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Clinical outcomes from The BodyMind Approach™ in the treatment of patients with medically unexplained symptoms in primary health care in England: practice-based evidence

Abstract

This article builds on Payne (2015) and reports on practice-based evidence arising out of the delivery of a new and innovative service using The BodyMind Approach™ (TBMA) for the treatment of patients with medically unexplained symptoms (MUS) in primary care in the National Health Service (NHS) in Hertfordshire, a county near London, England, in the UK. The analysis of data collected for three groups (N=16) over 18 months used standardised assessment tools and other relevant information at pre, post and at a six month follow up. The outcomes for patients in this small scale piece of practice based evidence indicated that there were reductions in symptom distress, anxiety and depression, increased overall wellbeing and improvement in activity levels. Patients developed self-management of their symptoms through understanding, acceptance and coping strategies. The increased knowledge, exchange of experiences together with understanding and acceptance from others promoted a sense of wellbeing. Thus, the programme was experienced to be a beneficial intervention. In addition to the clinical outcomes reported here there are other benefits for NHS England for example, savings on medication and referral costs and General Practitioner (GP) capacity enhanced. The clinical service is based on previous research conducted by Payne and Stott (2010). This article focusses solely on the analysis and interpretation of clinical outcomes from the practice-based evidence.

Keywords: The BodyMind Approach™; medically unexplained symptoms; primary care; practice-based evidence

Introduction

The innovative clinical service reported in this article is being offered to primary care patients with medically unexplained symptoms (MUS) through the National Health Service (NHS) in a county in England. Edwards, Stern, Clarke, Ibvijaro, and Kasney (2010) define MUS as ‘a clinical and social predicament, includes broad spectrum of presentations, difficulty accounting for symptoms based on known pathology’ (ibid p 1). They go on to say in Diagnostic and Statistical Manual for Mental Disorders (DSM IV-TR) that the nomenclature for MUS has several categories including somatisation disorder, conversion disorder, pain disorder, and that the criteria is cumbersome and unhelpful in practice.

Both the DSM-5 and the proposed International Classification of Diseases–11th Revision (ICD-11) change the criteria for MUS and replace the term by Somatic Symptom and Related Disorders (SSD). In DSM-5 F45.1 SSD is cross-walked to ICD9 code 300.82 (ICD10-CM F45.1). SSD is defined in DSM-5 as symptoms that are distressing or result in significant disruption to feeling, thoughts and behaviour, related to somatic symptoms as manifested by at least one of the following: disproportionate and persistent thoughts about the seriousness of one’s symptoms, or persistently high levels of anxiety about health symptoms and excessive time and energy devoted to these symptoms of health concerns (Diagnostic and Statistical Manual of Mental Disorders-5, 2013). It states that Somatic Symptom and Related Disorders includes the diagnoses of somatic symptom disorder, illness anxiety disorder, conversion disorder (functional neurological symptom disorder), psychological factors affecting other medical conditions, factitious disorder other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. All of the disorders share a common feature: the prominence of somatic symptoms associated with significant distress and impairment. Such patients are commonly found in primary care and less encountered in mental health settings. The term is thought to be more useful than that of MUS in primary care (Creed, Guthrie, Fink, Henningsen, Rief, 2010). SSD includes the former somatisation disorder, undifferentiated somatoform disorder, and pain disorder. The change is that the diagnostic criteria are no longer based on the presence

of MUS, but focuses on one or more somatic symptoms that are distressing and/or result in significant disruption of everyday life. Although there are criticisms (Voigt, Wollburg, Weinmann, Herzog, Meyer, 2012; Frances, 2013) this change removes the diagnostic problem of having to distinguish between medically explained and unexplained symptoms (Creed, et al 2010). The shortcomings of the MUS category is the mind-body dualism present in the unreliable classification of complaints as medically explained or not (Creed 2009; Sharpe, Mayou & Walker, 2006) and the random categorisation into different somatoform disorders (Leiknes, Finset, Moum & Sandanger, 2006).

This dualism reinforces the GP training to address physical rather than mental health issues and the patient's perception that their symptom is purely physical because of the sensory experience. It reinforces dualistic thinking and the idea that illness is either biological or psychological. The term defines the illness by what it is not: i.e. it implies no organic cause which is not necessarily accurate and limits treatment. Research has shown that most patients prefer a positive description of symptoms i.e. an explanation of what it is rather than what it is not. The term MUS may seem glib communicating that nothing can be done. Cognitive Behaviour Therapy (CBT) with relaxation and/or graded exercise has some effectiveness for some symptoms (Whiting, Bagnall, Sowden, Cornell, Mulrow, 2001). Although psychological treatment may work in some cases this does not reflect that the symptoms are necessarily psychological (Creed, Henningsen & Fink, 2011). Other terms in use in a Department of Health (DH) recent document on MUS (DH 2014) are claimed to be more acceptable to patients such as *persistent physical symptoms or functional syndromes/symptoms* (FS) (Stone, Stone, Wojcik, Durrance, Carson, 2002). The term "functional" here is used because it is assumed that the disorder is one of function, which may be physical and/or psychosocial function, rather than anatomical structure (Sharpe, 2000).

The clinical outcomes of TBMA as a treatment reported here are based upon the definition and criteria for MUS used in DSMIV i.e. before the changes made with reference to MUS in DSM-5.

The ® treatment service is delivered in the English NHS primary care setting by a University of Hertfordshire spin-out company Pathways2Wellbeing (P2W)TM. Primary care in the NHS refers to the first port of call for patients in the community which involves GPs working in local practices. Secondary care involves hospitals and other medical establishments or treatments to which GPs refer patients. GPs act as the access, by way of referral, to any specialist interventions in either primary or secondary care. The treatment service offered by P2W is called *Symptoms Groups* to patients and *The MUS Clinic* to the GPs referring patients with various medically unexplained symptoms (such as fibromyalgia, IBS, chronic pain or chronic fatigue) from primary care. At no time is the term MUS used with patients. The groups use TBMA, which is based on a bio-psychosocial model derived from aspects of interpersonal therapy, embodied group psychotherapy (dance movement psychotherapy/authentic movement), the arts and mindfulness. It is not designed as a form of psychotherapy, but an adaptation for non-psychologically minded patients deriving from an integration of the above. The groups are called *workshops* and the treatment is a *course*. This approach has been hitherto researched and delivered as a service in the NHS with patients with medically unexplained symptoms (MUS) (previously termed psychosomatic conditions). These patients have very limited pathways for supporting their wellbeing in primary care and are high health utilizers (Bermingham, Cohen, Hague, Parsonage, 2010). They suffer with chronic, physical symptoms or conditions which do not appear to have an organic, medical diagnosis and normally with co-occurring anxiety and/or depression. The negative impact of the conditions and lack of curative treatments means effective non-pharmacological interventions that promote better coping abilities need to be developed. TBMA treatment aims to bridge the gap between mental and physical health services for these patients with chronic MUS. It uses the inter-relationship between body and mind for the treatment of such patients with these persistent symptoms. Further details on the approach can be found in Payne (2013b) and Lin and Payne (2014). The University's newly endorsed company P2W is the vehicle for the service with the knowledge arising from the pilot research being transferred into a *real world* service delivery as clinical progress

reporting. This recent service delivery project (2012-2013) was funded by the DH initiative *Quality, Innovation, Productivity and Prevention (QIPP)* scheme in a competitive bid from the authors and Hertfordshire Primary Care Trust (Mental Health). The delivery took place in community settings with patients referred by GPs from primary care. The service was free at the point of delivery. The naturalistic delivery and the lessons learned from the experience are documented in Payne (2014). This article focusses solely on an evaluation of the clinical outcomes for the patients from a small scale implementation of TBMA in the NHS. The small sample size (N=16) and the lack of a control arm means that the outcomes cannot be generalised with any confidence. However, the indicative outcomes which are very positive are consistent with a previous pilot study conducted at the University of Hertfordshire (Payne & Stott 2010) and may be transferable.

Medically unexplained symptoms

Patients with chronic MUS (presenting for over six months with the same symptom/s) are quite complex and are high health utilizers for whom there are few pathways for support and self-management other than (for a few symptoms) CBT and/or pain relief. In a recent practice guideline published by the UK DH, (July 2014) as a part of Improving Access to Psychological Therapies (IAPT) initiative, it is concluded that “community mental health teams and primary care mental health services have not been successful in engaging with patients experiencing MUS, as patients often do not perceive their condition to be related to mental health problems, and attempting to engage them in traditional mental health approaches is often ineffective” (DH, 2014 p 5).

Therefore to review the research on self-management in CBT is not relevant to the purpose of this article.

A systematic review of research (Du, Yuan, Xiao, Chu, Qiu, 2011) was conducted for the self-management programmes on pain and disability for chronic musculoskeletal pain conditions (not necessarily MUS). For chronic back pain, there was insufficient evidence to determine the effectiveness of self-management programmes. In a more recent review (Oliveira, Ferreira, Maher, Pinto, Refshauge, 2012) for non-specific low back pain results

showed moderate-quality evidence that self-management has small effects on pain and disability which challenge the endorsement of self-management in treatment guidelines. MUS patients are high utilisers of health care resources. In 2008-9 approximately £3 billion was spent on patients with MUS in the NHS (11% of total budget) rising to £18 billion including the cost to the wider economy through lost productivity (Bermingham et al, 2010). *No serious medical cause* was the diagnosis in 25% - 50% of all primary care visits (Barsky & Borus, 1995) and only 10% - 15% of the 14 common, physical symptoms seen in half of GP consultations over 12 months were found to be caused by an organic illness (Morriss, Dowrick, Salmon, 2007), resulting in 85-90% being of unknown biological aetiology. These patients are often taking medication, regularly visit health professionals (more than five times per year) and for longer consultations than the 11 minutes per visit per symptom allowable in the NHS. Furthermore, they use many resources accounting for as many as one in five new consultations (Bridges & Goldberg, 1985). They frequently have high cost referrals to secondary care for tests and scans and usually present with anxiety and/or depression, which is understandable (Simon, VonKorff, Piccinelli, Fullerton, Ormel, 1999; Aguara, 2010). Dimsdale, Sharma and Sharpe (2011) showed that although MUS/somatoform disorders are common, for those health professionals seeing such patients there is considerable confusion regarding the diagnostic terminology and a reluctance to use these diagnostic labels. For example, GPs rarely use the terms MUS or somatoform disorder to their patients, instead diagnosing fibromyalgia, ME, IBS, chronic fatigue etc. Neither do GPs routinely use the ICD-10 subcategories of various somatoform disorders. Consequently, in the experience of the authors the specific number of this huge population in each GP practice is hidden from the GP practice data base. However, GPs can identify those known as *heart-sink*, *frequent flyer* and *fat file* patients whom they refer to the MUS Clinic. As a result of a systemic lack of classification many patients who have MUS/somatoform disorder are not able to be identified to receive the support of the MUS Clinic.

Grover, Aneja, Sharma, Malhotra and Varma (2014) found no significant differences between the various subcategories of somatoform disorders with regard to the prevalence of

somatic symptoms (including somatoform pain disorder), anxiety or depression and psychological correlates of alexithymia, hypochondriasis and somato-sensory amplification. Their findings also supported the co-occurrence of anxiety and depression in two thirds of this population. Anxiety disorder (formally hypochondriasis) or functional neurological disorder (formally conversion) may also be diagnosed.

Khan, Khan A and Harezlak (2003) call for better management strategies to be developed in primary care for prevalent, medically unexplained, persistent somatic symptoms which are a health care priority and a long term condition. Currently patients either attend physical or mental health services and the treatment is separately delivered as medication/pain management or psychological therapies respectively. This system is unhelpful to the patient since it splits off mental from physical health aspects. In England, CBT for three conditions: IBS; chronic fatigue and fibromyalgia, has been found to help mental health in the short term and encouraged through a government initiative called Improving Access to Psychological Therapies (IAPT) which also targets people with long-term conditions in which MUS can be categorised. However, only a third of MUS patients with varied symptoms attend this treatment (Hague, 2008), probably due to their physical explanation for their symptoms and the stigma attached to mental health services. Thus it seems CBT is unacceptable to this patient population, they require an accessible and integrated approach which acknowledges their bodily based physical experience whilst exploring this at emotional and cognitive levels.

The Research on which TBMA is founded

A pilot study into the TBMA intervention took place near London, England in 2005-2007¹ (Payne, 2009; Payne & Stott, 2010; Payne, 2010). From these earlier research studies, specifically the proof of concept pilot study (Payne & Stott 2010), patient benefits from TBMA intervention were improved wellbeing and activity levels; decreased symptom/anxiety/depression levels; improved self-management of symptoms; and lower or

¹ Funded by the East of England Development Fund and The University of Hertfordshire

stabilized medication levels. For GPs the benefits included reduced attendance at GPs and/or hospitals and reduced costs of medication.

Furthermore, a previous health economic analysis of TBMA compared with CBT showed that the cost savings would be large in primary care but that secondary care they would be even greater (Payne & Fordham, 2008) the findings of which are supported by a report from the DH (2012). Thus this evidence makes TBMA courses attractive for the NHS due to the current austerity situation in England.

Following extensive consultation with primary care GPs in a market research study by Payne, Eskioglou and Story (2009), funded by the East of England Development Agency, a need was identified by the GPs for a pathway for the treatment and support of this patient population, for most of whom they thought CBT/psychological therapies was inaccessible and/or inappropriate. In support of the lack of accessibility for patients of psychological therapies and/or referrals from GPs psychologists in IAPT complained that they were not getting enough referrals from GPs. When TBMA was described to these GPs in a focus group (and later in the QIPP project) as a possible pathway it was welcomed enthusiastically as being more acceptable and providing choice for patients.

The pilot study led to the development of a manual for the delivery of TBMA by experienced and qualified Masters level dance movement psychotherapists trained in TBMA by pathways2wellbeing. This manual is not a recipe for sessions but rather offers nudges for the planning, specific themes which need to be covered and when and for the conducting of group sessions. The mind-set/attitude of the facilitator is described as the most important ingredient for promoting change. The facilitator is encouraged to be mindful, sensitive, adapting practices to each group's needs, ensuring interventions, aims and outcomes are explained clearly to patients and addressing needs as they arise rather than being prescriptive. The manual content gives examples of sessions and case studies, emphasising the facilitator's competencies expected. The manual was further refined as the QIPP service delivery was conducted in an evaluation by the facilitators during the delivery, and no doubt it will be honed still further with each new delivery of the groups by more facilitators.

As well as the manual being continuously updated TBMA is being evaluated as an on-going process during delivery of the service. Manuals developed for conducting psychological therapies in research studies are not widely distributed and their contents do not appear to have been evaluated (Payne, Westland, Karkou & Warneke, 2014). Research findings based on the application of treatment manuals have led to the endorsement of psychological treatments based on the use of brand names e.g. Body Orientated Psychotherapy, CBT or Interpersonal Therapy. Endorsing brand-named treatments assumes they are practised in a manner consistent with the research treatment manuals but without evidence to support this assertion. In this service delivery treatment integrity has been ensured by a triangulation (a three-way comparative analysis) between what patients have said about their experience of the approach what the facilitator says she did in the pilot study (Payne 2009), and the manual which will continue to be evaluated by the facilitators and by expert opinion evaluators external to the delivery.

The BodyMind Approach™

There are many different definitions of psychotherapy, for example 'The treatment of disorders of the mind or personality by psychological methods' (Oxford English Dictionary 2015) or 'the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable' (Campbell, Norcross, Vasquez, Kaslow; 2013, p 98). It is normally the response to specific or non-specific signs of clinically diagnosable and/or existential crises, often dubbed *talking therapy* aiming to help clients to fulfil their potential or cope better with the emotional problems of life.

Whilst TBMA is not psychotherapy in the narrow definition of the term it has its roots in a psychotherapy school of thought. It works not only with the mind, emotions and cognition but also with the physical symptoms, it is a bio-psychosocial model.

TBMA can be seen as one solution to the problem of patients with MUS. It has been designed specifically to be accessible to this patient population and to provide choice. It aims towards integrating body and mind, starting with the bodily symptom and its sensory experience to promote self-management and wellbeing in people with chronic MUS. It employs somatic mindfulness (or *bodymindfulness*) - movement, a moment-to-moment awareness of the body in motion or stillness, from the discipline of Authentic Movement (Whitehouse, 1999; Chodorow, 1992; Adler, 2002; Payne, 2006a) which is sometimes employed in dance movement psychotherapy. Authentic movement is where the mover moves spontaneously with eyes closed/downwardly focussed in the presence of a witness. In TBMA authentic movement is coupled with mindfulness practices, adapted to be accessible to people with persistent symptoms employing simple practices scaffolding them into elements of the final form. There is no pressure to engage with anything with which patients might be uncomfortable. The facilitator always offers alternatives and choices. Kabat-Zinn (1982; 1985; 1986) pioneered the development of mindfulness meditation with patients with chronic pain and a mindfulness stress reduction programme for psoriasis (Kabat-Zinn, 1998) as well as applying it to patients with anxiety (Kabat-Zinn, 1995). Since then there has been a prolific study of mindfulness. It has been shown to reduce depression as well as anxiety. Hofmann, Sawyer, Witt and Oh (2010) conducted a meta-analysis of 39 studies that explored the use of mindfulness-based stress reduction. The researchers concluded that mindfulness-based therapy may be useful in altering affective and self-regulatory processes that underlie multiple clinical issues particularly anxiety and/or depression. Others have supported these findings, for example, Vollested, Nielson and Nielson (2012); Roemer, Lee, Salters-Pedneault, Erisman, and Orsillo (2009) and an earlier study by Grossman, Nieman, Schmidt and Walach (2004). A systematic review conducted by Sharma and Rush (2014) found that out of 17 studies combining mindfulness meditation and yoga 16 demonstrated positive changes in psychological or physiological outcomes related to anxiety and/or stress. Williams (2008) reviewed four studies showing a correlation between measures of mindfulness as a trait and cognitive features of depressive

vulnerability, specifically decreased rumination, avoidance of internal experiences and an increase in the relinquishment of negative thoughts and unattainable goals. Other studies demonstrate that a mindful or experiential mode of self-attention in depressed subjects is relatively more conducive to both improved memory for autobiographical events (Watkins & Teasdale, 2004) and improved problem solving ability (Watkins & Moulds, 2005).

Nevertheless none of these approaches address the lived bodily felt sensory experience from a phenomenological perspective or address the importance of body awareness as a vehicle for change. The subjective experiencing body (Gallagher & Zahavi, 2007), whether engaging with the world's affordances (Gibson, 1979) through the tactile sense, movement or in stillness, is the fundamental basis for all feelings, sensations, perceptions or object manipulation which in turn actively underlies cognition and meaning-making (Merleau-Ponty, 1962 & 1965; Dewey, 1991). There is thus an integration of physical and mental aspects, perception and action, doing and being. TBMA builds on this notion of the body functioning as a dynamic constituent of the mind rather than serving the mind. This enactive, subjectively *body-felt sense*, as described by Gendlin (1992), expresses basic meaning from a sensory –motor modality and reflects the individual's life history and current situation. It is pre-verbal and preliminary to habitual/pre-conceptual/abstract thinking patterns. During TBMA the body is therefore experienced from inside-out, as a lived container of sensations, images, thoughts and feelings etc. Joint attention with the facilitator or another participant as witness extends the experience as reflections are embodied from the outside-in as well. This opportunity to experience the connection between the body and mind whilst doing/being it opens up possibilities for new discoveries about the nature, and the meaning of, symptoms as located in the bodymind. This is an embodied way of knowing (Panhofer & Payne, 2011), contrasting with conceptual knowing.

Several disciplines cultivate mindfulness, such as yoga, tai chi and qigong, although most of the research literature has concentrated on mindfulness developed through mindfulness meditation. This self-regulation practice trains attention and awareness to bring mental

processes under greater voluntary control thereby promoting wellbeing and/or capacities such as calmness, clarity and concentration (Walsh & Shapiro, 2006).

Mindfulness refers to a psychological state of awareness, the practices that promote this awareness, a mode of processing information and a character trait and can be defined as a moment-to-moment awareness of one's experience without judgment. In this sense, mindfulness is a state and not a trait. While it might be promoted by certain practices or activities, such as meditation, it is not necessarily synonymous with them. TBMA by using kinetic mindful practices engages with the patient's attention to, and relationship with, their bodily symptoms (including pain), for example by exploring the sensory experiences, and engaging in action-based inquiry such as examining the nature and purpose of the symptoms. This mindful relationship to the body and symptoms helps patients become less attached to/identified with their symptoms as well as less reactive to them which diminishes their experience of them.

TBMA coaches patients through exercises involving postures and movement, breath and voice, mindfulness and body awareness. Practicing such exploratory exercises regularly in the group session (and at home) the patient may regain balance and self-regulation. For example, practising focussing on the breath (or the symptoms), then noticing any thoughts, images or bodily sensations, followed by re-focussing on the breath, and then reflecting on the experience through the creative arts thus nurturing a deep awareness of the body. By putting difficult emotions and sensations in a bodily context an indication of a new perspective and accompanying meanings can be gained. By holding all these aspects, including pain, in direct sensory awareness metaphor/imagery can be generated spontaneously. These can be drawn, made out of clay or written about in a personal journal often leading to further meaning-making and understanding of the role/nature/purpose of the symptoms. Participants are engaged in synchronous, effortful movement together in a circle (accompanied by music or not) which has been shown to reduce pain and act as a way to increase group cohesion (Tarr, Launay, Cohen, Dunbar, 2015).

TBMA helps patients to connect cognitive and emotional aspects with reference to their sensory/bodily states through the enactment of expressive movement in structured exercises. Cognitive activities are inseparable from the body as the brain takes an important part in intentionality which involves the process of perceiving and meaning-making (Mills 2005; Koch, Caldwell, Fuchs, 2013). There is no explicit involvement of any underlying psychological conflicts or the interpretation/identification (or subsequent modification of) unhelpful thought patterns. Patients learn to notice their bodily signals and explore their symptoms often without the need for verbalisation (McWhinney, Epstein, Freeman, 1997), thoughts change as a result of the embodied experience.

TBMA differs significantly from CBT in that it focuses on the physical symptom within an experiential inquiry-led learning framework to support patients to live well and cope better in a more meaningful way. There is an evidence base for the practice of CBT with some specific conditions included in the MUS category e.g. IBS (Mahvi-Shirazi, Fathi-Ashtian, Rasoolzade-Tabatabaei, 2012) and fibromyalgia (Woolfolk, Allen, Apter, 2012) but the method does not address the body-felt sensory experience of the symptoms, favouring solely the mental aspects of depression and /or anxiety. CBT has been researched in large trials and is recommended by the National Institute for Clinical and Health Care Excellence (NICE) for chronic fatigue and fibromyalgia. However, patients and GPs in the service delivery reported in this article spoke about patients' reluctance to attend anything concerned with psychological/mental ill health etc. There is evidence (Sartorius, 2007) to suggest that these patients are very wary of the stigma attached to any mental health label. It can be concluded that patients with MUS may be less willing to access CBT as they believe they have an organic cause rather than give a psychological explanation for their symptoms. Allen and Woolfolk (2010) and Gonzalez, Williams, Noel, and Lee (2005) demonstrate that this patient population are often resistant to CBT.

In contrast TBMA is not presented to patients as a psychological therapy. It allows patients in the early phase to concentrate on their sensory experience and action patterns involved in the symptom. However, there is often a subtle psychological component to the treatment

discovered by the patient later in the process. Hence patients do not concern themselves with the question of stigma in relation to participating in the treatment. Furthermore, TBMA addresses a range of symptoms and the symptom itself. It can include a number of different symptoms for a number of patients in the same group, together with various accompanying aetiology such as alexithymia (Ogrodniczuk, Joyce, Piper, 2013), in which there is confusion between emotions and bodily experiences, poor affect regulation and a fearful/insecure attachment style (Payne, 2013).

In TBMA the patient directs her/his attention to inner experiences of self, actively reflecting and commenting on bodily sensations as they are raised into awareness. Gradually participants become more connected to their embodied, direct experience of self. A more positive re-association with the body emerges which has often become dissociated due to the patient's symptom distress. In embracing the wisdom held by the symptom through the embodied, enactive dream state the patient enters into a more meaningful dialogue with their body. Berg, Sandahl and Bullington (2010) in a study of patient perspectives of the process of change in affect-focussed body psychotherapy for generalised anxiety disorder found that 'getting in touch with one's body' was a key (ibid p151). This in turn gave rise to feelings of being in control, for example noticing bodily signals such as muscular tension and being able to influence them, and understanding the link between bodily symptoms and emotions. They found that patients managed to integrate bodily feelings into their perception of themselves resulting in a deeper experience of their lived body.

Structure of the TBMA course

TBMA groups are short term for up to 12 patients per group; there are three groups per programme. Each session is two hours for 12 sessions over ten weeks as in brief therapy (Yalom & Leszcz, 2005). Groups are run locally in a suitable community setting. Following the groups in phase one, in phase two, and over the following six months contact is maintained. For example, a self-addressed letter written by the participant in session 12 is sent eight weeks after the end of the group, as is a letter personalised for each participant

written by their facilitator in month three after the end of the group. Finally, a text/email message is sent asking how they are doing, and, if indicated by their response to the question, in month nine, a referral to a self-help group is made, otherwise a discharge letter is sent to their GP.

Practice-based evidence

As well as the traditional trials in the evidence-based practice paradigm another form of evidence is being derived from naturalistic practice settings termed practice-based evidence (Barkham & Mellor-Clark, 2000).

Practice-based evidence is described by Guy, Thomas, Stephenson, and Loewenthal (2011) as complementary to the quantitative, and dominant, randomised control trial-based approach to evidence. A United Kingdom Council for Psychotherapy (UKCP) report (Ryan & Morgan, 2004, cited in Thomas, Stephenson, & Loewenthal, 2006) suggests that practitioners and service users need to be given a voice, acknowledging that they have direct knowledge and experience of what works and alternatively what needs to change, and how. Practice-based evidence can give them these opportunities.

P2W employs this practice-based methodology, albeit with smaller numbers. It contrasts with evidence-based practice in that it starts with practitioners and patients in real-world settings and builds up the evidence rather than as with the traditional top down evidence-based medical paradigm. Furthermore, it uses national/common psychological therapies and primary care outcome measures such as PHQ9 for measuring depression. Patient evaluations of experience and outcomes form an important part of the evidence. Additionally, it is using real-world patients electing to participate in the treatment group, rather than selected samples willing to participate in research to which they would be blindly allocated to either the treatment/treatment as usual without exerting any choice.

With this practice-based methodology and its evaluation using qualitative and quantitative patient feedback and the standardised psychological assessment tools there is an opportunity to build an evidence base rooted in routine service delivery. This could

complement the Cochrane data base² and together with it, yield a more robust knowledge base for the psychological/arts therapies.

This methodology values expert opinion and acknowledges the need to adjust practice according to the needs and preferences of the client and their socio-economic background.

This complementary paradigm of practice-based evidence also provides a means for practitioners to own and generate an evidence base embedded in routine practice. Both paradigms are needed as the aim for all practitioners and researchers alike is best practice.

Description of Patients in the Sample:

Ethnicity: White British – 10; Chinese – 2; Indian – 4 (we do not know if born in Britain from this background or if their country of birth).

Gender mix: The ratio was 5:3 women to men in this small sample of 16 completing the whole programme from pre-group assessment to follow up at six months. This reflects the literature whereby more women than men somatise.

Age distribution: Results from this small sample of 16 suggest that adults of all ages are likely to experience MUS. The biggest age group category was the 50-59 year olds (5/16 were from this category). The youngest patient was just below 20 years of age and the eldest patient was over 80 years old.

Number of patients in each group: Group 1: four; Group 2: six; Group 3; six.

Number at completion: 16/19 patients completed the full programme over the two phases to the end of the six month follow-up.

The number of group sessions attended per patient ranged from 8-11.

Attendance figures: Group 1 had 67%, Group 2 86% and for Group 3 it was 90%.

The following shows engagement throughout the programme:

Number entering treatment groups: 19 (one missed the intake meeting but attended the first two sessions then withdrew, a further one withdrew after first two sessions as too unwell and

² An international not-for-profit organisation preparing maintaining and promoting the accessibility of systematic reviews of the effects of health care.

one had to have an operation and could not drive so had to discontinue)

Number remaining in treatment: 17 (one remained until session 10 but could not sustain thereafter)

Number completing TBMA group treatment through to follow up: 16

Analysis of questionnaire data

Insert Table 1 here

The majority of patients were in the moderate or mild categories for anxiety which is broadly consistent with the literature which states that at least two thirds of patients with MUS will have anxiety (Grover et al 2014). Higher levels of anxiety show more of an improvement than at these lower levels. The majority of patients were women, a finding consistent with the literature (Speckens, VanHemert, Bolk, Rooijmans & Hengeveld, 1996). They were of a mixed educational background similar to that found by Nimnuan, Hotopf and Wessely (2001). Some studies claim that those unemployed, senior women and those from a non-Western origin experience more MUS (Verhaak, Meijer, Visser & Wolters, 2006). However, participants in this project were from a variety of backgrounds and ages. This is inconsistent with some other studies which found, for example, the older age group to be overly represented or, in contrast, younger, employed women to be over represented (Nimnuan, Hotopf & Wessely, 2001). However, all of these outcomes on the demographics in the project are consistent with the previous pilot study.

Educational background: Patients came from a range of educational backgrounds.

Employment status: 5/16 retired, one of which was due to ill health. 7/16 patients were in full-time employment; two in part time employment; one was unemployed and one a student.

Types of symptoms: There were 26 different symptoms for the whole cohort of 16 patients completing the programme to follow up. These included:

- breathlessness
- headaches
- chronic pain
- tiredness
- insomnia
- hand pain
- leg pain
- chronic fatigue
- IBS
- ME
- palpitations
- seeing white lights

- pain in the chest
- backache
- leg spasm
- insomnia

Assessment Measures:

Patients were assessed using standardised measures over the telephone by a clinical psychologist on three occasions. Firstly at pre- group, secondly in the final week of the group and thirdly at six months follow up. The measures used were:

PHQ9: This is a client rated tool for depression. It scores each of the nine depression DSM-IV criteria as "0" (not at all) to "3" (nearly every day).

Measure Your Medical Outcomes Profile (MYMOP2): This is an individualised outcome questionnaire, problem-specific (measures two symptoms chosen by the patient), including general wellbeing and impact of symptoms on a chosen activity. The greater the score, the more severe the symptoms will be experienced.

Generalized Anxiety Disorder 7 (GAD7): This is a brief measure for assessing Generalized anxiety disorder on a 7-item self-rating scale. It scores each item as "0" (not at all) to "3" (nearly every day) for each item. Severity of generalised anxiety is graded based on the GAD7 score as 0-4 None/5-9 Mild/10-14 Moderate/15-21 severe.

The Global Assessment of Functioning Scale (GAF): A clinician rating tool used to measure overall level of psychological, social and occupational client functioning on a scale ranging from 1 to 100. The higher the score, the higher the level of functioning will be. GAF covers the range from positive mental health to severe psychopathology.

P2W Questionnaire: During a telephone interview the assessor collected self-reported information on the participant's age; gender; ethnicity; socio economic group; occupation; educational levels; type and number of symptoms; amount of leisure activity; social support; work/school attendance; use of medication; attendance at GP/hospital. In addition GP referrals contained case histories and medical information.

Insert graph 1 here

Post-group outcomes from the standardised assessments

The outcomes are also presented as pie charts for greater visual impact and ease of interpretation by the general reader.

Insert pie charts 1-7 here

Insert Table 2 here

Interpretation of outcomes pre to post group

Improvements are noted in all areas shown from pre- to post group on the Pie Charts 1-7 and in the Graph 1 example above. Particularly important are improvements in the scores from pre- to post group as shown in the summary Table 2 indicating decreased levels of depression, anxiety and symptom severity. There are also improved feelings of overall wellbeing, social support, activity levels and global functioning. In addition patients report decreased GP visits, medication usage and hospital visits and improvement in their social support.

For the majority of patients' depression scores were mild or moderate reducing to zero, one patient reduced in her score from severe to moderate. The literature (Lowe, Spitzer, Williams, Mussell, Schellberg, 2008) states most patients with MUS will have mild to moderate depression consequently this sample of patients were more or less in a similar category in this regard. 13/16 of patients reported feeling less depressed after attending the group intervention.

Global functioning (psychological, social and occupational) levels also increased for 13/16 of patients post group. This is an important finding as functioning is usually impaired as a result of MUS causing inactivity, unemployment and a reduced capacity to study. Furthermore, social support collected by a questionnaire post group showed improvement for 7/16 of patients (Table 1) and this increased for 9/16 patients following attendance post group. This may refer to relationships with family and friends improving which could result from the higher levels of wellbeing - a positive sign, especially for those with insecure attachments.

This increased social support (frequently continuing long after the facilitated group workshops have ended) may help to account for why patients continue to improve long after the groups finish.

The Overall MYMOP scores improved considerably for 13/16 of patients at post group assessment when compared to pre group. This groups the scores of wellbeing, activity, and symptom distress, together to make an overall score. It is no surprise that this percentage is high when individual percentages for each aspect of MYMOP2 improved.

Anxiety levels decreased for 11/16 of patients at post group when compared to pre-group scores. 3/16 showed no change and 2/16 worsened in their scores for anxiety when comparing pre-group with post group. It appears from this result that patients reduce their levels of anxiety after the group experience. However, without a control group it is not possible to reliably attribute improvements to TBMA as a group experience solely.

Symptom severity is measured by up to two symptoms per person being reported to be better, worse or no change. 17/26 of symptoms were reported as improved post group compared with scores at pre-group. This improvement in symptom distress may help patients to feel less depressed and anxious and enable them to engage in more activity day-to-day. Increase in activity may in turn bring about greater social interaction resulting in improved feelings of wellbeing.

For 10/16 of patients there was improvement in general wellbeing as measured by overall MYMOP2. In problem specific symptoms almost all patients improved as well as in the category of symptom severity. Furthermore, the number of symptoms reported by patients pre-group reduced at post-group in over half the sample.

Activity levels increased for 9/16 (Table 2) of patients with half the sample increasing their leisure pursuits (Table 1) probably as a result of the increased functioning levels, which in turn could lead to feelings of wellbeing. No patients reduced their activity levels to below those at pre-group. For the remainder there was no change in activity levels at post group when compared to pre-group levels.

These results, albeit based on a small sample suggest that at the post-group assessment, using standardised psychological tests, patients report feeling the benefits of attending TBMA groups.

Post group to six month follow up outcomes from standardised assessments

Insert Table 3 here

Comparison between post group and the six month follow up outcomes as demonstrated on the standardised assessments

Insert pie chart 8 here

The percentage for depression in Pie Chart 8 in particular worsened for 9/14³ patients (it was the highest percentage of all categories) as did general wellbeing in MYMOP2 at 6/14 of patients (see Pie Chart 13) at follow up when compared to post group data analysis.

However, as there had been (13/16 patients) reduction in depression at the earlier post group stage the worsening of this percentage is not as great as might at first be thought. The post group analysis for depression and general wellbeing had improved for all but a very tiny percentage of patients when compared to pre-group. Consequently, it could be said that there is a reduction in the maintenance of the improvement shown at post-group. The higher percentage of increased depression at follow up may be due to the loss of the support of the group during the six months post-group to follow up. In contrast there were some participants who improved on their previously improved or no change post-group score for depression, others remained at the same level of improvement. It would be understandable that general wellbeing would decrease if depression increased. However, at follow up 3/14 patients improved in general wellbeing and 5/14 patients showed no change when compared to the post group improvement. Consequently, it could be said that 8/14 patients improved or maintained their overall wellbeing.

It could be speculated that GPs advising that medication for depression be tapered over a period of time influenced patients' perception of their levels of depression. Patients on anti-

³ There are now 14 patients because two patients withdrew in the 6 month post group to follow up assessment period

depressants could want to give them up if they were feeling better, however GP advice to remain on the medication due to physiological dependency will prevent them from doing this.

Insert pie chart 9 here

Global Assessment of Functioning (GAF) appears to have been about the same for each of the *improvement* and *no change* categories when comparing post to follow up. 10/14 patients either improved still further from their post group scores or maintained their improvement whilst only 4/14 patients reported feeling worse at follow up than at post group.

Insert pie chart 10 here

8/14 patients showed a large improvement in their overall MYMOP2 score, whilst 5/14 got worse only 1/14 showed no change when compared to the improvement shown in the post-group score.

Insert pie chart 11 here

Anxiety, as measured by GAD7, showed that there was improvement in anxiety (i.e. reduction) in 3/14 patients and no change from the post group levels of improvement for 6/14. Hence approximately 9/14 of patients reported either improvement or maintenance of their anxiety levels from post group as measured at follow up. 5/14 patients reported feeling more anxious at follow up when compared to post group. On balance most patients continued to remain less anxious at the six month follow up when compared to post group analysis.

Insert pie chart 12 here

There was a reduction in symptom severity distress 10/27 of symptoms (as in the pilot study outcomes) at follow up, with 12/27 reporting no change. Hence approximately

22/27 of patients reported either improvement or the same levels of symptom severity distress.

Even though some still experienced their symptoms maybe some could manage them better. Others remained the same as at post-group where there had been an improvement in coping. 5/27 reported a worsening of their symptoms. Once again the majority of patients had maintained their improvement post group or had continued to improve still further to the six month follow up stage.

Insert pie chart 13 here

8/14 of patients reported either improvement or maintenance of their general wellbeing at six months follow-up. A larger number, 6/14 patients, than at post group reported a decrease in general wellbeing via MYMOP2 scores at follow up as shown Pie Chart 13. This is inconsistent with the sustained improvement scores on other instruments. It is unclear why this is the case; perhaps missing the support of the group, leaving them feeling more alone with their symptoms. Nevertheless, 5/14 reported no change and 3/14 improved still further at follow up.

insert pie chart 14 here

Levels of activity further increased at follow up in 7/14 patients when compared to post group demonstrating some capacity to do more, and feel better for it perhaps. This is contrary to the percentage feeling worse for general wellbeing of 6/14 at follow up when compared to immediately post group.

Consequently, despite feeling less well overall in terms of general wellbeing and more depressed than at post group patients were still able to continue to maintain and even increase their engagement in activity perhaps as result of increased global functioning, reduced symptom distress and anxiety levels experienced at follow up.

Trends in the data

An important trend shown in the six month follow up data analysis is that the improvements made at post group are not only sustained at three months post group, as in the previous pilot research study, but patients report continued improvement at the six month stage. Patients maintained or improved their levels of progress on a number of measures including overall global functioning, overall MYMOP, anxiety, symptom distress and activity. In the pilot research study previously conducted with a bigger sample, which had been followed up randomly in case studies to four years post follow up, patients reported sustained improvement at that stage too.

It is not possible to know precisely why improvement continues so long after post group but it could be speculated that this may be linked to their embodied change in perception towards their body (and symptoms), the action plan to change the way they manage their life (and symptoms) which is tailor-made by each patient, as well as because of the group experience and the individual contact experienced in phase one and two. From the Participant Experience Form (PEF) patients appear to have enjoyed the group experience and hence attendance at all the groups was excellent.

Discussion

This is a very minor piece of practice-based evidence and as the numbers are still very small any interpretation must be undertaken with extreme caution. Interestingly, some patients develop new symptoms. Whilst this was not demonstrated previously in the earlier pilot study (Payne & Stott 2010), it has been reported in the literature.

Patients appear to have found the programme acceptable and were committed to attend the groups. From the PEF, they said that they had benefited from the group experience having no hesitation in recommending it to friends and family.

Therefore there are some hints from this treatment intervention data analysis about how Symptoms Groups can mobilise patients towards self-management. There is no alternative treatment available and appealing. This is because patients do not see the more widely offered CBT as relevant as most have a physical explanation rather than a psychological

one for their symptoms. In addition the stigma attached to psychological interventions means that they feel unable to access such therapy.

These patients are extremely high utilizers of health resources and consequently, supporting these patients is essential not only for the patients but for saving NHS resources and increasing GP capacity. The frustration experienced by both patients and GPs as a result of the lack of treatment options to support these high health utilizers can be resolved through delivery of programmes via The MUS Clinic.

Summary

First indications from the delivery of TBMA in primary care suggest that it can benefit patients with MUS and the health service by encouraging coping strategies which promote patient self-management thereby reducing the demand for and cost of services. In addition, it is acceptable to patients and provides more patient and GP choice of treatment for MUS. Furthermore, we know from patient self-reporting that the courses helped GP practices to conserve costs by reducing consultation time, and increasing capacity crucial in these times of low GP recruitment in the NHS in England. If the apparent positive trends indicated in this very small sample were maintained after the sample is scaled up, with addition of a control, the findings would be of great interest. This is therefore a subject for further research.

P2W intends to continue to improve the lives of patients with MUS in Hertfordshire, England and are actively pursuing similar service delivery elsewhere through the training of facilitators qualified in the fields of dance movement psychotherapy, body psychotherapy and appropriately qualified counsellors/psychotherapists/health professionals. P2W has trained 30 group facilitators in TBMA so far with a view to them facilitating groups privately under licence and in the NHS and/or in the private health care sector.⁴

⁴ Training courses, dates and information can be found at www.pathways2wellbeing.com
Or email info@pathways2wellbeing.com
twitter @p2w_ltd

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**Clinical outcomes from The BodyMind Approach™
for the treatment of patients with medically unexplained symptoms
in an English primary care setting: Practice-based evidence**

Table 1: To show pre to post group analysis of questionnaire

TEST	Improved	Worsened	No change
Leisure	9/16 (56%)	3/16 (19%)	4/16 (25%)
Support	7/16 (44%)	0/16 (0%)	9/16 (56%)
Absence from Work (Group 3 only)	1/6 (17%)	0/6 (0%)	5/6 (83%)
GP visits (Groups 2 & 3 only Missing data: 1 person)	4/11(36%)	4/11 (36%)	3/11 (28%)
Hospital visits (Groups 2 & 3 only)	7/12 (58%)	1/12 (8%)	4/12(33%)
Medication	3/16 (19%)	1/16 (6%)	12/16 (75%)
Number Symptoms	12/16 (75%)	0/16	4/16 (25%)
Employment status	0/16 (0%)	0/16 (0%)	16/16 (100%)

NB one person changed to a different type of medication and was entered under no change

Table 2: To show patient changes in function of pre to post group

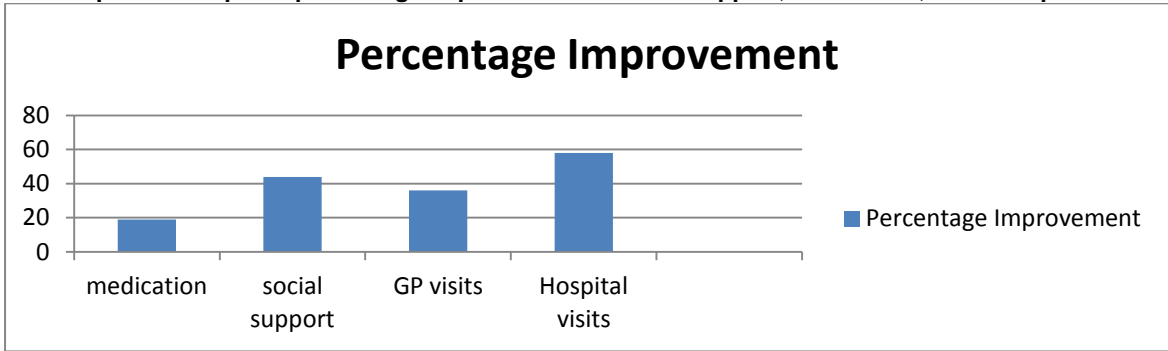
TEST	Improved	Worsened	No change
Depression PHQ9	13/16 (81%)	1/16 (6%)	2/16 (13%)
Global Functioning GAF	13/16 (81%)	1/16 (6%)	2/16 (13%)
Overall MYMOP2	13/16 (81%)	1/16 (6%)	2/16 (13%)
Anxiety GAD7	11/16 (69%)	2/16 (13%)	3/16 (19%)
Symptoms MYMOP2	17/26 (65%)	2/26 (8%)	7/26 (27%)
General Wellbeing MYMOP2	10/16 (63%)	2/16 (13%)	4/16 (25%)
Activity MYMOP2	9/16 (56%)	0/16 (0%)	7/16 (44%)

Table 3: To show patient changes in function post group to six months follow up

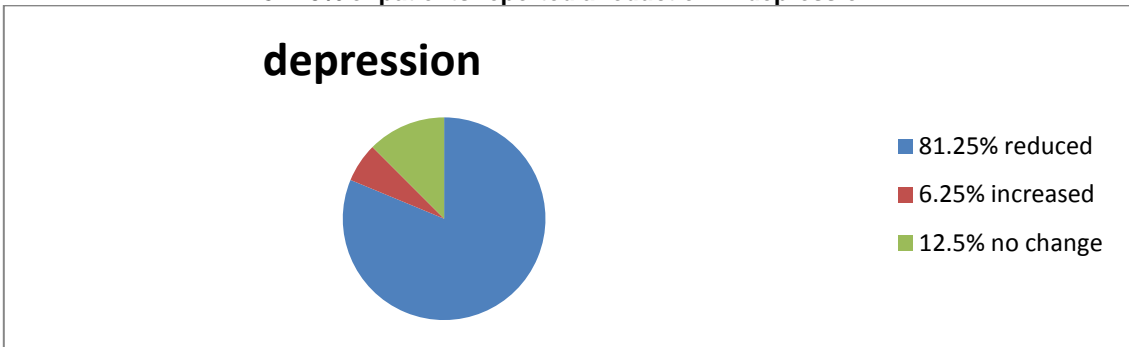
TEST	Improved	Worsened	No change
Depression PHQ9	3/14 (21%)	9/14 (64%)	2/14 (14%)
Global Functioning GAF	4/14 (29%)	4/14 (29%)	6/14 (43%)
Overall MYMOP2	8/14 (57%)	5/14 (36%)	1/14 (7%)
Anxiety GAD7	3/14 (21%)	5/14 (36%)	6/14 (43%)
Symptoms MYMOP2	10/27 (37%)	5/27 (19%)	12/27 (44%)
General Wellbeing MYMOP2	3/14 (21%)	6/14 (43%)	5/14 (36%)
Activity MYMOP2	7/14 (50%)	3/14 (21%)	4/14 (29%)

NB percentages have been rounded up; symptoms category reflects numbers of symptoms (up to 2 per patient)

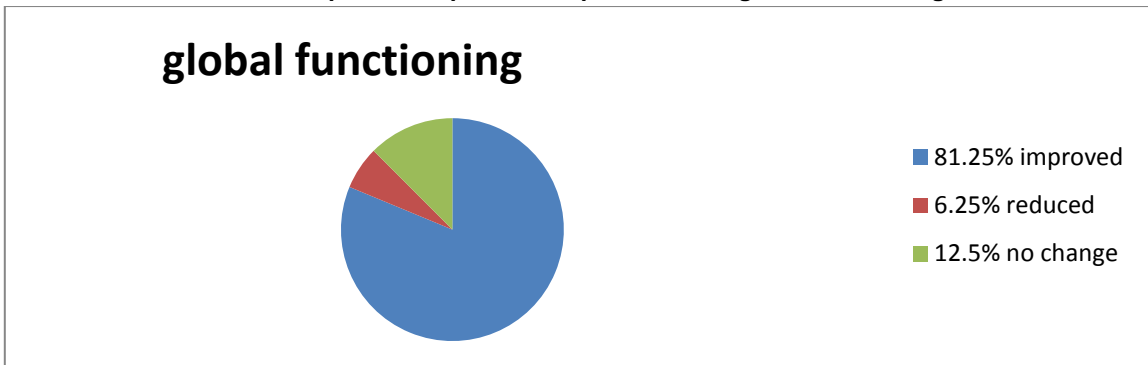
Graph 1: Example of percentage improvement in social support, medication, GP & hospital visits



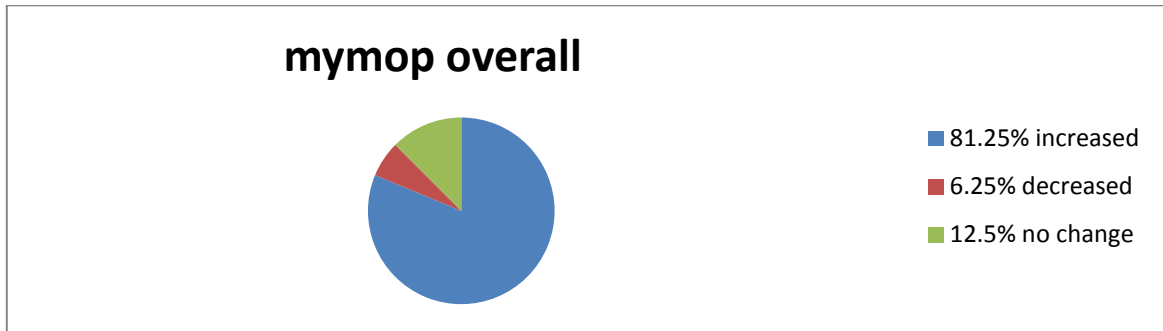
**Pie Chart 1: Patients reporting reduced feelings of depression
81.25% of patients reported a reduction in depression**



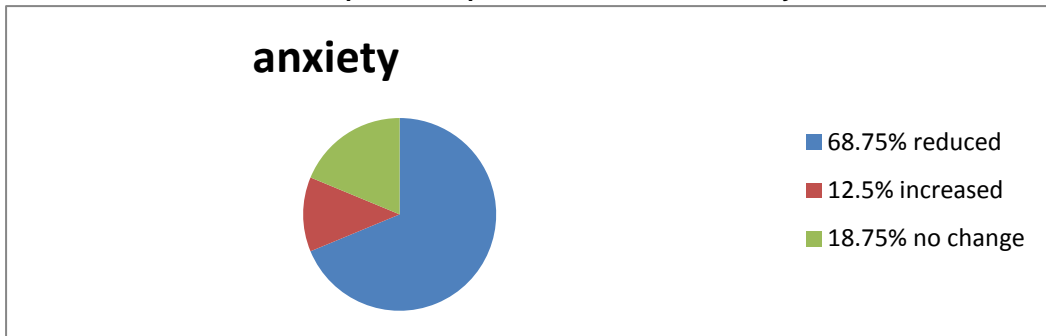
**Pie Chart 2: Percentage of patients reporting improved Global Functioning
81.25% of patients report and improvement in global functioning**



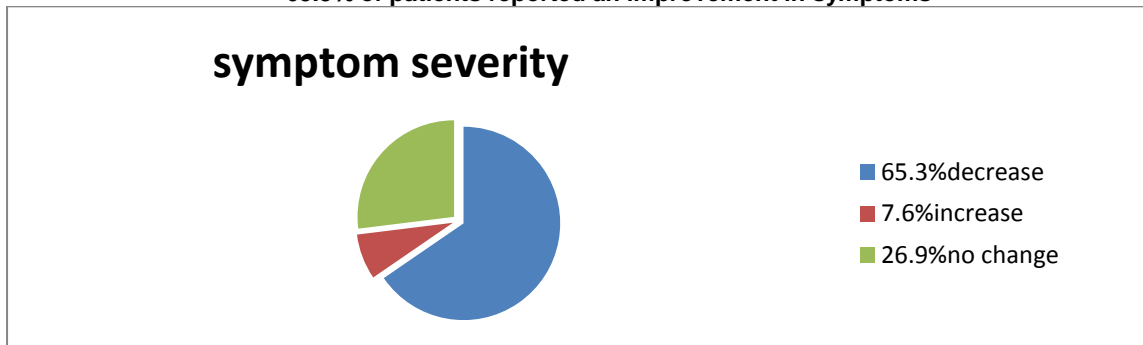
Pie Chart 3: Percentage of patients reporting increased overall score for MYMOP including activity, symptom severity and wellbeing
81.25% of patients report improvement in overall scores



Pie Chart 4: percentage of patients reporting reduced anxiety levels
68.75% of patients reported a reduction in anxiety

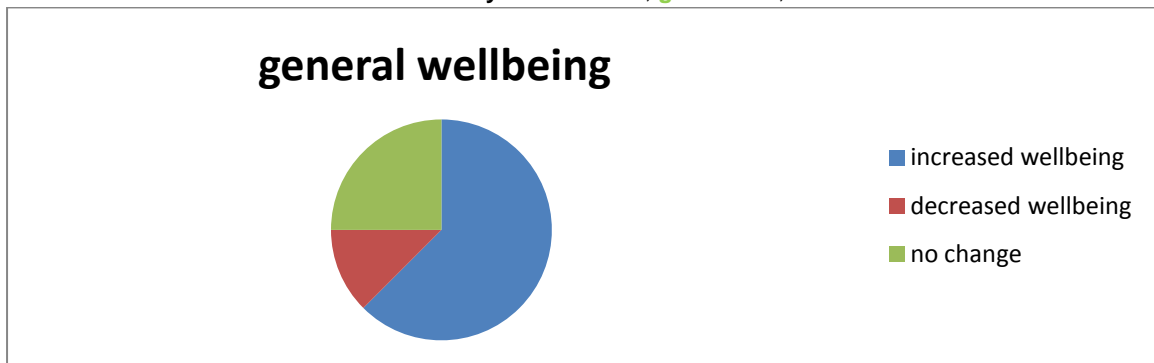


Pie Chart 5: Percentage of patients reporting Symptom Severity
65.3% of patients reported an improvement in symptoms

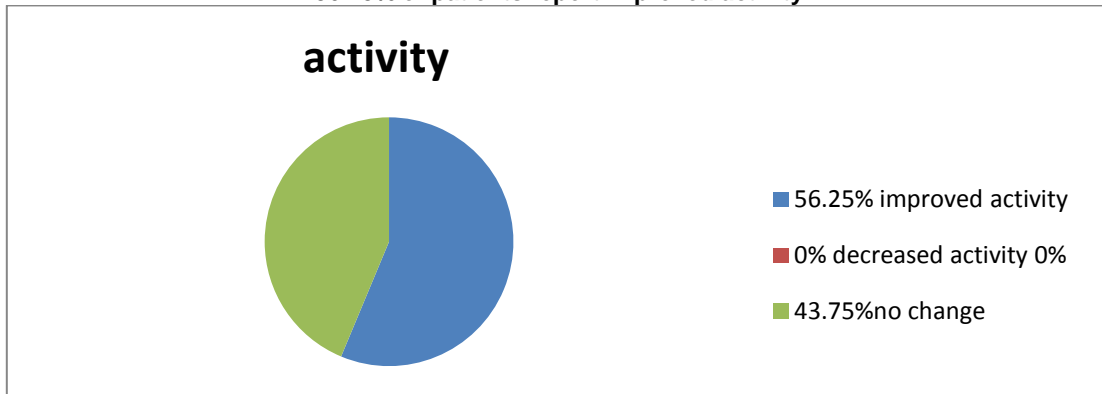


Pie Chart 6: Percentage of patients reporting increased general wellbeing
62.5% of patients report improvement in their feeling of general wellbeing

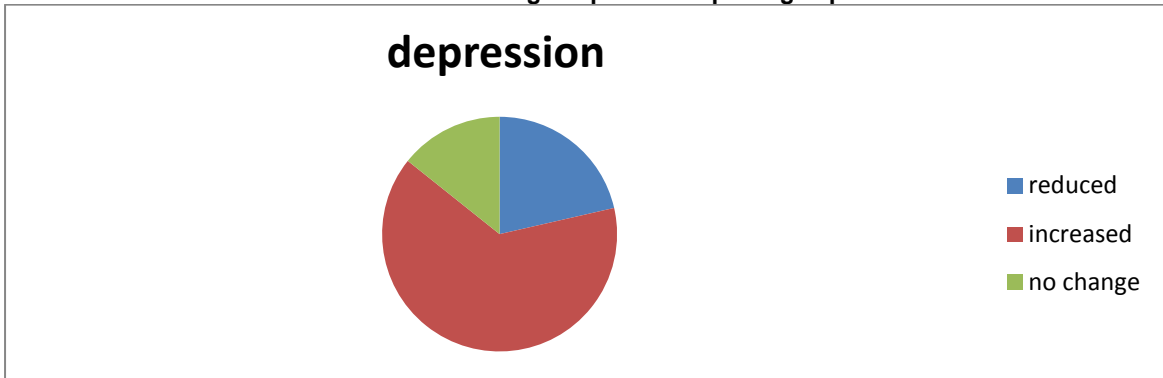
Pie Chart 1: Key: blue=62.5%; green 25%; red 12.5%



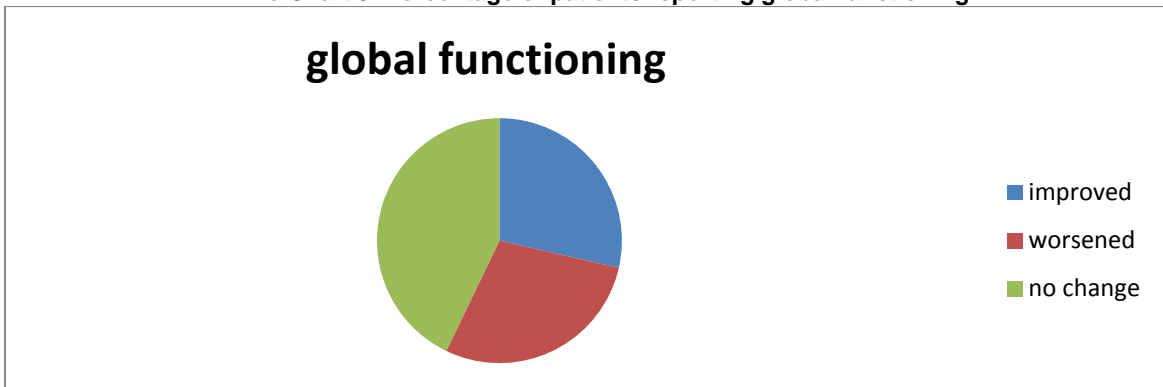
Pie Chart 7: Percentage of patients reporting improved activity
56.25% of patients report improved activity



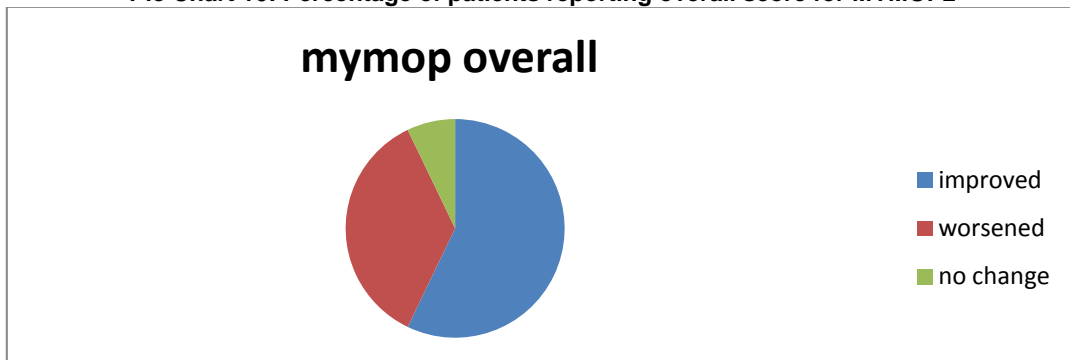
Pie Chart 8: Percentage of patients reporting depression



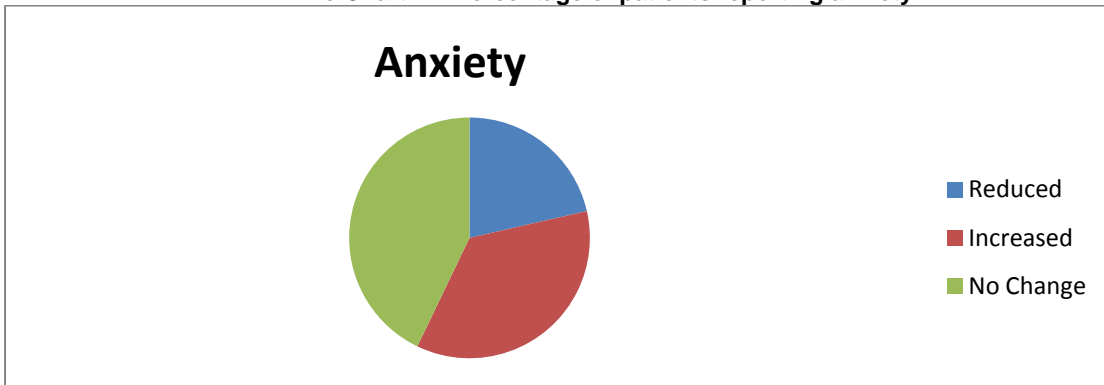
Pie Chart 9: Percentage of patients reporting global functioning



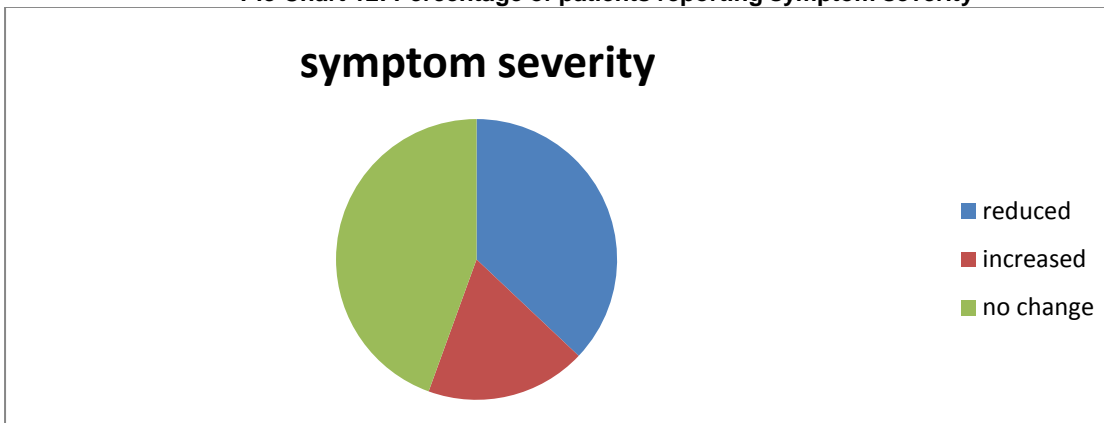
Pie Chart 10: Percentage of patients reporting overall score for MYMOP2



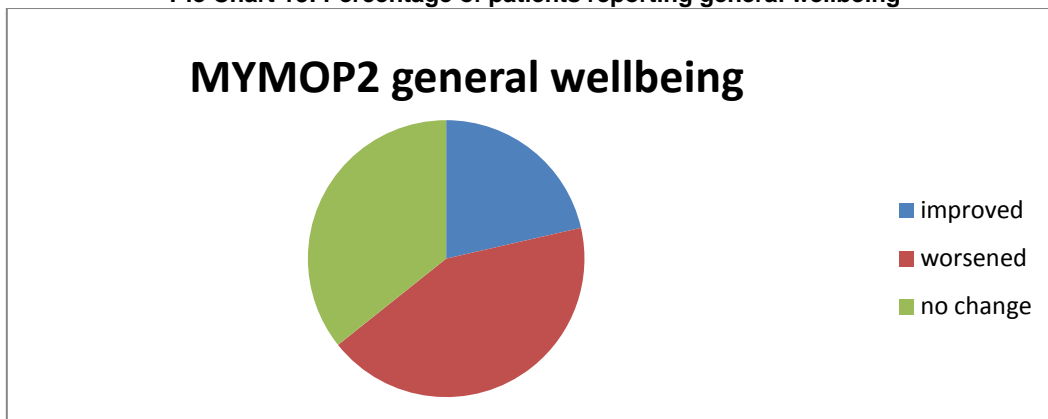
Pie Chart 11: Percentage of patients reporting anxiety



Pie Chart 12: Percentage of patients reporting symptom severity



Pie Chart 13: Percentage of patients reporting general wellbeing



Pie Chart 14: Percentage of patients reporting activity levels

