



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



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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 6 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.

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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, Ivbijaro, and Kasney (2010) define MUS as 'a clinical and social predicament, includes broad spectrum of presentations, difficulty accounting for symptoms based on known pathology' (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

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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 et al., 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 (Frances, 2013; Voigt et al., 2012) 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, 2008).

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 et al., 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 et al., 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 utilisers (Birmingham, 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 (2015) 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 (2015). 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 6 months with the same symptom/s) are quite complex and are high health utilisers 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 et al., 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 et al., 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 2008–2009 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 (Birmingham 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 (Morris, Dowrick, & Salmon, 2007), resulting in 85–90% being of

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