Behavioral Management of Migraine: PAINWeek 2016

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A PAINWeek audience experienced behavioral Rx during a presentation on effective non-drug treatment for migraine.

Attendees at the PAINWeek 2016 conference presentation by Dawn Buse, PhD, on the biobehavioral management of migraine found themselves immersed in a guided relaxation session, before going on to hear about a range of evidence-based biobehavioral interventions.

“Chronic pain is a complex condition that may begin with a physical trauma, but is maintained by a combination of psychological, neurological and psychological factors,” Buse explained. “Behavioral interventions include a range of techniques, available from a range of providers.” Buse is an Associate Professor, Department of Neurology, Albert Einstein College of Medicine of Yeshiva University, Bronx, New York.

Buse, like other presenters at the annual meeting, acknowledged the limitations in primary care practice which can preclude such treatment options, and offered on-line resources and texts that could facilitate the patient’s access. Her own relaxation podcasts and CD are available without cost, for example, at www.dawnbuse.com. (See additional no-cost resources at the end of this article.)

“There’s so much good stuff out there,” Buse said, “that even if someone can’t find a psychologist, there’s no need to spend any money or travel, or any time. You can find great relaxation” and other resources online.

Referral to a therapist for specialized biobehavioral interventions should be considered, however, if patients in primary care continue to be disabled by chronic pain from conditions such as migraine, Buse indicated. She suggested considering referral for the following:
► psychiatric comorbidities
► interference in quality of life, occupational, academic, social disability
► opioid dependence, misuse
► treatment refractory
► secondary gains

Buse explained the concept of “secondary gains”, and how the therapist may help to uncover the patient’s motivations for not actively participating in prescribed treatment (eg, to avoid work, responsibilities).

When referring the patient to a behavioral health provider, Buse emphasized the importance of reassurance from the medical provider that medical treatment and monitoring will continue as appropriate in collaboration with other therapy, and that the referral should not be viewed by the
patient as being “handed off.”
While acknowledging that there may be some reluctance to referring the patient for biobehavioral therapy, as well as obstacles to access to a therapist, Buse also emphasized the benefits for patients who receive the appropriate interventions.
In their published review of behavioral treatments for migraine management, Buse and colleagues point out that, “in addition to improving treatment outcomes independently and in conjunction with medical interventions, behavioral treatments may also reduce medical expenditures, improve adherence to medical treatment strategies, and improve satisfaction for both patients and healthcare professionals.”
Cognitive behavioral therapy (CBT) is the principle evidenced-based biobehavioral therapy, but Buse cited increasing evidence for others such as dialectic behavior therapy (DBT), which she noted has been used with some success in the particularly difficult-to-treat pain patients with personality disorder.
Buse explained the goals of CBT, and its utility within a comprehensive treatment program. “What we’re doing is seeking to identify and modify maladaptive beliefs, attitudes, and behaviors. It’s generally time-limited and problem-focused, as opposed to a psychodynamic approach which may be longer and more open-ended,” she said.
General targets of CBT include reducing “catastrophizing”, where the patient feels helpless and overwhelmed by the pain condition. The problems targeted in therapy can also be very specific, as Buse described a patient who was distressed over having to confront a period of migraines with too few doses of her triptan medication approved by her insurance. The ensuing treatment sessions, which included the patient maintaining a migraine headache diary, heightened the patient’s capacity to distinguish migraine onset, when a dose of the medication should be used, from other headache or discomfort.
“So, we go down all those paths and have all those discussions,” Buse said. “I do talk about quite a few things that a physician, a nurse practitioner, or other health care professional would spend time on.”
Other emerging therapies which appear to have benefit for patients with chronic pain include mindfulness based stress reduction (MBSR) and mindfulness based cognitive therapy (MBCT). Acceptance and commitment therapy (ACT) has also been effective but its techniques are most accessible to very high functioning patients.
In closing their case for including behavioral interventions in medical treatment of migraine and chronic pain conditions, Buse and colleagues indicate that “behavioral treatment strategies are cost effective, can be used in most or all stages of life where pharmacologic interventions may not be available or may be contraindicated (eg, childhood, pregnancy), and can help improve adherence to pharmacological interventions.”

Resources
Dr Buse suggest several Web sites for free resources clinicians can direct patients to, including those from the UCLA Mindful Awareness Research Center, the Huffington Post’s GPS for the Soul, and the mobile apps at www.Calm.com. She also recommended The Relaxation & Stress Reduction Workbook by Davis, Eshelman, Mckay and Fanning.

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