Psychological therapy

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Headache clinics

Headache clinics may be located in primary care\(^1\,\,^2\) or in neurology,\(^3\,\,^4\) or serve as a regional or national multidisciplinary centre for headache problems not effectively managed elsewhere in the healthcare system (see also Chapters 2, 4, and 12). The clientele will vary with the referral base of a headache clinic. However, clientele of the headache clinic, especially the regional or national referral centre consists primarily of chronic headache disorders complicated by conditions that maintain pain and disability or render headache problems refractory to standard therapies. Patients typically present with multiple comorbid problems, including secondary headaches (e.g., medication overuse), other chronic pain and medical disorders, psychiatric disorders, and/or psychological problems that range from established environmental reinforcements for headache-related disability to a history of physical or sexual abuse. Most headache specialists probably agree that the chronic benign headache disorders seen in the headache clinic are best conceptualized and managed as chronic (rather than acute) illness; in practice, however, headache clinics are not necessarily organized for the management of chronic illness.

Psychological therapies: description

Self-management

Self-management refers to the active involvement of the individual in the management of their chronic disease, and is specifically defined as ‘the individual’s ability to manage the symptoms, treatments, physical and psychosocial consequences, and lifestyle changes inherent in living with a chronic condition’.\(^6\) As illustrated in Figure 31.1, the effective self-management of chronic headache disorders requires that the individual: (1) can self-monitor headache-relevant information (e.g., early headache warning signs, headache triggers, acute medication use, and medication response); (2) possess specific behaviour management skills as well as general problem-solving skills and the motivation and confidence (self-efficacy) necessary to effectively use these skills in daily life; and (3) the ability to adjust headache-management efforts (e.g., the use of acute headache medications and non-pharmacological headache management skills) in response to self-monitoring data; and
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**Behavioural interventions**

The three behavioural interventions described below each provide a different set of skills for managing headaches and headache-related disability to be incorporated into self-management interventions. In practice, they are often combined.

1. **Relaxation training.** Relaxation training is a basic skill and an introduction to the use of behavioural headache management skills and should probably be included in all self-management programmes. Relaxation skills enable headache sufferers to exert control over specific headache-related physiological responses and to lower physiological and mental arousal. Patients are instructed to practise a graduated hierarchy of relaxation techniques (diaphragmatic breathing, progressive muscle relaxation, relaxation imagery, meditation) initially for 20–30 min per day; then, as they are able to master increasingly brief relaxation techniques (cue controlled relaxation, self-control relaxation), to relax briefly (e.g. for 30 seconds) throughout the day, and whenever they notice mental or bodily signs of tension, or signs signalling headache onset.

2. **Cognitive-behaviour therapy (CBT).** CBT provides an overall framework not only for teaching skills for both managing and coping with headaches, but also for addressing the comorbid psychological problems commonly seen in the headache clinic setting. CBT addresses the cognitive, affective, and behavioural factors that influence headaches and increase headache-related disability. Patients monitor the circumstances, in which their headaches occur or worsen, and thoughts and feelings surrounding these headaches. Once stressful or high disability situations are identified, dysfunctional cognitions are identified and challenged. Cognitive targets are stress, pain, or disability generating or thoughts (e.g. ‘catastrophizing’) and the beliefs that help generate these thoughts (e.g. ‘I’m unable to tolerate pain and must have immediate relief’). The goal is to teach patients to ‘catch’ and challenge these thoughts, thus managing headache-related stress, reducing disability and enhancing positive coping efforts. Cognitive problem-solving skills also help patients address environmental sources of stress or reinforcements for disability, as well as barriers to the effective application of behavioural headache management skills (where these are potentially changeable). Problem-solving skills also help patients solve problems that will inevitably be encountered as they attempt to integrate newly learned headache management skills into their unique daily routine.

3. **Biofeedback training.** The incorporation of biofeedback training into a self-management programme is likely to depend on headache diagnosis, patient interest and available resources. Thermal (hand warming) feedback (feedback of skin temperature from a finger), and electromyographic (EMG) feedback (feedback of electrical activity from muscles of the scalp, neck, and sometimes the upper body), are the most commonly used biofeedback modalities, although electromyographic feedback with the goal of teaching self-regulation of cortical excitability has received recent attention. Patients are instructed to use a home biofeedback training device or to practice the self-regulation skills they are learning during clinic-based biofeedback training sessions for about 20–30 min per day, and, as they master physiological self-regulation skills, they are encouraged to integrate their use of self-regulation skills into their daily routine in the same manner as described above for relaxation skills.

More detailed descriptions of the above behavioural interventions and the clinical issues that arise in treatment can be found elsewhere. Efforts to administer
self-management including interventions in formats that use home study or Web-based materials to reduce clinic contacts are relatively well established and efforts to develop these technologies to the point where on-site behaviourally trained clinicians would not be required are in their infancy, but promising. However, at this point limited contact and completely home-based treatment formats appear most appropriate for highly motivated patients with relatively uncomplicated headache problems. However, for the headache clinic patient they may prove a valuable supplement to clinic-based treatment and/or long-term maintenance intervention.

**Psychological therapy: efficacy**

**Self-management**

Four initial studies (n = 54-497) have evaluated brief self-management groups in primary care or neurology based headache clinics. Three of the studies evaluated single-session headache self-management interventions and a systematic medical management plan. Although results are qualified by the cohort designs in all three studies implementation of the self-management programme was associated with improvements in headache-related disability (severe headaches or standard measures of headache-related disability) and in reductions in headache-related emergency department visits (34-79 per cent; mean = 54 per cent). Reduced headache related visits, net cost savings, and improved satisfaction with headache care also were reported.

In the only randomized trial to date, 100 consecutive patients at a regional neurology based headache clinic were randomized to medical treatment by a headache specialist with or without receiving self-management. Three 90-min headache self-management classes (didactic instruction about migraines and migraine treatment, plus opportunity for discussion) were co-led by two trained lay volunteers with migraine. At a 6-month evaluation, self-management plus medical management was associated with significantly greater reductions than medical management alone in headache days (43 per cent versus 0 per cent) and functionally incapacitating headache days (43 per cent versus 23 per cent) per month. The self-management condition also was associated significantly with fewer total patient calls (54 versus 244) and fewer unscheduled headache clinic or emergency department visits (25 versus 50) than medical management alone. In addition, acute therapy use tended to be lower (5.3 versus 15.6 days/month), analgesic over-use less frequent (0 per cent versus 36 per cent of patients), and adherence with preventive medication higher (96 per cent versus 59 per cent of patients) in the self-management condition.

These initial findings suggest that cost-effective programmes for the self-management of chronic headache disorders can play an important part in the headache clinic setting. Future efforts would benefit from drawing on the knowledge that has been gained in the last decade in developing self-management interventions for other chronic disorders. 9,11,12,18

**Management of comorbid psychiatric disorders**

CBT for headaches can be expanded to also address the most commonly encountered comorbid psychiatric disorders encountered in the headache clinic. Space does not permit descriptions of cognitive-behavioural techniques for treating each disorder, and clinical trials too numerous to summarize; only a few illustrative findings with references to reviews can be presented here. In major depression CBT and antidepressant medication appear equally effective in the short run, but the combined treatment not only increases the response rate (especially for patients with severe or chronic depression) but provides protection from relapse or recurrence. 27-29 In the case of the anxiety disorders (where a core element of CBT involves exposure to internal and external anxiety cues) long-term outcomes appear better with CBT than with (antidepressant and/or benzodiazepine) drug therapy; in fact, while the addition of drug therapy (especially benzodiazepines) to CBT improves short-term response, it tends to yield poorer long-term outcomes than does CBT alone. 29,30 With an increasing number of anxiety disorders (panic disorder, social anxiety disorder, and post-traumatic stress disorder) standardized protocols also have been developed that can effectively be administered by allied health professionals.

CBT can also be modified to help manage problems encountered with patients with axis II disorders, particularly borderline personality disorder in the headache clinic setting. 31 A recent comparison of patients with borderline personality disorder with consecutive patient and demographically and headache frequency matched comparison groups conducted at a regional neurology based headache clinic confirmed clinical observations that headache problems are unlikely to be
managed effectively in these patients with medical treatment options alone. In this study borderline personality disorder was associated with more pervasive headaches, greater disability, higher levels of depression, and medication overuse headache, and persistent management difficulties as reflected in frequent unscheduled visits for acute treatment and a poor response to medical therapies.

Conclusions

The benign chronic headache disorders seen in the headache clinic setting are often best conceptualized and managed as chronic conditions. The self-management framework that has proven valuable in managing other chronic disorders can help patients make effective use of medical, psychological and other therapies in actively managing their headache problems.

References


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The role of the clinical nurse specialist in headache
Ria Bhola

Introduction
The role of the clinical nurse specialist (CNS) as a relatively new concept within nursing practice has developed rapidly. This role first began in the USA as early as the 1960s and has since grown. In the UK the concept was developed in the 1980s, leading to the emergence of new posts in some centres. However, the last decade has seen a significant change in the range of tasks undertaken by nurses.

Throughout the 1990s managers and clinicians in the UK National Health Service (NHS) have been challenged by the fast pace and diversity of change, while seeking to provide efficient and effective patient services. This together with encouragement from the Royal College of Nursing (RCN), led to the development of specialist nursing roles. In the next decade these posts continued to expand and were promoted by several factors:

- The reduction in junior doctors' hours, resulting in nurses extending their roles to take on tasks previously performed by junior medical staff.¹
- The UK Central Council for Nursing (UKCC) formally recognized two levels of nursing practice beyond initial registration and set out guidelines for role expansion and reforms in nurse education.²³
- The national service frameworks, stringent government targets for health outcomes and the belief that advanced nursing roles can make a valuable contribution.⁴
- Patient demands for greater choice and accessibility.

A review of nursing practice by the UKCC emphasized the importance of combining experience and formal education for nurses in order for them to undertake greater professional responsibility and exercise increasing clinical discretion through advanced practice.² This report endorsed the development of specialist and advanced nursing roles. More recent drivers have been further government targets and the European Working Time Directive. The UKCC⁶ later proposed the concept