# Different strokes for different folks: The BodyMind Approach™ - supporting people with MUS to self-manage

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# OVERVIEW

- Definition, Prevalence and Cost
- Patient profile/experience
- The BodyMind Approach™
- Outcomes
- Best practice: our experience
- Questions

# DEFINITION, PREVALENCE AND COST

- Clinical & social predicament, includes broad spectrum of presentations, difficulty accounting for symptoms based on known pathology (Edwards et al 2010)
- We know MUS are very common, accounting for as many as 1 in 5 new consultations in primary care (Bridges; Goldberg, 1985)
- Extremely costly approximately £11.64 Billion, 10% NHS budget 2015/16

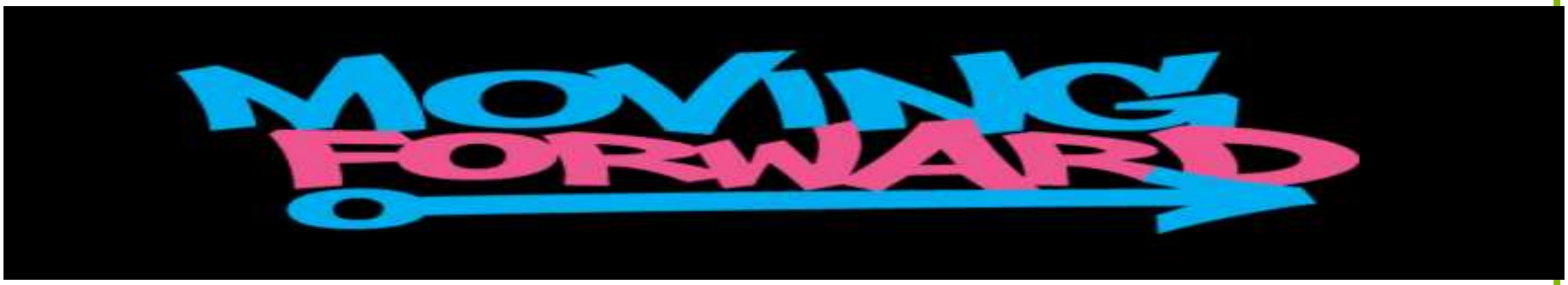
# PATIENT PROFILE/EXPERIENCE

- Often non-psychologically minded
- Distressed/desperate due to **bodily** experiences
- Chronic
- Co-morbid anxiety/depression
- Isolated/abandoned
- Intimidated by stigma/fear of MH label

# PARITY OF ESTEEM FOR MH

In order to realise parity of esteem services need to:

- Provide holistic, integrated care
- See our emotional and physical health as one



# THE BODYMIND APPROACH™: A UNIQUE PRIMARY CARE SERVICE

- Works from the body to the mind - action, perception, emotion and cognition integrate (Varela et al., 1991; Lakoff & Johnson, 2003)) in an expressive, creative, relational, embodied approach
- Ideal for the non-psychologically minded
- Terminology, theory and philosophy
- Structure and content informed by practice
- Referral criteria

# THE BODYMIND APPROACH (TBMA)™

- Assessment – tools and procedure
- Facilitation
- Group – approach and heterogeneous nature
- De-medicalisation
- Action planning
- Follow up

# RESILIENCE IS THE ABILITY TO BOUCE BACK

# PROMOTING RESILIENCE AND SELF REGULATION

TBMA helps patients to:

- value their internal subjective bodily experience

- rather than seeing their body as an object to be fixed

- results in a change in both perception and action.

# RESILIENCE

# CLINICAL OUTCOMES

## To show pre to post course reliable change

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

# To show the effect of participants' symptoms on ability to work

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

# PARTICIPANT SATISFACTION I

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

# PARTICIPANT SATISFACTION II

## Highlights

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

# PATIENT QUALITATIVE EVALUATION

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

"Achieved a return to work and overcoming of fibromyalgia"

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

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

"The focus was on the MUS issues"

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

Pathways 2 Wellbeing

University of Hertfordshire

UH

NHS Hertfordshire

# PREVIOUS STUDY FOLLOW UP

Compared to **post group**: Improvements not only sustained at 3 months post group (as in pilot) but maintained or improved further at the 6 month stage in:

**functioning** **wellbeing** **anxiety**

**depression** **symptom distress**

Compared to **pre-group**:

- Improvement or maintenance of **activity** levels-50% of people becoming more active /50% remained the same
- Improved **wellbeing** maintained in 50% of people
- Improvement in **social, occupational and overall functioning** in 75% of people

# BEST PRACTICE I

- Understanding the patient experience
- Physical underpinnings link the functioning of the body and mind
- Psycho-education helps find a way to live well with their condition
- Therefore, the bodymind link can be used to manage the distress of this condition

# BEST PRACTICE II

- The focus for all practices is the lived body experience
- Employ the sensory experience of the symptom
- The facilitated group cultivates a sense of belonging
- Opportunities for finding meaning in the symptom

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# Questions

Over to you!

# Suggestion

- Invite interested delegates to collaborate to produce a shared strategy to address primary care services training in, and engagement with, the best practice offered by all presentations today