

Management of Distressing Bodily Symptoms in Health

The BodyMind Approach: Using a
Biopsychosocial Model

Helen Payne
and Susan Brooks



‘Helen Payne and Susan Brooks have given us a theoretically sophisticated approach for those who suffer from Medically Undiagnosed or Organically Diagnosed Symptoms, also known as Bodily Distress Disorder. The book provides a substantial piece of much needed research into this arena, a guide for those who treat individuals suffering from the dilemma, as well as a programme for those individuals who must endure these chronic symptoms. The authors clearly understand how those afflicted feel out of control in relation to their symptoms, which leads to further somatisations of depression, anxiety and obsession. The BodyMind Approach (TBMA), unique and holistic, encourages programme participants to attend to their movements and accompanying sensations, emotions and perceptions that retain long held and concealed meanings. Learning to trust their bodily knowing, participants develop a newly born curiosity in reflecting upon themselves. In doing so, enduring habitual convictions are dismantled, and pathways for creating novel narratives emerge.

I strongly recommend this book for a wide audience including researchers, holistic practitioners, those interested in transformative learning methods, those who are afflicted with debilitating symptoms and their family members.’

Ruella Frank, PhD, *author of* *Body of Awareness: A Somatic and Developmental Approach to Psychotherapy, The First Year and the Rest of Your Life, and The Bodily Roots of Experience in Psychotherapy*

‘This book makes an important contribution to the literature through in depth descriptions of distressing somatic symptoms and significant propositions of how to manage them. As the book unfolds, it becomes clear that The BodyMind Approach needs to be considered as an important addition to current offers in healthcare addressing the self-management of embodied and emotional aspects current provision does not offer. Strong evidence and abundance of clinical experience is married with insights from people struggling with their own symptoms, making this book a must for professionals, trainees and the general public alike.’

Professor Vicky Karkou, *Director of the Research Centre for Arts and Wellbeing, Edge Hill University*



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Management of Distressing Bodily Symptoms in Health

Somatisation or medically unexplained symptoms (MUS) are distressing bodily symptoms for which tests and scans return normal. They can be incredibly debilitating conditions and people seek health care frequently due to their distress. They are common worldwide – yet there are few interventions available to help those suffering with the physical and emotional pain they cause. This book presents a solution to this problem by providing a comprehensive introduction to The BodyMind Approach (TBMA), developed by Helen Payne, and outlines guidance on applying TBMA principles to facilitated groupwork with patients/clients.

Readers will learn how TBMA's biopsychosocial learning model can be used to support patients in their self-management of anxiety associated with body distress disorder, as well as their accompanying bodily felt experience.

Chapters explore:

- Adult learning theories and The BodyMind Approach
- An overview of medically unexplained symptoms/body distress disorder
- The BodyMind Approach
- The BodyMind Approach Programme
- Training of The BodyMind Approach facilitators
- Qualitative research on The BodyMind Approach
- Somatisation and adult attachment theory
- The BodyMind Approach to support students in higher education
- Somatisation, The BodyMind Approach and chronic stress

This unique book is essential reading for healthcare professionals and mental health practitioners, as well as those who are, or wish to train, as a TBMA facilitator. It will also be a compelling read for a variety of other professions, including, but not limited to, dance movement psychotherapists, art psychotherapists, counsellors, health coaches, clinical psychologists, GPs, pain clinic staff and nurses.

Helen Payne, PhD, Professor of Psychotherapy, has been researching somatic symptoms since 2005. She works part time at the University of Hertfordshire conducting research and supervising doctoral students in the School of Life and Medical Sciences, department of Psychology. In 2012 she led the formation of Pathways2Wellbeing as Director and Clinical Manager for delivering TBMA in primary healthcare. She is a trainer in the Discipline of Authentic Movement.

Susan Brooks, MSc, MA, MSc, MBA, has worked as a teacher, social worker, biologist, senior manager, assistant chief probation officer and university senior lecturer. Susan offers an unusual skill mix which brings a holistic and truly biopsychosocial perspective to the understanding of distressing bodily symptoms. She joined Helen in 2012 as a Director in forming and managing the University of Hertfordshire spin out Pathways2Wellbeing and collaborated on the research projects.

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To all the patient-participants, facilitators and trainers
who have engaged with the delivery and training in
The BodyMind Approach.



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Disclaimer

The interventions and materials in this book may be beyond the authorised practice of mental health professionals. As a licensed professional you are responsible for reviewing the scope of practice including activities defined in law as beyond the boundaries of practice in accordance and compliance with your profession's standards. It is recommended that full TBMA facilitator training is undertaken before delivering the practices to clients/patients.

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Preface

Undiagnosed distressing, chronic, physical symptoms where no organic cause has been found have been termed medically unexplained symptoms (MUS) in the past. In this book we have employed the term 'somatisation' and used this interchangeably with the terms MUS and body distress disorder (BDD) (the most recent umbrella term for these symptoms and for diagnosed conditions both often accompanied by significant anxiety and/or depression). Medically unexplained symptoms can be incredibly debilitating conditions and people seek health care frequently due to their distress. They are common worldwide – yet there are few interventions available to help those suffering with the physical and emotional pain they cause. This book presents a solution to this problem by providing a comprehensive introduction to The BodyMind Approach (TBMA), developed by Helen Payne, and outlines guidance on applying TBMA principles to facilitated groupwork with patients/clients. Somatisation is generally defined as the tendency to experience psychological distress in the form of somatic symptoms and seek medical help. In this term includes physical symptoms for which tests and scans come back as normal and the emotional distress associated with these symptoms.

The following questions are explored:

How can working with the body help people with chronic bodily symptoms for which all tests come back normal?

How can working with the interrelationship of body and mind develop greater self-management?

How can we help health professionals to work more effectively with chronic bodily symptoms for which there is excessive emotional distress?

This book holds some of the answers.

The aim is to showcase entirely new material developed specifically for this book as well as a few published, yet updated, articles on novel intervention called The BodyMind Approach, researched at the University of Hertfordshire, and delivered with encouraging outcomes in the NHS. The

book aims to enlighten health professionals, patients and trainees in The BodyMind Approach.

The book shares insights into the delivery of TBMA which has been designed as a self-management intervention for patients with chronic bodily symptoms for which all tests and scans return negative. The scope of the book covers the subjects of medically unexplained symptoms now included in the term body distress disorder, therefore the authors have named them both as somatisation. The book describes the aetiology of MUS and BDD; how TBMA is designed as a perceptual learning approach; TBMA programme; the facilitator training; qualitative research into TBMA; the link between insecure attachment and MUS; stress in higher education students and MUS; and the stress response in MUS. Finally, there is an epilogue which looks towards the future.



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Introduction

Background

This chapter invites the reader to delve into the background of medically unexplained symptoms/body distress disorder and The BodyMind Approach (TBMA). Somatisation in this book is defined as the tendency to experience emotional distress in the form of, and due to, chronic somatic symptoms and to perpetually seek medical help for them. These symptoms may be initiated and/or prolonged by emotional responses such as stress, anxiety and/or depression. This book delves deeply into the biopsychosocial approach within the context of embodied perceptual learning. The aim of the intervention described in this book called TBMA is to support self-management for people experiencing persistent and chronic somatisation, whether medically explained symptoms (MUS) or those explained with an organic diagnosis. This change to encompass an organic diagnosis when accompanied by disproportionate stress/anxiety is a relatively recent one. There is another term used, health anxiety, which is a fear and preoccupation with the belief that one has, or is in danger of developing, a serious illness like cancer or a heart attack. This belief takes over one's life. There is a drive by both doctors and patients to give a name to any condition, which is understandable. Doctors are driven to find a diagnosis for their patient as this enables them to decide on the course of treatment and patients also feel reassured by a diagnosis. Where there is no organic diagnosis, the name given to patients is a label such as fibromyalgia, irritable bowel syndrome (IBS), chronic pain and/or fatigue and so on. Alternatively, since all tests and scans return normal, there is no label or diagnosis, hence in the past the term used was MUS, although it was rarely offered to the patient, who was told instead simply that there was nothing amiss (albeit the patient still experiences the body distress).

Historically there has been a dualism between physical and mental health. However, physical/organic categories overlap with psychological/mental categories in a third category which interfaces between them. There is still stigma attached to mental health conditions, so it is important to recognise this interface whereby both categories are important for diagnosis and treatment.

Creed et al. (2010) found the term MUS unacceptable to patients and less holistic; this has resulted in a new diagnosis for both MUS and symptoms with a physical explanation of body distress disorder (BDD) as a third category. There have been many terms to describe these conditions (please see the Appendix for a list of synonyms) each of which has attempted to better describe the condition for doctors and patients. Since there is such a proliferation of terms the authors of this book have decided to use the term somatisation, as an umbrella term to cover both MUS and BDD and any synonyms for these conditions. At times readers will see the term MUS or MUS/BDD or indeed somatisation.

Medically Unexplained Symptoms/Body Distress Disorder

Most of the research to date has been on MUS and hence for simplicity we have continued to use the term in places in this book. However, there is a move to describe the MUS condition as BDD which removes the requirement that it is unexplained, but as yet, there is little research using this term. Both medically explained and unexplained symptoms are included in BDD. One important key feature in the diagnosis of BDD is that the notion of the patient not being believed disappears, as they are seen to have excessive emotional distress whether or not the symptoms are organic in origin. It is the degree to which the patient expresses anxiety about their symptoms which is the deciding factor.

Body Distress Disorder is a diagnosis for an individual who experiences too much distress due to a persistent or recurrent (e.g., chronic pain, fatigue) bodily symptom or symptoms, to the degree that there is a distress, attention on and preoccupation with the symptom(s) that interfere with daily functioning. The term BDD replaces the old category of MUS used in International Classification of Diseases (ICD)-10. In the DSM5 the concept of somatoform disorders has been replaced by “Somatic Symptom Disorder”. A change in the new criteria is that BDD can exist with any somatic/physical illness. The bodily distress does not have to be unexplained medically.

The authors have wrestled with the implications of the change in terminology from MUS to BDD in DSM5 and ICD-11. These include: a) the fact that in BDD the organic diagnosis may be known, and b) BDD can encompass psychological issues such as anxiety/depression as mental health concerns. This has made the authors consider the relevance of TBMA to diagnosed medical conditions/mental health conditions, because TBMA is a programme based on perceptual learning rather than a psychological treatment, albeit trauma informed. However, many elements of The BodyMind Approach programme lend themselves to modifying the stress responses to bodily sensations and associated anxiety and depression. In the research, participants expressed relief from the distressing symptoms, anxiety and/or depression and increased wellbeing and activity levels linking these improvements to the facilitated

TBMA group experience (Payne & Brooks, 2016). The authors have therefore concluded that there is a strong likelihood TBMA may be relevant to BDD. In this book the authors have selected places where it is relevant in addition to MUS to include BDD, showing it as MUS/BDD or somatisation.

In our view in BDD, the associated somatic symptoms – such as headache, back ache or IBS – which are unconnected to the physical diagnosed condition (medically explained) are most likely the result of excessive anxiety about that diagnosed condition. It may be that these symptoms can be worked with via TBMA as well as the excessive anxiety which is usually present.

The condition termed MUS is now included in the term BDD which refers to there being an outcome of excessive body distress rather than the descriptive model of MUS. Furthermore, BDD labels the symptoms as a disorder rather than implying there is nothing medically wrong, even though the organic cause may still be unknown. It is characterised by chronic persistent somatic symptoms that bring excessive and disproportionate thoughts, feelings and behaviours regarding those symptoms and/or are very distressing or result in significant disruption of functioning. To be diagnosed with BDD, the individual must be persistently symptomatic for at least six months. The American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM5) (APA, 2013) made significant changes to the criteria and removed the overlap across the somatoform disorders and clarified their boundaries. These changes are said to better reflect the complex interface between mental and physical health.

Another key change in the DSM5 criteria is that while MUS/BDD were a key feature for many of the disorders in DSM5, a BDD diagnosis does not require that the somatic symptoms are medically **un**explained. In other words, symptoms and/or co-morbid anxiety may or may not be associated with a diagnosed medical condition. Nevertheless, at the time of TBMA research, referrals were concerned solely with patients whose tests and scans all returned as normal. Unless Western society changes its views on mental and physical health to become holistic, combining mental and physical health as one, symptoms with no organic pathology will remain unexplained.

The previously published articles in this book which referred to MUS solely have not been fully amended to reflect this change in terminology. It is important that patients have an acceptable term for their condition and have a service relevant for that condition, especially when so many refuse mental health services and pain clinics, often these are either irrelevant or do not help.

Where we have explored MUS, our working definition is as follows: “A clinical and social predicament, which includes a broad spectrum of presentations where there is difficulty accounting for symptoms based on known pathology“ (Edwards et al. 2010, p. 209). This definition avoids the challenge of choosing either an organic or a psychological explanation enabling a biopsychosocial treatment to address both hypotheses. Labels for these functional somatic symptoms include fibromyalgia, non-cardiac chest pain, headache, backache and IBS.

These changes are just as much political as medical enabling clinical psychologists to recommend CBT to patients for the anxiety/depression comorbid with the bodily symptoms. However, this omits the bodily distress element entirely. Both need to be worked with together as in TBMA.

The diagnosis can be given more easily where there are also coexisting medical problems. It avoids the tendency to conclude there is no condition. Interestingly, ICD-11 still has separate chapters for mental and physical conditions, again reflecting the dichotomous structure of the medical system. In the new DSM6, expected in 2025, the term MUS/BDD may change again.

The BodyMind Approach: Origins and Development

This next section illustrates the two authors' backgrounds and contributions to the development of The BodyMind Approach (TBMA). TBMA was originally designed for people experiencing physical (somatic) symptoms which do not appear to have an organic cause and remain medically unexplained despite tests and scans, previously termed MUS.

The first author, Helen, was invited in 2001, to consider her next topic for research at the university. On searching the literature for something which linked to her research interest in dance movement psychotherapy (DMP) she came across the term “psychosomatic” in health psychology. On searching further into this topic, it appeared to be ideal for DMP research since it spoke to both psyche and soma. This resonance between mind and body flagged up the patient population who experienced bodily symptoms which had no medical explanation. Firstly, there did not appear to be any treatment or cure for such symptoms. Secondly, they were often referred for mental health treatment which was unsuccessful or which they withdrew from in large numbers. Pain clinics were the other option for patients in pain, which were often reported as not appearing to help either. Medications from GPs were mostly anti-depressants, which seemed to reduce some symptoms, e.g., chronic pain. Overall, there were no effective treatments and those that were in place divided the person into either physical or mental health. Since Helen viewed DMP to be an intervention capable of addressing both physical and emotional needs, it occurred to her that she could perhaps explore how DMP might be helpful, or not, to this patient population (see Payne, 2025 for further description of adapted Authentic Movement /AM). A pilot study was then implemented (Payne, 2009a, 2009b, 2009c). In each of these aforementioned articles the evolution of TBMA is illustrated. For example, although the intervention started as DMP, it then morphed into DMP (TBMA), and finally with the self-management and learning elements integrated it became TBMA for self-management, leaning away from psychotherapy due to the greater understanding of the patients' mindset, avoiding mental health. Furthermore, it was clear a learning model would be far more suitable/

effective for this patient population which gives TBMA a uniqueness not found in other approaches.

After receiving ethical approval from the NHS and funding from the East of England Development Fund, Helen, together with a research assistant, promoted participant recruitment to the pilot study by presenting the study to various local general practitioners (GPs) surgeries. Health professionals did not really appreciate the term DMP unfortunately, and the patients referred were mostly those who had experienced dance as a child. One of the outcomes of the analysis of the pilot study interviews with patient participants in the study was how the intervention, then termed DMP, had supported a strong link between their body and their mind (Payne & Stott, 2010). Since the dance element in the term DMP was not favourably received by GPs for recruitment and patients made the connection between the movement of their body and their minds, a change in the label used to describe the approach emerged. This in turn led to a focus on learning as opposed to psychotherapy and key to this was self-management. Therefore, the intervention evolved organically developing its theory and practice in an action research model, each iteration informing the next. The title for the intervention of The BodyMind Approach therefore arose instead. Furthermore, it transpired people experiencing these symptoms mostly had a physical explanatory model, just not yet diagnosed. Many refused mental health interventions and were very wary of the term “therapy”. Therefore, changing the title, underlying theoretical model and sessions to classes with embodied learning and an arts-based focus was more easily accepted by patients and health professionals. Furthermore, the classes did not aim for healing, mental health therapy or treatment per se, rather developing patient self-management. The term self-management is also more acceptable to the health professional community since patients are expected to take more responsibility for their care.

It is important to note the emphasis in TBMA is on the body first and foremost since the symptom/s patients experience are held in the body. However, the approach employs the symptom experience to reach the mind of the patient participant. Additionally, as there is no term for Body and Mind as an entity in the English language unlike in the German word “Liebe”, the subjective body, the two words Body and Mind were joined together as one written as BodyMind, “Body” taking precedent and with a capital letter M in Mind. The term “BodyMind” for the classes was key since connections made between the participants’ bodies and their minds were emphasised by them in the first pilot study (Payne & Stott, 2010). The term BodyMind Approach was crucial in distinguishing it from the emerging term “mind-body” which is now more commonly employed in health care.

We did not tell patients the intervention was called TBMA we simply emphasised the classes were learning more about their symptoms to make it more acceptable. In subsequent research studies the term “Symptoms Group” was employed as most patients and health referrers found this name for the

intervention made it more understandable. This also led to greater accessibility. Subsequently, as adult learning became more embedded in the theoretical framework the classes were termed “Learning Groups” – learning more about your symptoms and how to manage them. These terms have proved to be more satisfactory to patients/GPs than employing nomenclature such as “mental health” or “therapy” (e.g., one patient recently stated at the beginning of a group “If this is to do with mental health then I am not staying!”).

The second author originally suspected her MUS was happening as a response to stress in her environment but not a mental health condition. Much of the book stems from her keen interest in the physical manifestation of emotional distress. Her lived experience has been both as an insider and outsider to the topic. Her background is wide ranging Master’s level knowledge covering the academic disciplines of human biology; education; social science and business. This provides her with a holistic overview of the theorising and delivery of TBMA. She has worked in a variety of settings including both secondary and higher education and the criminal justice system as both a practitioner and senior manager in a public service. Again, these experiences provide an overview of systems, group interaction and organisational dynamics. She was closely involved with the first author with the setting up, running and management of the spin out University of Hertfordshire company Pathways2Wellbeing. The research and dissemination of TBMA were additional aspects for which she was heavily involved.

Whilst TBMA intervention has its roots in embodied psychotherapy (namely dance movement psychotherapy) it is not a form of psychotherapy. It does not seek to explore or heal/integrate trauma, although it is trauma informed (for example, developmental trauma – see attachment chapter). Generally, the facilitators are trained psychotherapists experienced in group work but modify their approach to TBMA to focus on learning and self-management.

The intervention is designed to support patients with their MUS/BDD to self-manage their symptoms. The learning ecology (Siemens, 2007) in TBMA crosses borders between the arts, adult learning and health. This interfaces several major approaches that do not usually speak to one another. It takes place in a safe facilitated group with a focus on the symptom distress as a gateway to learning more about themselves and how to self-manage the symptom/s. It aims to overcome the obstacles of the patient mind-set about the symptoms, believing in a physical explanatory model, despite health professionals suggesting the symptoms are a result of mental health. Additionally, the lack of treatment options in both mental and physical health facilities leave the patient population with no hope for change.

The intervention was originally developed as a specialist, community-based programme (termed an MUS Clinic to GPs) for primary care patients with MUS based on research (Payne & Stott, 2010) and practice-based evidence (Payne, 2015, 2017a; Payne & Brooks, 2016, 2017), conducted at the University of Hertfordshire, United Kingdom. During the research a cost

effectiveness study was conducted by a health economist to demonstrate the expected savings to primary care of implementing TBMA (Payne & Fordham, 2008). The subsequent delivery in the NHS was through a spin-out body (Pathways2Wellbeing) from the university, transferring knowledge for impact (Payne, 2017b).

Impact Statement

As a result of reading this book we anticipate health professionals who are working with people with MUS/BDD will have better guidance about how and when to use TBMA as an intervention in primary care available through either the National Health Service (NHS) in the UK, or abroad, or private health care. We hope policy makers, health professionals, writers and health bloggers will find this book useful.

The anticipated impact of implementing TBMA in health care could be:

- A change in how health professionals perceive people with MUS/BDD and their need for self-managed care (which can be found via TBMA groups).
- Health professionals in pain clinics, GP surgeries, A&E, hospital specialisms and mental health services will consider TBMA groups a pathway towards self-management for people experiencing MUS/BDD.
- Health professionals will need information about TBMA group deliveries, access to a trained facilitator, referral pathways set up and the argument for funding to be provided.
- Research previously undertaken demonstrates encouraging outcomes for patients with MUS. There is also an economic cost benefit model for estimated savings to primary and secondary care available which could be utilised.

Professionals who will be interested in the research include Integrated Care Boards (ICBs), GPs, wellbeing practitioners, arts psychotherapists, counsellors/psychotherapists, clinical psychologists, physiotherapists, specialist consultants, A&E, academics and GPs based in hospitals. They can all be involved in promoting the means for the delivery of TBMA groups through lobbying ICBs for funding. Barriers might include Cognitive Behaviour Therapy (CBT) practitioners as they might consider TBMA as a competitor to CBT services, although we acknowledge “many roads may lead to Rome”.

Patients will be impacted as they will learn how to self-manage their chronic symptoms both bodily and emotionally. GPs in primary care will be impacted as these patients will not need to have so many appointments for their symptoms, freeing up precious time for GPs to see patients they can help.

Pain clinics, specialist consultants, wellbeing practitioners and clinical psychologists will receive fewer referrals for patients with MUS, freeing up time for them to offer appointments to those they can support effectively.

The ICBs will be impacted as the cost savings of investing in TBMA programmes can be reinvested into other health services.

Purpose of the Book

As well as informing health professionals, this book will provide suitably qualified practitioners with a step-by-step manualised protocol. The aim is to facilitate a group approach to self-management using TBMA with people experiencing chronic bodily symptoms, such symptoms may or may not have a medical diagnosis. Both groups experienced high levels of emotional distress interfering with day-to-day life. It will guide practitioners towards content for sessions, attitudes of mind, together with principles for practice to deliver this research-informed approach. The aim of TBMA is to address the whole person, holistically within a biopsychosocial model, each element of which will be explained in detail in the forthcoming chapters. The programme helps people to come to their own individual understanding of their condition, something which people with MUS often struggle to do.

What This Book Covers

The content of this book draws on previously published material, for example insecure attachment (Payne & Brooks, 2019), which has been updated. The book draws on both the qualitative and quantitative research studies (for example, Payne & Brooks, 2016; Payne & Brooks, 2020). Additionally, it builds on related works by other authors. For example, van der Kolk (2014) writing on mind, brain and body in the transformation of trauma and Maté (2003) on mental health in relation to psychosomatic conditions and the cost of hidden stress. However, there has also been a considerable amount of new theoretical material developed since the research was conducted by the authors.

The book discusses MUS/BDD definitions and terminology and its effects on patients. It considers the theory and principles of TBMA and gives the details of the programme for MUS patients. It explains the flexibility afforded to the facilitator by using content based on a themed approach designed to meet the needs of each group and guided by the facilitator's own professional training, expertise and skills in TBMA. The chapter on training facilitators covers the on-line programme content for each of the four training modules as well as the necessary mindset, attributes and competencies.

There may be repetition because some material in this book has previously been published, though it is updated here. Since each chapter can be read as standalone content some repetition is necessary and inevitable. Additionally, frequent changes in terminology mean that at times, throughout the book,

these terms are explained. Nevertheless, we have endeavoured to make each chapter free-standing and understandable.

There are chapters on MUS/BDD; TBMA; The Programme; Training Facilitators; Qualitative Research; Attachment and MUS; TBMA, Student Stress and MUS; and Stress in MUS/BDD in Relation to TBMA. The epilogue brings everything together and offers suggestions for future research and practice.

The Audience

This book is essential reading for suitably qualified health professionals who are a TBMA facilitator or wish to train as one. They will require a background in adult groupwork and creative somatic practices and should be involved in supporting patients/clients in mental health services. Practitioners such as dance movement psychotherapists, and suitably qualified psychotherapists, counsellors, health coaches and counselling psychologists with an embodied background are all eligible for training. Practitioners working with patients/clients experiencing chronic physical symptoms such as fatigue, fibromyalgia, IBS, backache, headache etc., for which there have been tests and scans returning negative for a medical, organic, diagnosis, will find the content enlightening and invaluable. Many health professionals will recognise patients/clients in this predicament and will also know that there are few interventions available. Many people with MUS and likely BDD do not engage with mental health services (CBT), because they do not believe that they have a mental health issue. Many are seeking a physical explanation for their bodily symptoms, which are both physically and emotionally distressing. Pain clinics and pharmaceutical medicines or physiotherapy do not support their emotional wellbeing and are often also rejected. Therefore, people with MUS keep returning to their GP or A&E for more investigations since the symptoms persist.

The programme fulfils both practitioners' needs for a protocol to work with these bodily symptoms as well as those of people experiencing such symptoms. Medically unexplained conditions are very debilitating and very common not only in Britain but world-wide. The lack of interventions which make sense to people with the condition and the fact that this leads to their disengagement from services, whilst continuing to pursue a quest for the cause of their symptoms, makes the condition very costly and difficult to treat. Equally, we theorise that the anxiety experienced by people diagnosed with BDD may also find support through TBMA, helping them to manage their stress response.

The book includes a detailed overview of the programme for delivering TBMA to groups. For trained facilitators and those wishing to train it gives a comprehensive summary of TBMA training course and the relevant research. For suitably qualified practitioners wishing to train in TBMA there are international on-line training courses which take place twice a