Abstract

This article describes how adults learn to self-manage chronic bodily symptoms, a complex and costly health problem. It proposes a theory of learning for an innovative, research-informed intervention, The BodyMind Approach (TBMA), aimed at developing confidence, competence, skills, knowledge and understanding for self-management for people with medically unexplained symptoms (MUS). TBMA is inter-disciplinary, combining embodiment and arts in health with transformative learning. The problem is presented together with how the intervention cultivates learning for sustaining the self-management of symptoms is presented. Promoting self-management fills the gap between patient needs and health service capacity. Previous studies identify learning through this method enables people to manage their symptoms when under stress in an ever-changing environment, supporting sufficient structure, agency, reflexivity, self-efficacy and self-regulatory strategies to maintain resilience in the face of life adversity, despite their symptoms.

 *Keywords:*adult learning; transformativelearning; The BodyMind Approach; self-management; medically unexplained symptoms

**The BodyMind Approach as transformative learning to promote self-management for patients with medically unexplained symptoms**

**Introduction**

 Medically unexplained symptoms (MUS) result in more disability than other chronic conditions (McAndrew, Chandler, et al., 2016; McAndrew, Helmer, et al., 2016), and are

considered among the most difficult to treat (Hinchey & Jackson, 2011; Jackson & Kroenke, 1999; Steinmetz & Tabenkin, 2001). MUS is a term which replaces ‘psychosomatic conditions’ and defined as ‘persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology’ (Henningsen, Zipfel & Herzog, 2007). It is a generic term to encompass irritable bowel syndrome, chronic fatigue, headache, back ache, chronic pain, fibromyalgia, etc. (Fink & Schroder, 2010; Department of Health, 2008). More recently the Diagnostic and Statistical Manual of Mental Disorders version 5 (American Psychiatric Association, 2016) recommended a new term ‘somatic symptom disorder’ which as yet has to come into common parlance.

 Edwards et al. (2010 p. 210) define medically unexplained symptoms as “a clinical and social predicament, including a broad spectrum of presentations, difficulty accounting for symptoms based on known pathology”. MUS is very common. At least one symptom was diagnosed in 40–49% of all primary care patients in a Dutch meta-analysis but which included studies from the UK (Haller et al., 2015). One in three consultations in primary care concludes without specific diagnosis (Rosendal et al., 2015) and approximately one in six consultations involve MUS (Rosendel et al., 2003; Steinbrecher et al., 2011). MUS is also extremely costly, accounting for approximately £11.64 Billion, 10% National Health Service (NHS) budget 2015/16. This was spent on services such as repeated tests and scans for the working-age population, additionally the cost of sickness and decreased quality of life is estimated at over £18 billion (Bermingham, Cohen & Hague, 2010).

 Evidence-based treatments for MUS exist but have inadequate availability in primary care, are mainly cognitively-based and only appropriate for some symptoms. Psychological therapies help few patients, due to stigma and patients’ perception that they do not have a mental health problem. Similarly, physical approaches including pain relief, pain clinics and graded exercise do not address the psychological aspects of MUS. There appear to have been no interventions aimed at improving self-management for this long-term condition, unlike for asthma or diabetes for example.

 People with these persistent and chronic symptoms are often not open to psychological explanations for the symptoms “most patients with MUS believe they have a medical problem, as distinct from any mental health problems. They are therefore more able to trust a physician to respond appropriately to their “physical” health problems (see Mai, 2004)” (Mobini, 2015 p.3) and “one of the major obstacles of delivering any psychological treatment to this clinical population is that often psychological treatment is considered as irrelevant and so referral to mental health services as unacceptable” (Mobini, 2015 p. 9) referring to the patients’ views. People are frequently desperate for relief due to chronic **bodily** experiences, have co-occurring anxiety/depression (Burton et al., 2011), and in the first author’s experience often feel isolated/abandoned and with a mind-set which mirrors that of Western society in which mind and body are seen as separate entities - for a physical ailment a physical treatment is expected, for a psychological ailment mental health treatment is recommended. Most patients tend to rationalise co-occurring anxiety/depression (Burton et al., 2011) as being because of their symptoms rather than a cause and sometimes become overly devastated by their experience.

 The Joint Commissioning Panel for Mental Health (2017) recommended NHS commissioners provide appropriate multi-disciplinary services for people with MUS in primary and inpatient care, community/day services, and A&E to enable people to access appropriate services to improve outcomes and to save substantial costs for the NHS.

**The BodyMind Approach**

 People suffering MUS with this mind-set need different interventions in order to engage them with services. The BodyMind Approach® (TBMA) is not a cure since it aims to support patients to learn to self-manage symptoms. It integrates body and mind as it is derived from an embodied form of psychotherapy - movement psychotherapy (Author 1) - taking a phenomenological stance emphasising the lived experience of the body. TBMA is designed as experiential learning (Kolb, 1984), and an inter-disciplinary facilitated group practice through body-based activities and symbolic expression via the arts. For example, it combines mindful movement, body awareness, mark-making, clay work, movement metaphor, distancing techniques and activities derived from the arts in health and health education, which come together in a structured, series of workshops according to a manual. Participants are guided through a process of self-reflection, exploration and self-discovery leading to enhanced self-awareness from which they can re-frame their knowledge and experiences of their symptoms. In a study, outcomes from pre-group to post group demonstrate a transformative shift from previous levels of anxiety, depression, symptom distress and wellbeing to improved levels in each aspect, sustained at six months follow up (Author 1). These outcomes, together with post group workshop comments from participants, showed a change in perspective and altered, more effective patterns of coping which could be argued culminate in a new understanding and/or perception of their condition (O’Sullivan, Morrell, O’Connor, 2002). Their beliefs and assumptions underpinning their understanding of their debilitating symptoms are explored individually and with others and are sometimes challenged. A dialogue with their symptoms emerges from which a different perception grows. Meaning-making[[1]](#footnote-1) is central to this process, i.e. discovering meaning inherent in the nature of the symptom and the sensory experience in the body [8;9;13;20;26]. Being ‘present’ to the symptom and others in the group affords participants the opportunity to learn openness and to value their inner experience. Body-compassion can arise from the self-care activities which promote giving kind attention to areas of body distress [1;2].

 The terms ‘BodyMind’ and ‘Learning Group’ for the workshops arose from analysis of participant perceptions via interviews of their experience of the groups in the original research study (Author 1) in which the connections made between their body and mind were emphasised (Author 1). These terms have proved to be more acceptable to patients/general practitioners (GP) than employing nomenclature such as ‘mental health’ or ‘therapy’ (for example, one patient recently stated at the beginning of the group “If this is to do with mental health then I am not staying!”).

 TBMA reflects the inter-relationship between body and mind employing, for example, ‘bodymindfulness’ and other practices. The intervention is based on previous research (e.g. Author 1) and practice-based evidence (Author 1; Author 1; Author 1). The theorising below has been developed from this practice and observations gathered and analysed, including patient evaluations.

 TBMA is a different intervention from those designed for mental health i.e. talking approaches or solely physical treatments thus offering more choice for patients and GPs. TBMA enables an exploration of the lived body experience (Varela, Roch & Thomson, 1991; Lakoff & Johnson, 2003) of the symptom by working from the body to the mind in a facilitated learning group. It offers parity of esteem with physical health respecting and integrating the unconscious with the conscious, the body with the mind, and physical with mental health.

 A cost effectiveness study was undertaken comparing TBMA with cognitive behaviour therapy (CBT) which found substantial savings (Author 1). The subsequent practice-based evidence mirrored this cost saving as patients no longer felt the need to visit their GP, Accident and Emergency (A&E) or hospital. Patients sustained this improvement at six months follow up (Author 1; Author 1) and when the data was subsequently analysed for reliable change (Author 1) it showed TBMA could fill the gap between patient need and health service requirements to reduce costs and increase capacity.

 To help the reader understand what happens in TBMA workshop Table 1 below presents a sample of topics and suggested practices integrated as appropriate to group needs by each facilitator.

Insert Table 1 here

 Rather than adding to the theory of transformational learning the purpose of this article is to present a theory based on an application of adult learning theory and theories of transformational learning to understand the success of TBMA as a tool for self-management. There are five aspects inherent in this approach to transformational learning with reference to symptom self-management: structure, agency, reflexivity, self-efficacy, and self-regulation. They all contribute to the development of resilience, essential for managing symptoms.

**Adult learning theory**

 For Bruner (1961), the purpose of education is to enable thinking and problem-solving skills which can then be transferred to a range of situations. Adults bring with them a range of experiences and perceptions that can enhance or inhibit learning. Illeris (2007) argues that adults have resources that they can draw on in their learning and are motivated to engage in learning they see as having meaning and which may achieve specific goals. In the case of TBMA adults engage voluntarily and will have the motivation to improve their quality of life in relation to their unexplained symptoms. However, negative past experiences of learning may bring barriers to engaging with TBMA that could be inhibitors to learning (Wojecki, 2007; Illeris, 2014a). Some adults may see themselves as lacking agency in a learning context, so the learning process/context will need to build capacity and confidence in their identities as learners that they can learn, develop and change. Illeris (2007, p.242) argues that when the hoped-for outcome of learning is a significant change and requires a readjustment or transformation in ideas or perceptions, then a person’s learning identity can inhibit change “…even though the person wishes for it and is prepared to accept that the readjustments are necessary”.

 Learning in this context involves the development of skills, understanding and knowledge and additionally changes in perspective and identity that could be seen as transformative. This involves changing “our taken-for granted frames of reference” (Mezirow, 2000, p.7) with the potential to think and act differently in the future. This type of learning is, as Illeris (2007, p.47) points out, “…extremely demanding and a strain and only takes place when the learner is in a situation with no other way out that can be experienced as sustainable”. In the context of TBMA participants are likely to be fairly desperate for change, and motivated to engage in this type of learning although it may require a change in identity, from being defined by others and themselves in relation to the medicalisation of symptoms to someone who can develop a new story of their life whereby symptoms become normalised. Sarbin (2004) suggests that individuals develop their identities through story and Bruner (1990) has focused on the importance of the self-narrative as a way of making meaning. An important aspect of what Ricoeur describes as ‘narrative identity’ (cited in Wood, 2002) is that transforming one’s story can lead to transforming oneself and ‘story revision’ (McAdams, 1988, p.18). The topics and practices employed in TBMA aim to enable participants to begin to change their stories [3;4;5;6;9;13;14;16;20;24;25].

 The methods used in TBMA have been designed to support participants through creating a psychologically safe space [2;7;10;14;25] which is vital if learners are to take the risks necessary to initiate change. Setting the group context is therefore very important. Learning is both individual and social and group participants can both challenge and support. Challenge is necessary to engage in transformative learning as this requires critical reflection as part of the process [24;26]. Brookfield, (2017) stresses the importance of the role of others in helping to challenge assumptions and explore new possibilities. The group is also important as stories are embedded in cultures and fellow participants can help to challenge cultural stories related to wellbeing, wellness and illness [8;23;25;26]. Agency (explored more fully in the section below on learning to self-manage) as the ability to influence events, is strongly influenced by self-efficacy beliefs that drive motivation and perseverance and influence achievement (Bandura, 1989). Agency can be bolstered by group members provided the learning context is appropriately safe and facilitative.

 Constructivist learning theory, which sees learning as an active, exploratory process, suggests that adults learn from experience and reflecting on that experience. Narrative learning involves the construction of the narrative of experience. While often undertaken through language this intervention also uses expressive movement/creative arts methods to access experience in ways that can help challenge assumptions embedded in surrounding cultural discourses [9;13;17]. This is likely to challenge participants in terms of their preconceived notions of learning and needs to be carefully structured in the session content and overall TBMA programme. The intervention also involves individual and group decision-making to facilitate agency and the taking control of learning [3;7;10;14;19;22;25]. New skills, insights and perspectives should enable these adult learners to take more control of their own symptoms and to begin to re-story their lives.

**Transformational learning**

 Transformative learning, as defined by Mezirow (1997), refers to transformations of meaning (making meaning from the symptom during practices: 9;13;26), perspectives, frames of reference, and habits of mind (such as beliefs about symptoms) in which emotional and social conditions are important. In TBMA there appears to be a transformation of perspectives, for example, from dependency, whereby the person’s perception is the symptom is the ‘enemy’ to be removed by the health service, to one of self-responsibility, seeing the symptom as an ‘ally’ whereby body compassion develops.

 The importance of individual learning pathways (Mezirow, 1997) is acknowledged by TBMA. Each practice is undertaken with the participant ‘bearing their symptom in mind’. Each journey will be different, yet a group closeness develops as they witness each other’s journeys. When considering transformational learning in TBMA, life experiences, feelings, beliefs, habits, mind-sets and lifestyle in relation to perceptions of the symptoms are appraised in the group from which further transformational learning can occur. For example, one person’s goal at the outset was “I want to be able to clear out the under-stairs’ cupboard but my symptoms will not let me”. The formulation that her symptoms prevented her achieving her goal had changed by the end of the workshops. She became aware that she had more mobility and more energy than she had previously experienced. She achieved her goal and cleared out that cupboard.

 Dirkx, Mezirow and Cranton, (2006) state transformative learning “suggests a more integrated and holistic understanding of our subjectivity, one that reflects the intellectual, emotional, [embodied, social,] moral, and spiritual dimensions of our being in the world” (p.125). In TBMA the subjective experience of the self and the bodily, sensory experience of symptoms are emphasised [12;15;16;21]. Imaginative, social, emotive/embodied, intuitive, creative, and expressive ways of being and knowing (McNiff, 1998, 2004) are therefore employed in a combination of education and consciousness-raising to promote self-management.

 Transformation also points to a shift in the epistemological and ontological orientation of the person, as Boucouvala (1997) explains, including a deeper awareness and recognition of the essential unity of mind and nature, self and other in a participatory consciousness (Heshusious, 1994) representative of the transpersonal. Transformative learning through TBMA could lead to a more connected (i.e. linkages between sensory experience, perception, feeling and cognition) and more positive relationship between body, mind and other providing a healthy platform for the self-management of symptoms. The unity of body (including the brain), and mind, which according to Siegel (2017) is both between and within us (in the person and between the person and the ‘other’ whether nature, people etc.) appears to be one outcome of TBMA. The practices invite the conscious mind to explore personal experience, engaging participants in reflection on subjective, personally experienced reality by making sense/ creating meaning, increasing self-awareness, regulating emotions, and having an open presence of mind. Participants’ and facilitator comments from practice-based evidence such as evaluations and research interviews from Author 1 ( ) study indicate these linkages can be made (Author 1 forthcoming).

 Learning generally stresses the cognitive dimension at the expense of emotional and social dimensions and the situatedness of learning processes (Illeris, 2004). Observers have argued for increased attention to the emotional dimension (Kegan, 2000; Cranton, 2005; Dirkx, 2006; Taylor, 2009). Embodiment research has emerged as an interdisciplinary field, focusing on the complex interactions between bodily, cognitive, and emotional processes (Niedenthal, 2007). Embodiment is the idea that *knowledge is grounded in bodily states* and in the brain’s modality-specific systems (Niedenthal, 2007; Winkielman et al., 2015). From an embodied perspective, body posture and movement influences thinking, conclusions drawn, and decisions reached.

 Adult learners make sense or meaning out of their experiences (Mezirow, 2006). Social and emotional dimensions influence ways they construe that experience, and the dynamics involved in modifying meanings undergo changes when learners find them to be unhelpful (Mezirow, 1991). Tennant (2012) refers to the learning-self as the target for transformational learning. In TBMA the consequence of this learning appears to be a new relationship with (or organisation of) the Self and perception and/or experience of bodily symptoms which results in an effect on wellbeing, depression and anxiety.

**Identity and medically unexplained symptoms**

 Change in identity associated with transformative learning (Illeris, 2014a) is crucial to note since patients with MUS usually over-identify with the persistent symptoms to the detriment of every other area of their lives and/or aspects of their identity. Often this change in elements of their identity involves holistic learning which engages body, mind, emotions, and spirit. Illeris (2014b) proposes “when transformative learning is defined in relation to identity, it becomes possible to establish a direct connection to the current conditions and frames of society that create both the growing need for, and the conditions of, the transforming processes” (p.153). Nowadays identity implies a continuous requirement to change to maintain the feeling of being oneself, a balance between stability and flexibility, and between being oneself and changing oneself (Giddens, 1991). Part identities surround what Stern (1985) calls the ‘core identity’. Any preference to change features of identity appears to be contingent on the person’s subjective experience of the closeness the changes are to core identity.

 Adults do not transform elements of their identity easily if they do not have the internal motivation. TBMA aims to facilitate learners to discover this motivation for change. By overcoming resistance and defences and connecting to their life-world through subjective experiences, interest for change is stimulated. The design of the personal action plan can reflect changes in mind-set which are subsequently reflected in concrete changes in habits, understanding and acting - all of which are, of course, embodied.

 The act of witnessing and being witnessed (Allen, 1995, 2005) [12] can promote a new perception of identity within a cohesive and safe culture for process and relationships. Hence, “[t]o witness is to be-with. The witness is changed in this being-with, enlarged by witnessing the unfamiliar or strengthened by witnessing the resonate” (Allen, 1995, p.110). The witness (Adler, 2004; Author 1, 2006) can affirm, validate, and connect us to each other, our creative processes, images, and experiences. Participants in TBMA are not only offered witnessing by the facilitator but supported to be witnessed by others and, as a witness, to make offerings to each other.

 Jungian thought in holistic transformation theory (Boyd & Myers, 1988; Cranton, 2003; Cranton & Roy, 2003; Dirkx, 1997; Kovan & Dirkx, 2003) is also relevant for understanding identity and transformation. These authors maintain the goal of transformation is individuation and transformative learning is a process of discrimination based in extra-rational processes such as affect, intuition, imagination, expressive processes, somatic elements, and spirituality (Lennox, 2005). Transformation is seen as the developmental process of the individual personality through the integration of its personal and collective unconscious aspects into consciousness. Since it is facilitated by the development of an inner witness it reflects a psycho-spiritual development.

**Learning to self-manage**

 Learning to self-manage is a current issue in the field of health, especially for long-term conditions. For example, educational interventions have been used as strategies to improve health outcomes of patients with low health literacy (Schaefer, 2008). Studies have found health education can improve patients’ knowledge and treatment of a disease leading to better treatment adherence and patients taking a more positive role in the management of their health (Meyer, Leventhal, & Gutmann, 1985).

 Self-management involves the principles of adult learning whether or not combined with biological, psychological and social interventions, treatments or techniques, and whether or not seen as education. The overall aim is to maximise the self-regulatory function of the individual, empowering them to be confident in their abilities and capacity to care for themselves and control, or reduce the impact of, their condition on day-to-day health and/or prevent the impact increasing.

 A Cochrane Collaboration Review examined the more rigorously tested primary care management interventions such as patient education, nursing support, regular GP reviews to promote patient outcomes and the process of care for diabetes concluding that patient-oriented interventions of an educational or supportive nature were amongst the successful approaches (Renders, et al., 2001). This confirms earlier literature that chronic disease interventions positively affecting patient wellbeing necessarily include systematic efforts to increase patients’ knowledge, skills, and confidence to manage their condition (Von Korff, et al., 1997), in other words creating an educational environment.

 Traditional patient education emphasized knowledge acquisition and didactic classroom teaching. While such interventions increased knowledge, they were unsuccessful in changing behaviour or improving disease control and other outcomes (Clement, Clark, & Gong, 2000). The focus towards improving patients’ knowledge of their condition, and their confidence and skills in managing it (Norris, Engelgau & Narayan, 2001) has been more successful. This research reinforces the patient’s crucial role in managing the condition, helping them to develop reasonable goals for improving their self-management, to identify any barriers to this achievement and designing a plan to carry out actions to reach those goals. Supportive reminder systems to reinforce the plan are also recommended (Woolf, et al.1999).

 Group educational interventions emphasizing peer contribution, patient empowerment and the acquisition of self-management skills are effective asthma, and other chronic conditions according to another Cochrane Review (Gibson, et al., 2003). Patients need to learn to manage the complex psychosocial issues arising from their condition. Thus, self-management may be one of the main ways of closing the gap between patient needs and health service capacity (Barlow, Wright, Sheasby, Turner & Hainsworth, 2002).

 The BodyMind Approach® offers just such a community-based, interactive, group workshop model, informed by pedagogical roots in adult learning and teaching, and with transformational, self-directed learning at its heart. In TBMA the learner is actively involved in identifying their goals, and problem-solving to reach them, via an action plan for self-management. Self-responsibility is encouraged, and self-directedness is inherent in setting realistic, relevant goals and helping participants to learn how to manage symptoms. Learners are actively facilitated to learn to control their symptoms. TBMA emphasises the learner’s lived experience of their bodily symptoms, from which needs arise leading to goals being identified. The patient takes the initiative in understanding their symptoms (and themselves through their symptoms), in deciding on goals and arriving at tailor-made methods and strategies to fulfil those goals. The most consistent positive outcome of interventions to improve self-care has been improvement in self-efficacy (Bandura, 1977) an important element of self-management.

Insert Figure 1 here

**Five Concepts**

 We see five concepts as inherent in this approach to transformational learning in symptom self-management: structure, agency, reflexivity, self-efficacy, and self-regulation. They all contribute to the development of resilience, essential for managing symptoms alone, without the support of the facilitated group/ health care professionals.

 *1. Structure* is generally used to describe societal arrangements, some of which are more fixed than others, which both arise from, and influence, individual action.

 *2. Agency:* refers to human beings’ ability to act to change something.

Structure and agency offer an explanatory framework for the efficacy of TBMA for learning self-management, however, the relationship between the two concepts is complex. Giddens ([1984](#_ENREF_134)) argues that structure and agency should be seen as complementary, a position supported by Bourdieu ([1986](#_ENREF_46)). In this conception, humans draw on structures in order to act, and, in acting, impact on these structures, often reproducing them. Thus, social life is actively constructed. Such a complementary existence appears perfectly reasonable until subject to deeper scrutiny. In the context of MUS, the social structure of the medical profession wields a clear power over individuals, subjecting them to tests and labels which may feel hard to challenge. Individuals are not wholly free to contest the systems (such as the NHS) in which they find themselves and their agency is, in reality, compromised. This compromising of agency remains an issue if, as Parker ([2000](#_ENREF_244)) does, one constructs structure and agency as separate, with structures acting to constrain or enable individual actions. So what influences structures to become enablers or constrainers? Archer ([2003](#_ENREF_13)) suggests it is the human capacity to strategically plan to avoid structural impediments or to capitalise on structural enablers. This capacity is strengthened through the exercise of reflexivity, which is encouraged in the TBMA group workshops.

 *3. Reflexivity* is a process of self-awareness through which we can critique our natural interpretation of life through reference to previous experience ([Siraj-Blatchford & Siraj-Blatchford, 1997](#_ENREF_277)). Goffman ([1959](#_ENREF_138)) conceptualises the reflexive process as drawing on a deeply-held view of who we want to be, with actions judged by the degree to which they move us in the direction of this ideal self. In the case of those with medically unexplained symptoms, this ideal self would clearly be one in which the impact of the symptoms was reduced.

 Archer’s ([2003](#_ENREF_13)) work focuses on the impact of the reflexive process not only on individuals but also on society and on the relations between them. She proposes a particular manifestation of the reflexive process, termed “the internal conversation”, (ibid p.9) which, she suggests, can act as a supporting mechanism for individuals in establishing a course of action. The internal conversation is essentially an inner dialogue which allows individual’s increasing control over their lives. A critique of this perspective might focus on the responsibility placed on individuals to chart their own course in a complex medical environment. However, it suggests that individuals can learn to self-manage difficult sets of symptoms. The concept of self-efficacy throws light on ways in which such a difficult endeavour might be managed. In TBMA reflexivity is enhanced through the journaling of, for example, thoughts, body sensations, feelings, insights, images, experiences at the end of each group workshop.

 *4. Self-efficacy* refers to an individual’s belief in their ability to exert influence over outcomes, as with patient empowerment, which has been shown to be effective in the self-management of diabetes, asthma, and other chronic conditions (Gibson, et al., 2003). An association was demonstrated between patient empowerment, higher perceived self-efficacy and quality of life scores (Tsay & Healsted, 2002), as well as with increased communication, partnership, self-care, and medication-adherence behaviours (Curtain et al., 2008). Empowerment of patients is an effective model of intervention used to facilitate quality of life, decision making and self-care (Heidari et al., 2007). Self-efficacy affects an individual’s functioning in four ways: cognitively, through impacting on the degree to which people can plan for, and visualise, success; motivationally, with self-efficacy beliefs influencing effort expended to achieve goals; affectively, with beliefs about potential success determining stress levels in attempting to achieve a goal; and developmentally, in the avoidance of things we believe we cannot achieve and the subsequent inhibiting of life chances ([Bandura, 1977](#_ENREF_20)). Thus what happens next is contingent on the degree of control we perceive ourselves to have over the future ([Zimmerman, 2000](#_ENREF_320)). Completing a task successfully could impact one’s belief in one’s ability to do it a second time. However, Pajares ([1997](#_ENREF_243)) refutes this, citing research to demonstrate that the power of self-efficacy belief systems renders them a better determinant of future success than previous success.

 *5. Self-regulation* involves the ways in which we control and manage ourselves, our emotions, inner resources, abilities and impulses.Self-regulation is the process of continuously monitoring progress toward a goal, checking outcomes, and redirecting unsuccessful efforts (Berk, 2003). An awareness of thought processes is required together with motivation to actively participate in learning processes (Zimmerman, 2001). It involves the learners’ beliefs in their capability to engage in appropriate actions, thoughts, feelings, and behaviours to pursue valuable goals, while self-monitoring and self-reflecting on their progress toward goal-completion (Zimmerman, 2000) Horne (2002) proposed preliminary support for an extended self*-*regulatorymodel of treatment adherence incorporating beliefs about treatment as well as illness perceptions.Self-regulation is essential to enabling resilience (Barlow, 2001) - the capacity to deal with adversity; to have the capability to recover quickly from change, stress or misfortune. Self-regulation is connected to self-management in which learning how to manage emotions to bring positive outcomes will either help or hinder progress. Through the various practices designed to enhance self-regulation participants appear to learn to value their internal, subjective, lived bodily experience rather than seeing their body as an object to be fixed. Changes take place in both perception and action whereby a new habit is embodied enabling them to take back control thus developing resilience.

 The concepts of structure, agency, reflexivity, self-efficacy and self-regulation provide a useful explanatory framework for the success of TBMA in supporting learners to be able to self-manage their MUS. The centrality of the learner’s experience both within themselves and between them and the environment, plus their goals, and an individualised action plan enacted post group both draws on, and strengthens, individual agency. Self-management becomes embedded as demonstrated in a six-month follow up study (Author 1). Learners begin to believe in their ability to effect a change in their situation and thus their motivation to do so is enhanced. They are helped to take responsibility for their own body and the symptoms affecting their day to day lives rather than depending on the medical profession.

 Home-practice of specific exercises is encouraged so individuals learn the strategies can work for them and are reproducible in different and unexpected situations. This supports them once the group has ended and the six months of phase two helps them to stay on track with their action plan.

**Conclusion**

 This article suggests that people suffering MUS need different interventions to those currently generally offered (Author 1). TBMA is one such new methodology, based on an integrated understanding of body and mind and aspects of adult and transformational learning. The efficacy of TBMA is in supporting patients to learn to self-manage explained through the underpinning concept of transformational learning. The five concepts of structure, agency, reflexivity, self-agency and self-regulation are inherent to symptom self-management and appear to enable people to maintain resilience in the face of life adversity despite their symptoms.

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1. The numbers in brackets refer to examples of topics/practices identified in Table 1 as they relate to the discussion on transformational learning, for example, those involved in creating a psychological safe place and other aspects suggested as important for learning and transformation in this context. [↑](#footnote-ref-1)