally directed attention. At the same time both internal body sensations and external stimuli can enter and leave awareness without judgment. For example, in kindly attending to the symptom sensation interoceptively can, ironically, reduce the distress experienced. A mindful state results from participating in this state as though one was an empathic witness 'benignly regarding the self'.

'Bodymindfulness' incorporates body awareness practices and movement in the present moment ('kinaesthetic mindfulness'). It can help with dis-identification with bodily symptoms which is so often tied up with identity for the individual with MUS (Sanders, Winter & Payne, 2018).

The design of TBMA to support insecure attachment

The intervention is referred to as 'learning groups'; 'symptoms groups' and 'workshops' with a focus on the lived body experience of the symptoms rather than any mental health or psychological title. People are referred to as 'participants' rather than 'patients' which may help a sense of agency since it reduces dependency and any expectations the facilitator will be unsatisfactory. The programme normalises the symptoms, i.e. non-medicalising them which helps acceptance of the condition and promotes feelings of agency, where previously there may have been none. For all insecure attachment styles this sense of agency can be helpful for engagement.

The group workshops are held twice a week for the first two weeks. This intensity at the outset helps to promote cohesiveness in the group. Bonds can be forged with each other and the facilitator, promoting engagement and reducing drop-out. The 12 x 2 hourly sessions are optimal for change (Lambert, 2013) with enough time for engagement. The individual consultation with the facilitator conducted before the group commences and the week it ends is in the same venue as the group sessions which can add reassurance for individuals with pre-occupied insecure attachment styles. Participants are aware they will be contacted by text, email and letter by the facilitator every six weeks for a further six months, i.e. they are not dropped after the group ends. A participant who has a pre-occupied insecure attachment style will be reassured by the level of contact on-going, initially the fearfully attached will be frightened but they can opt in or out after six sessions. The participant with a dismissive insecure attachment style will disengage and sabotage the group. However, the facilitator having a very high level of psychological skills can 'hold' the group and provide enough safety to prevent disintegration occurring.

The sessions are carefully structured to cultivate interaction with rituals and predictable events for safety which will have supported participants with fearful or preoccupied insecure attachment styles substantially. There is predictable on-going contact between participants and facilitator, even after face-to-face contact has concluded, via text, email and letters, seems to reduce concerns whether participants have fearful, dismissing or a pre-occupied attachment style.

The power of the group

For people with MUS who are insecurely attached the group can act as a support and pathway towards learning to make healthy attachments in a safe setting. The group acts as a source of peer support rather than support being from one health professional i.e. from only the therapist/teacher as in one-to-one approaches. Friendships test out and strengthen the ability to form more secure attachments. Group solidarity and approbation develop, encouraging each other towards improvement. The group shares goals, for example, improving health and wellbeing and the belief in

hope for change. These shared goals/beliefs help form the group identity, rationale for the sense of belonging, the protection offered, and the group's continuous existence through the bond created (Bar-Tal, 2000). This type of group for this population which have tended to have experienced isolation can be a welcome 'comfort blanket' bridging them into a different world of experimentation and exploration.

The group gives permission to share intimate personal stories. Participants discover common experiences shared in the group, they feel less isolated, make friends and often meet up following the group. The fact people wish to meet after the group is in line with group identification and group attachment. Smith, Murphy and Coats (1999) explain the subsystems and functions regulating one-to-one attachment are the same as attachment to social groups. These include seeking support and responsiveness and emotional disclosure, all of which are affected by personal history which in turn affects future relationships. Bearing this in mind careful preparation is given to the beginning and ending of sessions and of the whole programme. For example, cohesion is strongly encouraged, and safety promoted from the outset. Additionally, there are individual consultations with the facilitator, an action plan for going forward post group and non-face-to-face contact every six weeks for six months. The group's capacity to act as an attachment object and provider of security can affect neural integration. The group may help to down-regulate participants' emotions by being a regular, steady influence in their lives. Porges' Polyvagal Theory (Porges, 2003) concludes that human social interaction combined with taking the psychological mind-set into account in interventions turns off the sympathetic fight/ flight response. The calming of the sympathetic nervous system, combined with feeling listened to, enables people to feel safe enough to engage in the play. This enables the work of creativity, imagination, self-reflection, self-regulation and self-management (Porges, 2003).

It is possible that the group may be self-selecting since people who tend to avoid attachment or who are anxiously attached may filter themselves out before committing. Anxiously attached participants may be frightened of rejection so might be overly positive of their experiences.

The facilitator as a catalyst

Bowlby (1982: 207) suggests 'the link between leader and group is a facilitating, rather than a necessary element of the individual's attachment to the group'. Sochos (2015) claims there can be an attachment to the group via an image which symbolises the group. There is a sense of security and protection derived from the leader - a powerful other - however, in TBMA the attachment is with the facilitator and group members. It is symptom which can be symbolised.

The facilitator initially holds the hope for the group and that change is possible which helps transform the group mind-set to a more positive one. Facilitators have a passion for the approach which influences engagement from the group. They are all trained and certified in TBMA, have experience of over five years in leading groups of adults in mental health and a background in embodied, enactive approaches. Furthermore, facilitators are selected based on their qualities of warmth, empathy, and genuineness (Rogers, 1961). The facilitator's training and attitudes are specifically geared towards supporting individuals with insecure attachment.

The individual consultation with the group facilitator at the outset sets the tone for the group workshops, building early rapport with the group facilitator to provide safety. An insecurely attached participant will have opportunities to see and experience secure attached relationships, and to transform the relationship with the facilitator over time. This early relationship set up may help calm anxieties and helps to ensure future participation and relationship formation.

The individual consultation with the facilitator at the end of the group helps reflection, closure, clarification of their action plan and support arranged for this during the following six months. This session provided for preparation for the ending of the group face-to-face is so important for pre-occupied insecurely attached participants who will not have had many experiences of good-enough endings. The subsequent six months of non-face to face contact with the facilitator supports continuity, a sense of agency to self-manage and the embedment of new habits promoted via their action plan.

Each insecure attachment style has its own characteristics and we speculate on how these are interacted with through the design of structure, facilitation and practices of the TBMA intervention below.

Dismissive

In this style there is a positive view of self (I am ok) and a negative view of others (you are not ok). A dismissing type of attachment style may bring the expectation of inadequate attention or care will be received from others. Those who care for them, such as GPs are not OK. In TBMA people are in a group with shared experiences of the health service which may, perhaps, reinforce their lived experience of inadequate care. However, the other participants are not their health professionals (not authority figures) and this is an important advantage for their sources of support. People share their experience, strengths and hopes for change. This is empowering. Participants are encouraged to consider ways to care for themselves (self-sooth), manage stress levels and re-interpret their symptom distress.

This individual usually rejects any form of mental health referral and generally sees the health service as unhelpful for their MUS. In order to facilitate acceptance and access for this style TBMA is framed as 'workshops' for 'self-management' rather than a medical intervention or mental health treatment methodology.

People with a dismissive style deny and minimise the impact of their own experience and their feelings. They tend to lack confidence in the helper and in their ability to help themselves. They may have poor self-reflection and tend to be critical of practices and helpers to date (e.g. GP). In order to accommodate this the facilitator accepts and welcomes their stance non-judgementally and reflects it back to the participant to support and validate it. This avoids criticism of the helper. Other group members then act as models for reflection, again taking their attention away from the facilitator. The facilitator encourages mobilisation to generate more experience on which to reflect and to think about the meaning of their symptom.

Pre-occupied

In the pre-occupied style people tend to feel overwhelmed by their symptoms. The stance taken by the facilitator is that many people have unexplained symptoms which she can work with thus normalising the condition reducing fear. There is also the threat of what will happen if they lose their symptoms i.e. a leap of faith into the unknown. Eventually, after a while, when trust has been established this can be addressed by exploring the pros and cons of having the symptom. The facilitator forms a stable attachment figure, as does the group thus engendering trust. The non-verbal communication of the body is a root to access what is unknown, as yet, regarding the meaning of the symptom. So, practices employing movement such as gestures and postures to represent the sensation of the symptom may bring meaning to the forefront and in-depth knowing which cannot be arrived at in any other way.

In the pre-occupied attachment style, there is a negative model of self, a positive model of others- “I am not OK, others are OK”. The pre-determined frequency and nature of the contact post group is reassuring for people with a pre-occupied insecure attachment style. The facilitator models self-acceptance and compassion enabling people to develop a more solid, coherent sense of self and to acknowledge their own vulnerabilities resulting from their experiences.

Additionally, since the attachment style is more secure as a result of the TBMA programme this may enable them to become less dependent on the GP as the monitoring of the six months follow up data showed. This participant may find the ending of the group problematic and experience it as loss. The closing meeting with the facilitator mitigates some of this but also groups do tend to go on voluntarily meeting up following the ending. Another, strategy to support the participant who has a pre-occupied insecure attachment style is the on-going non-face to face contact every six weeks post group. The shared-decision making (with the facilitator) of their tailor-made action plan (derived from experiences in the group to support new habits of self-management) also helps with the ending process and sustainability.

The efficacy of TBMA in promoting self-management enables participants who have a pre-occupied attachment style to accept their condition obviating the need for further tests and scans. TBMA promotes a belief they can live well and thrive despite their symptoms. Their symptom distress levels and anxiety decrease as they let go of the need for a medical explanation.

Fearful

Individuals who have a fearfully insecure attachment style have a negative model of self and others - neither are OK. They may present as angry, frustrated, difficult, prone to develop a self-image as unworthy of support from others and of caregivers as unreliable, or even dangerous. TBMA promotes a sense of agency and self-care i.e. deserving of care for themselves. The facilitator understands the importance of always present for the group demonstrating reliability, which in turn offers safety. Both participants with fearful insecure attachments and the facilitator may experience misunderstanding and frustration. However, regular supervision supports the facilitator to contain any frustrations and to ensure best practice when working with this participant.

People with a fearful insecure attachment style may worry about not being believed and/ or taken seriously by health care providers who may assume they have a mental health condition. In TBMA the participant's lived body experience is believed and symptoms honoured. They also worry about their symptoms which defy diagnosis despite numerous tests and scans which can lead to catastrophising about them. The embodied, pre-verbal feelings, thoughts, relationships and impulses form an attachment style in childhood which is repeated symbolically in the adult's relationship to their symptom. TBMA helps people change their stance towards their experience of the symptom through a shift in the view of self. This may be a dynamic relationship with the symptom and the self. The view of self becomes much more than simply the symptom thus reducing the tendency to catastrophise.

The participant may sense their emotional neediness may drive others away. Emotional needs are welcome in the group, although the facilitator ensures shared attention is available to each member. People who are fearfully attached may avoid long-term care situations because of concerns about greater intimacy with providers and an assumption they will be given insufficient care. Hence TBMA is short term, the number of sessions overall is 12, the first four are in the first two weeks (i.e. two sessions per week), of two hours duration each, with an opt-out after session six. Twelve sessions are the optimum for engagement for group psychotherapy according to Lambert (2013).

Fears about caregiver dependability promotes GP-shopping, i.e. visiting each GP in a practice and/or changing practices frequently, and a fragmentation of care. TBMA groups have a number of participants to offer resources and care. The caregiver may experience people who are fearfully attached as difficult to reassure, inadequate, needy, and fragile. Facilitators are trained to expect participants like this and have strategies to support them e.g. offering alternatives to practices, treating the practices as experiments to try out – reducing risk and stakes, lessening exposure. Individual consultations with the facilitator before the group sessions provide an opportunity for this participant to ask questions and gain reassurance leading to feelings of safety. This mediates the initial stress of attending a group of unknown people.

The outreach of six months non-face-to-face contact subsequent to the group ending can feel safer than being in the group whilst maintaining an on-going relationship with the group facilitator. This can replace seeking care in settings such as A&E. TBMA is designed to support participants over a period of nine-months from acceptance of the referral. It has been found that the 12 face-to-face sessions over ten weeks in the first three months are just about manageable and bearable for the participant who is fearfully insecurely attached.

Conclusion

The research conducted previously supports the hypothesis that TBMA can support people with insecure attachment styles and MUS to self-manage. This article has illustrated how the design of TBMA is built on three insecure attachment styles associated with MUS. It goes on to explain how TBMA helps people with MUS and insecure attachment styles to learn to self-manage. Its contribution to knowledge lies in that it describes a novel group model (TBMA) designed specifically as a new alternative pathway for supporting people with MUS, some of whom may be insecurely attached. TBMA is particularly suited as an intervention for people with MUS because symptoms are experienced in the body first and foremost. TBMA honours those symptoms using them as a gateway to the mind and subsequent self-management, in contrast to CBT which tend to marginalise the body. TBMA is also different because it is a groupwork model including people with all sorts of conditions in a generic group.

Early attachment is first experienced through the body via touch from the primary caregiver (White, 2004). Body memory (Giuseppe, 2018) of early attachment is reflected in relationships in the future, including the relationship with the symptom which can become a metaphor for the individual's insecure attachment. TBMA works with the symptom and its meaning employing the body-felt sensation of the symptom as the basis for learning self-management. It seems likely that the pain from ACEs is transported into the body unconsciously and held there as a bodily memory only to be triggered in response to stressful situations to form a MUS. By learning to address the stress MUS suffering can be self-managed.

TBMA is innovative since all elements involved have been designed to compensate for insecure attachment issues. This includes programme structure, qualities of facilitation, group methods and content to take account of safety, self-regulation, and bodymindfulness. The group and facilitator are crucial to outcomes for participants helping them to prevent the repetition of a dysfunctional attachment style, affecting the maintenance of self-management to sustain recovery. TBMA enables a re-sculpting of the self and the symptom and their relationship to each other. The improved self-management participants exhibit when tested for effectiveness through rigorous practice-based evidence resulted in reduced symptom distress, depression, anxiety and increased wellbeing, activity

and overall functioning. It is proposed the behaviour changes noted have become conscious which is essential for self-management. Importantly, there are also potential reduced costs for the health service and in GP time and resources (Payne, 2014).

The hypothesis that TBMA can address insecure attachment in people with MUS can be tested in the framework of current knowledge by conducting an adult attachment assessment (Bartholomew & Shaver, 1998) pre and post intervention with participants suffering MUS undergoing TBMA treatment.

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