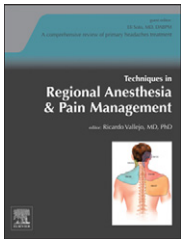
Techniques in Regional Anesthesia and Pain Management 16 (2012) 69–75

Available online at www.sciencedirect.com

SciVerse ScienceDirect

www.elsevier.com/locate/trap



Behavioral approaches to headache: A practical guide for non-mental health providers

*Madeline Gittleman, PsyD, MSED**

Department of Pain Medicine and Palliative Care, Beth Israel Medical Center, New York, New York

ARTICLE INFO

Keywords:
Behavioral approaches
Headache
Relaxation training
Biofeedback
Cognitive behavior therapy
Communication
Four Habits Model
Empathy
Education

ABSTRACT

Behavioral treatments such as relaxation training, biofeedback, and cognitive behavioral therapy have repeatedly demonstrated significant efficacy for the treatment of migraine- and tension-type headache. Behavioral treatments and pharmacologic treatments together also have an additive effect such that the combination of the 2 treatments is more effective than either treatment alone. The action mechanisms of behavioral approaches revolve around the following constructs: (1) self-efficacy; (2) internal vs external locus of control; (3) stress management skills; and (4) pain-coping skills. As these constructs can remain relatively stable over time, behavioral treatments offer lasting results for the management of pain. Despite the aforementioned clinical insights, financial constraints and limited access to behavioral health experts make it difficult to fully integrate behavioral approaches into treatment. As such, this article serves as a guide for medical doctors and clinicians of various disciplines to gain awareness of and integrate these approaches into their headache armamentarium. We present approaches to maximize patients' openness to a multimodal model and keys to distinguish patients who require specialist-level care. We close with a call for greater inclusion of behavioral medicine in graduate level medical training.

Published by Elsevier Inc.

Introduction

The biopsychosocial model of headache posits that pain is triggered, exacerbated, maintained, and alleviated through the interplay of physical, psychological, social, and environmental factors.[1] Successful treatment of headache therefore calls for a comprehensive multimodal approach.

Much research has focused on the constantly evolving pharmacologic and procedural (surgical) approaches to headache. However, with greater acceptance of the mind/body connection, research over the past 3 decades has also focused on behavioral treatments.[2,3] Interestingly, findings have demonstrated that behavioral interventions are not only effective in reducing frequency and intensity of headache and improving quality of life, but they are also effective in more generally improving pain treatment adherence and treatment outcomes.[4,5]

Although many headache centers have incorporated psychologists as part of their interdisciplinary pain teams, physicians have the unique opportunity to directly integrate behavioral strategies into their clinical work.[5] As active collaborators with their patients, physicians' awareness of

*Correspondence author at: Department of Pain Medicine and Palliative Care, Beth Israel Medical Center, 16th Street, 1st Avenue, New York, NY 10003.
E-mail address: mgittleman@chpnet.org

1084-208X/$ - see front matter Published by Elsevier Inc.
http://dx.doi.org/10.1053/j.trap.2012.11.009

and ability to address the emotional, cognitive, behavioral, and social aspects of pain can be invaluable. Adding behavioral approaches to one's clinical tool kit also allows the physician to view the patient from multiple perspectives, thereby avoiding the old adage—if one's only tool is a hammer, every problem looks like a nail. Headache sufferers are a heterogeneous group with multidimensional presentations. Therefore, they fare best with individualized multifaceted treatment plans. This paper seeks to provide non-mental health providers with an overview of behavioral approaches and a guide for how to incorporate these approaches into daily headache treatment. The paper also seeks to briefly present specific scenarios that call for more in-depth behavioral treatment thus require referral for specialist-level care.

Engaging the patient

The sine qua non of incorporating into treatment the techniques described below is the task of engaging the patient as an open, an active, and a cooperative collaborator in the treatment plan. As engaging the patient is the critical first step in all behavioral treatments, it is presented first.

Initial encounter

With the advances of the 21st century and the fast pace of society, people have lost patience for the process of progress and have come to depend on quick fixes.[6] As such, when people seek medical attention they expect immediate relief. Their locus of control is completely external to themselves, centered on the doctor with whom they feel no partnership. That is, they expect something "medical" will be done to them, not with them. Chronic illness and pain disorders pose an even greater problem for patients in that they require long-term management as opposed to acute management, thus resulting in patient frustration. Chronic headache sufferers also often enter into treatment with an array of worries and a sense of desperation after seeing multiple specialists, enduring tests, and attempting remedies to little or no avail.

In order to engage these patients, Nicholson et al. recommend that clinicians approach the intake in a directive yet flexible manner. They suggest clinicians maintain a mental outline of the information they would like to obtain while eliciting the information through open-ended questions. This establishes the development of a collaborative clinician-patient relationship as opposed to a one-time solution-focused consultation.[7] Contrary to popular belief, research has also shown that engaging patients in this way generates a greater depth of relevant information in a shorter period of time[8] (see Table 1 for a list of open-ended questions for initial visits).

Communication

As medical treatment is often dependent on the collaborative relationship between patient and clinician, communication is key to building successful outcomes.[9] Frankel and Stein utilized the existing research on effective clinical interviews and created "The Four Habits Model", a practical guide for clinicians to communicate in meaningful ways with patients. Based on this model clinicians are encouraged to organize their behavior around the following: (1) investing in the beginning—establishing a rapport; (2) eliciting the patient's perspective or obtaining relevant information; (3) demonstrating empathy; and (4) investing in the end—motivating patient towards treatment adherence. The model (Table 2) specifies techniques that pertain to each habit with examples of beneficial outcomes.[10]

Empathy is often conceptualized as a trait that cannot be learned. Indeed, it is likely that there are people who are more naturally empathic; however, it is a trait that can be acquired with training and practice. Cohen-Cole and Bird identified 5 ways in which clinicians can emotionally join with patients: (1) reflection—"I can see that you are…"; (2) legitimation—"I can understand why you feel…"; (3) support—"I want to help…"; (4) partnership—"Let's work together…"; (5) respect—"You're doing great".[11] As is the case with generally good communication, use of empathy in clinical interactions leads to greater patient engagement and satisfaction.

Education

In addition to communicating effectively and connecting to the patient, education is a crucial component for headache treatment. For patients, education serves as a key to self-management, a motivating force for adherence to treatment and a foundation for building self-efficacy. Due to the complex biopsychosocial nature of headache, education as a treatment in itself has been shown to decrease headache pain and its frequency, improve quality of life and reduce utilization of healthcare resources.[12] To achieve these positive outcomes, instructions to the patients should focus on etiology and pathology of headache; monitoring of headache;

Table 1 – Sample questions for the initial encounter.

Open-ended questions	Information elicited
"What brings you here today?"	History of present illness
"How do you understand your headache symptoms?"	Insight into condition; core beliefs; attribution of meaning
"What alleviates/worsens your headache?	Awareness of triggers; capacity for self-management
"How do your headaches affect you (physically and emotionally)?"	Physical functional status; emotional functioning
"How do you deal with your headaches?"	Pain coping abilities
"Who interacts with you around your headaches?"	Support system
"What is most bothersome/most important to you?"	Treatment goals
"What are you hoping for with headache management?"	Treatment expectations