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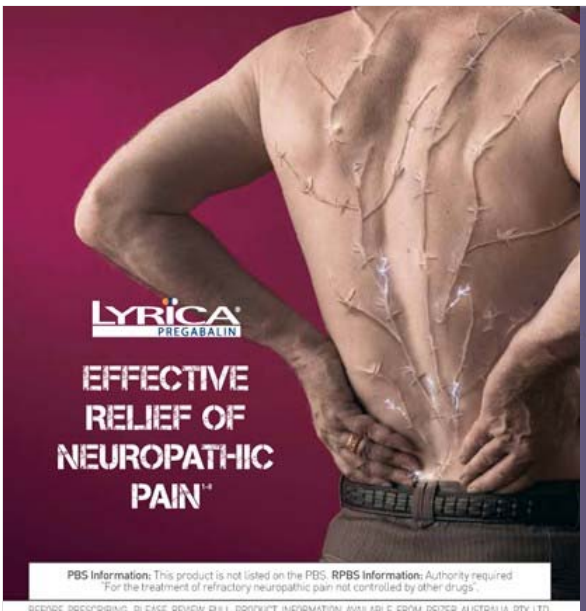


Pain Management
IN GENERAL PRACTICE

Pain Management in General Practice Journal is peer reviewed and is the only journal for General Practitioners that has cardiovascular disease as its single focus. It provides up-to-date information on specific conditions, current management, recent research findings, preventative medicine and current guidelines. Pain Management in General Practice Journal is published by Health Publishing Australia.

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## Message from the Editorial Board

Welcome to this first edition of Pain Management in General Practice.

General Practitioners are usually the first medical contact for patients presenting for the assessment and treatment of pain, consequently the editors and contributing authors are delighted to be able to bring this publication focussing on up to date information on all aspects of pain management to you.

Pain is a common and often distressing symptom of many conditions. It can present acutely following a fracture or with an acute abdomen, it can be persistent, irritating and demoralising when caused by low back pain or frightening and severely disabling when caused by cancer.

Recent surveys have shown that up to 20% of the Australian population have had pain which has lasted for > 3 months in the past year. So pain is common! In Canberra in March this year a National Pain Summit was held to highlight and bring together key players and politicians to develop a National plan to address the problem of unrelieved pain. In future editions we will bring you more on these National developments.

In this first issue of Pain Management in General Practice we bring you a wide variety of articles which cover disease specific pain from Rheumatoid arthritis and more generalised musculoskeletal pain. A commentary on the use of opioids for chronic non cancer pain which echoes "position statements" from both the Royal Australian College of Physicians and the Faculty of Pain Medicine, which will hopefully be of guidance in this sometimes controversial area .

The role of exercise and non drug physical therapies is reviewed along with the place for psychological assessment and treatment particularly in the management of Migraine.

We hope that these short articles will be helpful in your busy practices and will welcome feedback on their value and of course suggestions for topics in future editions of Pain Management in General Practice.

**A/Prof. Roger Goucke**
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Clinical Professor in the School of Medicine and Pharmacology at the University of Western Australia.

## In This Volume:

# Migraine: Consider Referring to a Psychologist

The lifetime prevalence for migraine is 25% for women and 8% for men, and the preceding year prevalence for migraine is 15% for women and 6% for men (Rasmussen et al, 1991). In attempts to rank the severity of different diseases, migraine has been ranked among those causing the greatest degree of handicap, together with conditions such as quadriplegia, dementia and active psychosis (Dahlof & Solomon, 2006). It has been estimated that migraine costs European society €27 billion per year (Olesen et al, 2007), and American society US$17 billion per year (Berg & Ramadan, 2006).

In the UK, Latinovic and colleagues (2006) analysed data from 253 general practices over a nine-year period and reported that 6.4% of headache patients were referred for tests or to specialists, of whom 2.1% were referred to neurologists, 1.1% to general physicians, and smaller proportions to opthalmologists and ear, nose and throat specialists. In Australia, the BEACH program, a continuous national study of general practice, revealed that 2.8% of headache patients were referred to neurologists (Charles, Ng, & Britt, 2005). The only other specialists listed in this study were physiotherapists and optometrists, who received 2.8% and 1.5% of headache referrals, respectively.

## WHY SHOULD MIGRAINEURS BE REFERRED TO PSYCHOLOGISTS?

The medical literature characterises migraine as a neurovascular disorder, emphasises the importance of genetics, and advocates pharmacological treatment. Whilst there is empirical evidence to support all these propositions, it does not alter the fact that headache disorders generally and migraine specifically occur in a developmental and psychosocial context. That is, whether you experience migraines depends on how you lead your life – family relationships, work environment, exercise patterns, diet, sleep routines, and so forth.

Martin (1993) has advocated a functional model for conceptualising the common primary headaches which seeks to answer questions such as why do migraines occur when they do, why is the person experiencing migraines at this point in her/his life, why did the migraines begin when they did, and why is this person vulnerable to migraine attacks? The questions are investigated by considering antecedents on the one hand and consequences on the other. For example, the immediate antecedents of migraine attacks are the triggers and the most common triggers of migraine are stress/tension, menstruation, visual disturbance, noise, odours/smells, hunger, specific foods, alcohol, weather, lack of sleep and fatigue (Martin, 2010a). The setting antecedents are the lifestyle factors that moderate current vulnerability. For example, the impact of a stressor as a precipitant of headaches will depend on whether the person has an adequate social support system to buffer them against the effects of stress.

The consequences of headaches include the immediate reactions to headaches and the long-term effects of headaches. Consequences are included in the model because of the negative feedback loops that often develop. For example, stress triggers a migraine and the person reacts by becoming stressed at the pain and the impact of the migraine on completing commitments, so that a stress-migraine-stress loop is created. Another example, might involve the situation whereby the main source of stress was a dysfunctional marriage so that the marriage would constitute a setting antecedent for headache. If stress from the marriage led to a migraine which in turn resulted in irritability and arguments, then having a migraine could feedback to the dysfunctional marriage creating even more strain in the relationship. An example of a feedback loop involving a long-term consequence would be migraine attacks spoiling social occasions leading to social withdrawal and therefore a diminished social network, resulting in less social support and therefore no buffer against stress.

## WHAT DO PSYCHOLOGISTS DO WITH MIGRAINE REFERRALS?

If a psychologist adopts a functional approach to headaches then the main goal of assessment is to answer the questions posed above as this will provide guidance for developing a treatment plan. Information is collected by three methods. The first method is interviewing because many questions need to be asked about headache triggers, trigger moderating factors, how the disorder developed, reactions to the headaches by the sufferer and significant others, headache symptoms and history. The second method is self-monitoring whereby, for example, the migraineurs monitor their headaches by recording hourly

# Migraine: Consider Referring to a Psychologist cont....

ratings throughout the waking day, as well as other information, such as medication taken for the headaches. The third method is using questionnaires/inventories to provide additional information. For example, a high proportion of migraine sufferers will have elevated levels of depression and anxiety, so questionnaires that measure emotions/mood might be used. Assessment is usually completed across two 50-minute sessions.

There are certain treatment techniques that are likely to be used regardless of the specific controlling variables of the headaches, including education about the headaches, relaxation training, cognitive training targeting maladaptive thoughts and underlying beliefs, and pain management strategies such as imagery training and attention-diversion training. Other techniques would depend on the results of the assessment. For example, if stress was a key trigger and the main source of stress was tension between the migraineur and her children then one component of treatment might be parent training. If the patient reacted to the first signs of a migraine attack in maladaptive ways, such as trying to get done all the activities that it would not be possible to do if a severe migraine attack developed, then treatment might include teaching her to react in ways that would reduce the chance of a migraine attack occurring or to minimise its intensity and duration. Treatment usually takes about ten 50-minute sessions, and patients are assigned 'homework' tasks to complete between sessions.

## RECENT DEVELOPMENTS IN MIGRAINE MANAGEMENT

The standard advice for decades has been that the best means of preventing migraine attacks is to identify and avoid triggers. Researchers regularly make this point in articles, for example, "Comprehensive migraine treatment programs emphasize awareness and avoidance of trigger factors as part of the therapeutic regimen" (Friedman & De Ver Dye, 2009, p. 941). One of the 'seven elements of good headache management' listed by the World Health Organization is "identification of predisposing and/or trigger factors and their avoidance through appropriate lifestyle change" (World Health Organization, 2006, p. 77). This advice appears on numerous internet sites. For example, on the web site of the American Headache Society under 'Instructions for Patients' is a handout entitled 'Trigger Avoidance Information' which includes an 'Identifying Headache Triggers Worksheet'.

This advice has been challenged recently by Martin and colleagues in a series of articles (Martin & MacLeod, 2009; Martin, 2010a, 2010b) on a number of grounds. First, there is limited empirical support for the advice, and second, how do you avoid the diverse range of factors that can trigger migraine attacks? Martin also argued that avoidance of triggers may lead to increased sensitivity to triggers (sensitisation) or decreased tolerance for triggers, in parallel with the well established relationship between exposure to anxiety-eliciting stimuli and sensitivity to those stimuli. He has completed a series of studies showing that, as for anxiety, short exposure to headache triggers results in sensitisation to the triggers whilst prolonged exposure results in desensitisation to the triggers (Martin, 2001; Martin et al, 2006). He also demonstrated that repeated, prolonged exposure to a headache trigger resulted in habituation to the trigger (Martin, 2000). Hence advice to avoid all triggers might lead to fewer headaches in the short-term but could result in more headaches in the long-term as tolerance for triggers decreases.

On the basis of these arguments and findings, Martin has advocated a 'Learning to Cope with Triggers' philosophy as a basis for managing the triggers of migraine (Martin, 2010a). This approach recognises there are many different coping strategies and that different ones are needed in different situations. Avoidance of triggers will sometimes be the strategy of choice, for example, in situations where exposure to the triggers would be dangerous or at least not consistent with healthy living. However, for most triggers the goal should be to learn to cope with the trigger, or to desensitise/adapt/habituate to the trigger, which can be achieved by graduated exposure. Graduated exposure involves exposure at levels that are challenging but fall short of precipitating significant headaches, with length and intensity of exposure increased as tolerance develops.

## EVIDENCE FOR THE EFFECTIVENESS OF PSYCHOLOGICAL TREATMENT FOR MIGRAINE

In 2005, a Special Series on 'Clinical Trials Methodology with a Focus on Behavioural Treatments for Headache' was published in the journal Headache (Vol 45:5). In this series, Rains et al. (2005) summarised the results of five meta-analytic reviews for psychological treatment of migraine (thermal biofeedback, electromyographic biofeedback, cognitive behaviour therapy - CBT, and relaxation training) published between 1980 and 1999, and concluded that average improvement ranged from 33% to 55%, compared with 5% for no-treatment controls. In an Editorial to the series, a neurologist concluded that "We know that there is overwhelming evidence in support of behavioural therapies for headache prophylaxis", and went on to note that "The effect of behavioural therapies may persist for years, as opposed to pharmacological therapy" (Maizels, p. 411, 2005).

The functional approach discussed in this article is a form of CBT and in a randomised controlled trial was associated with the following changes: (a) average decrease in headaches of 68% post-treatment, and 77% at 12-month follow-up; (b) average decrease in medication of 70% post-treatment; and (c) 78% of participants reached the commonly accepted criterion for clinical improvement (50% or greater reduction in headaches) (Martin et al, 2007). These improvements were obtained with only eight treatment sessions, and with a group of participants who had been suffering from headaches for a very long time (average chronicity of 24.4 years).

The United States Headache Consortium developed evidence-based guidelines for the treatment of migraine based on an extensive review of the medical literature and compilation of expert consensus, and found Grade A evidence ('multiple well-designed randomised clinical trials, directly relevant to the recommendation, that yield a consistent pattern of findings') in support of behavioural treatments (thermal biofeedback, electromyographic biofeedback, CBT, and relaxation training) for migraine (Campbell et al, 2010).

Pharmacological treatment of headaches is often associated with side effects, whereas behavioural treatments tend to be associated with benefits beyond headache reduction such as decreases in depression and anxiety, and reduced sleeping problems (Martin, 2009).

## PRACTICAL ISSUES RELATED TO REFERRING TO PSYCHOLOGISTS

General practitioners considering referring patients to psychologists are directed to Meadows and Martin (2007) for information on issues such as how to find the right psychologist, and what rebates are available for seeing psychologists.

*No conflict of interest declared.*

**References available on request**


SUMMARY

- **To fully understand migraine it is important to consider the psychosocial and developmental context in which it occurs – the triggers and factors that moderate the triggers, and the reactions to headaches that often create vicious circles.**
- **Psychologists use interviews, self-monitoring and inventories to assess headaches.**
- **Psychological treatment involves education, relaxation training, cognitive therapy, and training in pain management strategies, as well as focussing on any issues specific to the particular patient's migraine, such as targeting the sources of stress if stress is a trigger for migraine attacks.**
- **Migraine triggers are best managed from a 'Learning to Cope with Triggers' perspective where the emphasis is on desensitising triggers rather than avoiding all triggers.**
- **Psychological treatment for migraine has been shown to be highly effective with good long-term outcome and beneficial 'side effects'.**


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