Episode 198: Mindfulness-Based Cognitive Therapy for Migraine

Lindsay Weitzel, PhD:
Hello everyone, and welcome to HeadWise, the videocast and podcast of the National Headache Foundation. I'm Dr. Lindsay Weitzel. I'm the founder of Migraine Nation and I have a history of chronic and daily migraine that began at the age of four. I am super excited to tell you that I am here today with Dr. Elizabeth Seng. Hello. Dr. Seng, how are you?

Elizabeth Seng, PhD:
I'm well. Thank you for having me.

Lindsay Weitzel, PhD:
Thank you for being here. Dr. Seng is an Associate Professor of Psychology at the Ferkauf Graduate School of Psychology at Yeshiva University. She's also a widely published author in the field of headache psychology, and has recently published papers on our topic today, which is mindfulness-based cognitive therapy for migraine, also known as MBCT-M for short. Now this is a great topic because this is something that we can do that will really make a difference in our migraine disability. And I love talking about it and I love hearing about it.

So Dr. Seng, why don't you start for people in our audience who might not know who you are or know too much about you. Why do you begin by telling our audience a little bit about yourself, and why you love working in the headache field?

Elizabeth Seng, PhD:
So I have been working with people with migraine and other headache disorders for over 20 years. And I was initially drawn to working with people with chronic pain because I noticed how marginalized they were in the health care system. A lot of doctors, a lot of other medical providers, don't really want to hear the stories of people who are living with chronic pain.

And it always felt so defeating when people with pain would come back and say, I'm sorry, but this isn't helping. I still need more. And I saw that those interactions could be really negative, and I wanted to try to help with that situation. When I was in graduate school, I then really fell in love with working with patients who have migraine and other headache disorders, because I saw that the people in this community are just so extremely resilient.

People who have migraine and other headache disorders often have them, as you have described during the prime of your life, when you have so many other things that you want to be doing, but are being knocked over by these really disabling symptoms. And I saw that there were a lot of treatments that could help. So that's kind of why I've stayed on the field for so long. And I'm so excited to get to continue to work with patients living with chronic migraine.

Lindsay Weitzel, PhD:
Okay. Well, we are excited to learn from you today. I'm excited to learn from you today. There's so much on this topic to learn. So as I mentioned, our topic is mindfulness-based cognitive therapy for migraine or MBCT-M. And it has been shown to significantly decrease disability related to our migraine. So let's break it down. What exactly is MBCT-M and how is it different from other forms of cognitive behavioral therapy?

Elizabeth Seng, PhD:
Mindfulness-based cognitive therapy is actually closer and more derived from mindfulness-based stress reduction than it is from cognitive behavioral therapy. So it's really important to understand what we think of mindfulness is. I think of mindfulness as this attention regulation strategy. It's where are we putting our attention. When you're thinking mindfully, you're attending to the present moment, but you're also attending to the present moment without judging it.

So you're not saying what I'm experiencing is good or bad. It just is. And when you use mindfulness, kind of by definition, you're not worrying about the future and you're not feeling regretful about the past and you're not feeling terrible about the present moment because you're allowing it to be what it is. Mindfulness is a very difficult skill to learn.

And mindfulness-based stress reduction is not modified for any specific disease state. So one of the reasons why we chose to study mindfulness-based cognitive therapy is that mindfulness-based cognitive therapy lets us target interventions specifically for people living with migraine, and it lets us include a little bit of using these mindfulness technique to change the way we think when it comes to stressful situations like migraine attack.

Lindsay Weitzel, PhD:
So let's talk about exactly what's involved MBCT-M. If someone comes to see someone like you, what might they encounter? What are they going to do? What are they going to learn?

Elizabeth Seng, PhD:
So formal mindfulness-based cognitive therapy is often given in a group format. And so often given with a handful of people. And that can be really, really helpful because you get to hear about other people's experiences as they're trying to do something which is pretty hard: learn how to use them and apply it to their daily lives as they're living with a chronic illness.

I am a therapist, and because of how the American healthcare system works, it's actually very difficult to pay for group treatments. So in routine clinical practice, it may be more common to find mindfulness-based cognitive therapy being given on an individual basis. And that's actually why in the recently published pilot trial, we actually did give it on an individual basis.

We wanted it to be more pragmatic and more like what people will get it in real life. MBCT is typically eight sessions. Each session will include practicing a new mindfulness skill. Some of those are things like eating mindfully, paying really close attention to what you're eating, and starting to just train your brain rather than saying, oh, that tasted good and moving on. Really saying, yeah, but what am I experiencing right now. Really diving into the moment. Meditation of breath is often part of mindfulness, but if you

find that uncomfortable, it certainly doesn't have to be. Mindfulness can be applied to everyday situations and can be a skill that you can use to help you stay more in the present moment, not worrying about the future, and not feeling regretful about the past, and experiencing it for what it is. So that's what most people will find when they come to MBCT.

Lindsay Weitzel, PhD:
Now there is something that occurred to me while you were talking and being someone that has been in pain a lot of my life and talked to a lot of people in pain. What happens when someone says, but the pain is in the present moment. What do you answer to that question?

Elizabeth Seng, PhD:
So one of the reasons why people like both mindfulness-based stress reduction and mindfulness-based cognitive therapy for chronic pain conditions in general, is because they provide a lot of emphasis about really paying attention to the quality of your pain experience. And rather than thinking pain bad, say, is it hot or cold? Is it heavy or light? Asking other qualifiers that aren't intrinsically positive or negative. And that can help you get more of a handle on your pain.

There's also a technique that you can use called pain transformation or the pain dial, where once you have a handle on what your flavor of pain is that day, you can imagine a dial and you can imagine turning that dial down a little bit. That could be helpful.

Lindsay Weitzel, PhD:
So there's some terminology that I think it would be helpful for everyone to learn and understand as we're learning about this today. And one of the terms is cognitive appraisal. It's discussed a lot when people talk about MBCT-M. What is cognitive appraisal?

Elizabeth Seng, PhD:
So cognitive appraisals are what makes MBCT-M different from mindfulness-based stress reduction. That includes these components of cognitive behavioral therapy. So a cognitive appraisal or in the context of cognitive therapy, an automatic thought is a thought that arises automatically in any given person arising out of a situation. So every person does not respond the same way when the same situation arises.

A very classic example is you're walking down the street and you see a friend on the other side of the street, and you wave at them, and they do not wave back. What's the first thing that you think? And so if you're somebody struggling with depression, the first thing that you may think could be they don't want to be my friend. They don't want to deal with me.

Lindsay Weitzel, PhD:
Or if you're having a bad pain they might think that too, right?

Elizabeth Seng, PhD:
Exactly. Whereas there are many, many alternatives like maybe they didn't see me, that lead you to just feel better about the situation and to go about your day in a way, maybe even reach out to them on Facebook. Go about your day in a way that is more aligned with your values and how you want to live your life.

We come by our automatic thoughts really honestly and if we didn't have automatic thoughts, we couldn't do anything. That's consciously think about how you drive, right? You just do it and it happens and you don't crash. It's kind of amazing. Our brains are incredible. So we've built all of these roads in our minds that help us do the things we need to do every day.

Sometimes people call these heuristics. They're these easy rules, shortcuts in our mind. We come by them very honestly. We come by them because of our genetics. We come by them because of our lived environment. The thing that cognitive therapy and MBCT are trying to focus on are these roads in our mind, these automatic thoughts, that are taking us places we don't want to go.

We came by them honestly. They protected us at some point in our life. But now they're leading to a place with more pain and more disability. And we want to see if there are some little dirt roads that we might be able to expand that might lead us places that are more aligned with our values and how we want to live our lives.

Lindsay Weitzel, PhD:
I like the way you put that. That's awesome. So there is sort of under the same question I had related to cognitive appraisal. It seems that one of the reasons that MBCT-M is effective is it decreases something called catastrophizing. Now I'm bringing it up on purpose, because I think that the word catastrophizing can sometimes be really triggering to people with severe pain, chronic migraine, etc. I think it's sometimes used in not the best way.

We don't want to be seen as catastrophizers, or anything like that. So why don't you go ahead and talk to us about what catastrophizing is and how it is involved in this type of therapy or this type of mindfulness, etc..

Elizabeth Seng, PhD:
So I want to talk briefly about the finding from the study and then the broader context. So MBCT doesn't specifically deal with catastrophizing. Literally it deals with whatever automatic thoughts the patient is coming up with. I did the supervision for all the therapy in our study. For many of the patients catastrophizing wasn't among the automatic thoughts that's problematic for them.

So the fascinating thing is that there are other cognitive tools that I would have expected to change more in this treatment, specifically cognitive fusion. Because the treatment does specifically address that. And we talk a lot about how this idea that thoughts are not facts.

Lindsay Weitzel, PhD:
What is cognitive fusion

Elizabeth Seng, PhD:
Cognitive fusion is the idea that thoughts are facts. When the thought passes through my head that's me thinking it. That's me. Whereas thoughts they pass through our heads all the time and some of them are not exactly you. So cognitive defusion says I am not my thoughts. My thoughts happen and I can own some of them and I can let some of them go by and it doesn't need to bother me. That is something that there's literally an entire session called thoughts are not facts. So I assumed that if MBCT works really differently than the other behavioral migraine management strategies we've used in the past, we expected cognitive fusion would be more important for reducing disability than pain catastrophizing.

And we were wrong. It turns out that pain catastrophizing still ruled the day and was the biggest change mechanism associated with reductions in migraine related disability. So the reason why that finding was so interesting to me is because whatever pain catastrophizing is, it's really important and it's really changeable. So in the broad context of chronic pain, we started off talking about how one of the reasons why I was drawn to this field is because pain is so stigmatized in the health care system.

And I think that that's the reason why any automatic thought that we noticed was more common in people who have chronic pain versus people who have pain and then it no longer interferes with their lives. That would have become stigmatized.

Michael Sullivan is the person who came up with the term pain catastrophizing in the 90s. He's recently written a lovely opinion piece about how we could change the name. But it's still going to be a problem because it's still something that's common in people who have a really stigmatized condition. And that what we need is a culture change around believing people's lived experiences with chronic pain. And that the dismissiveness that has absolutely been documented in the medical community around this idea of pain catastrophizing and people are pain catastrophizers, it will continue to follow whatever we call it.

The thing is that pain catastrophizing it turns out is really important. So I want to talk a little bit about what it is. And then I'm not going to say the word anymore.

So some of us learned early in life that the world is dangerous and that we need to worry in order to make the world safe. We need to think about the worst-case scenario. And this is a common automatic thought pathway in our mind that helps keep us safe and is common to many people with anxiety, many people with all sorts of problems.

What we've noticed is that people who have that kind of thought pattern, where we're worried about the worst-case scenario, that seems to be really problematic in terms of pain. So some of the early research showed, for example, that people who have this kind of thought pattern are less likely to go back to work after a workplace injury than people who don't. And that people who have this kind of thought pattern have poorer surgical outcomes than people who don't.

So that's why people started to think maybe this is important. One of the most amazing things to me about this style of thinking, that this is the worst-case scenario, this is never going to get better, is that it changes so quickly. For many people they're like a little surprised once they start to really hear themselves. They're like, oh my gosh, I did not realize how much my mind is thinking this. And just awareness can help people change. So the fact that this thought pattern changed in our study, where

we saw large reductions in disability, but we didn't see much of a change in headache days as the primary outcome at all, really shows that this is a kind of thought pattern that is very changeable. It's not like it changed because the symptoms changed. People changed and they saw improvements in disability and the ability to live their lives.

So there's two reasons why I think the term is problematic. The first is that it's commonly been used to call individual human beings catastrophizers. That's just completely inconsistent with what we see: that it's actually extremely modifiable, that any intervention seems to change pain catastrophizing, and it's something that we can do to help people feel better. The second piece is the term itself. So when you say catastrophizing, it makes it sound like these worst case scenario thoughts you're having. It's like they're a total catastrophe.

Here's the thing with chronic pain though. People have these catastrophic thoughts like this pain is never going to get better and then five years later, you're like, how's your pain? And they're like, not better. They're not ridiculous thoughts. They're lived experiences.

So it's not helpful to have that dismissiveness baked into the term. I think it is important for people to know that in the 60s, when Beck was coming up with the first cognitive therapy for depression, there are similarly dismissively termed automatic thoughts for everyone.

One of them is called fortune telling. The idea being that you are worried about the future, and it kind of dismissively says so what, you can tell the future. One of them called mind reading. The idea being that you think you know what other people are thinking. But calling it mind reading is very dismissive, like you're a mind reader.

There is an unhelpful history of calling automatic thoughts, most of which are really helpful but some of which are not so helpful in some cases. But calling those unhelpful, automatic thoughts, these really dismissive things that I think for some patients helps them identify them and helps them latch on to it. But for many people, they just find stigmatizing. To package this conversation together, the fact that we weren't even really trying to hit pain catastrophizing, but that changed so much, both shows that it's whatever it is. This idea of worst-case scenario thinking in the context of pain.

It is important and I don't want to lose that. I don't want to lose something that's helpful to people. But it also shows that pain catastrophizers don't exist. There aren’t catastrophizers.

Because it's so modifiable and it's so changeable. And I hope that as we continue this conversation and try to brief, reframe, reorient, figure out how can we talk about automatic thoughts and chronic pain that don't lead to so much stigma that we can also hold on to the pieces that are very hopeful. And these are these are things that we can change that can help me feel better and I'm struggling with this chronic illness.

Lindsay Weitzel, PhD:
I love how you approach that. I love what you said, and I think that one of the things that helped me years ago, I actually remember where I was when I first heard the term. I actually was in Rhode Island. I don't know why I remember that. And someone used that term and I was really taken aback. I was like, excuse me, that's really annoying to me. And it would help me is when I learned that it's used kind of for everyone. Everyone does it to an extent. It's not just people in pain, it's just something that we can

change as people in pain and feel better. And that's why it's kind of linked with our condition, with migraine, with pain, etc. so much. So that's sort of what helped me, because I remember being taken aback the first time I heard it.

Elizabeth Seng, PhD:
When I taught undergraduates at Ohio University, we had a really bad parking situation as many colleges do. This is a large school in a small town in Appalachia. The parking is not great. I was describing catastrophizing as something everyone does and like, look, you know how some days you come to campus and you can't find a spot and you're like, it's okay, I'll find a spot.

It'll work out. And then some days you woke up late, you forgot your coffee, whatever it is. But when you come to campus and you can't find a spot, you're like, oh, my gosh, I'm never going to find a spot. I'm going to miss class. I'm going to fail the whole class. I'm going to fail out of school.

I'm never going to get a job. That's catastrophizing. And we all experience catastrophizing at some point. And in our lives it is absolutely a thought pattern that I think many people recognize and can identify with. And for some people, the word itself gives them something they can latch on to. They're like, oh my gosh, sometimes I'm fine, but sometimes that does happen and it almost feels like it's just like not me doing it.

I often use the word spiral because that is sometimes how it seems to feel. It's like this spiral. But you're absolutely right. Regardless of what it is, this spiral, this worst-case scenario type of thinking is common to the human experience. Everyone does it at varying points in time, and it is also true that the more we do it, and the more we go down that automatic path in our mind, it opens us up to outcomes that we don't want and to having a harder time living our lives according to our values.

Lindsay Weitzel, PhD:
So basically catastrophizing is one of the cognitive appraisals that were approached in MBCT and were worked out in your study to help people with their pain. Is that a good way to summarize that?

Elizabeth Seng, PhD:
That's a good way to summarize it.

Lindsay Weitzel, PhD:
So if our audience members want to delve deeper into this topic of MBCT, what is the first step? Are there books or resources that you can send people to who are interested in learning more before they delve into a group therapy or a personalized therapy approach?

Elizabeth Seng, PhD:
Yeah. So I would really recommend starting with the writings of Jon Kabat-Zinn, who is the person who really brought mindfulness to the attention of Western medicine. *In Full Catastrophe Living* is just an extraordinary book, and it's the first book that I would start with for people who are living with migraine and other neurologic episodic diseases, where pain is only one component.

And they're really these like multi sensorial neurologic diseases. I have not found a lot of the mindfulness for pain resources as useful. There is much more written for like musculoskeletal conditions which yeah very different. So the other book that I would recommend is actually *Falling Awake How to Practice Mindfulness in Everyday Life* from Jon Kabat-Zinn rather than the chronic pain focused books.

Because what we know about lifestyle and migraine is that consistency is so important in waking up at the same time, eating at the same time, going to bed at the same time, having caffeine at the same time every day. These things, they do seem to help. The more that we can incorporate mindfulness in our daily lives, I think the more that it becomes a part of that routine and can be a helper as we go through our days.

So those would be the books that I would recommend. Many therapists practice mindfulness-based techniques. I think most competent therapists out there, if you said, oh, I heard that mindfulness is something that is interesting and I might want to try to incorporate that into what we're doing, would be able to incorporate that into your plan.

Lindsay Weitzel, PhD:
Okay. That sounds awesome. I love to give people something to go out and learn and find. Is there anything else you'd like to add that you think we may have missed or anything before we go today?

Elizabeth Seng, PhD:
No. I hope that as people listened to our conversation that those of you who had not thought about how these cognitive appraisals can be dismissive, have a little bit more of an understanding about why many people in the pain community feel dismissed when the terms are used. But I also hope that people who have been not interested in engaging in the idea that automatic thoughts might matter, heard a little bit of something that they may recognize and that in fact might be helpful.

Lindsay Weitzel, PhD:
Well, thank you so much for being here and bringing your expertise on this to all of us. I think everyone I'm sure learned something, I learned something, and I love talking about this topic. It is so helpful, as it's helpful to everyone, not just people with migraine. So I hope everyone enjoyed this conversation. Thank you to Dr. Seng and thank you everyone for tuning in today.

Please join us again on our next episode of HeadWise. Bye bye.