Episode 174: How Can a Pain Psychologist Help Me with My Migraine or Other Headache Disorder

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 excited and honored to be here today with Dr. Dawn Buse. Hello, Dr. Buse. Thank you for being here.

Dawn Buse, PhD:
Hello, Dr. Weitzel. Thanks for having me again.

Lindsay Weitzel, PhD:
So, most everyone knows that Dr. Buse is a clinical professor of neurology and a psychologist who specializes in headache. She is very well known and respected in our community and as a researcher and clinician. And I get excited every time I have a chance to record with her.

Today, our topic is why should I work with a pain psychologist and when should I do so. I think this is really important because sometimes we feel like we are sort of getting pawned off to pain psychology. Maybe if our doctor, we feel like, oh gosh, our doctor can't, my doctor can't fix me. So, he's telling me to go to pain psychology. A lot of people don't know what happens there, how they can help us, or what aspects of different things that we've already tried on apps and stuff are going to occur there. So, we're going to ask the expert.

We're going to ask Dr. Buse exactly how pain psychology can help us. And I can't wait to hear what she has to say. Dr. Buse, this is your area of expertise. I might not talk as much as usual because I'm so curious about everything you're going to say. So, please quickly just remind everyone why you're so motivated to work in this field.

Dawn Buse, PhD:
What a great question. Well, I love working with people with migraine and chronic conditions and chronic pain because there are a lot of things that we can do in addition to the terrific medications and interventional treatments that we have. There's a lot of things we can do that are behaviorally, lifestyle, psychologically, and other ways focused that can really make a big difference.

In fact, one of the first people that I got very excited about when I was back in my training in graduate school and thinking about internship, thinking about specialties, John Kabat-Zinn, had published some research on mindfulness-based stress reduction for low back pain. And I thought that was really exciting to see how you could add on to medication, surgeries, everything that would be done in a medical setting. He can add this extra element and get to good outcomes.

And even before that, Herbert Benson, a cardiologist at Harvard Medical School Massachusetts General Hospital, started talking about different personality types and examining transcendental meditation for cardiac health and other health and well-being. So I always thought this was very exciting to think about,

how could we see real health benefits that are scientifically measurable, that may complement medications, may stand alone for chronic conditions. And I really am passionate about helping people live well with chronic conditions, of which we know migraine is a chronic condition.

It generally kind of comes on in childhood, adolescence, maybe young adulthood. And for most people, stays with them for many decades. So it may not be lifelong, but it is longer term. And so I really got excited about the idea of helping people still live lives to the best extent that they could, still enjoying their life, achieving goals they want to achieve, be it work, school, family, social, personal, and living lives that they want to and deserve to live to the best of their ability. So, as a health psychologist, that's really a focus of mine.

Lindsay Weitzel, PhD:
I love the way you worded that. And I might ask something that I didn't know I was gonna ask now that you said it that way. I think that some of the frustration that some patients have who've been in a great deal of pain, whether it be with migraine or some other condition, is that people might talk to us in a way, like all we have to do is try these things, whether it be cognitive behavioral therapy, some sort of mindfulness, and we're gonna be cured.

And you just worded it very different. And so I think that a lot of people talk to us like we've done something completely wrong, and we need to just do these types of therapies, and then we're gonna be cured. Can you comment on that?

Dawn Buse, PhD:
Absolutely, absolutely. It's very easy to feel like the message you're hearing from the healthcare professional, or from us on these podcasts, or from other people as saying, you are still having migraine attacks because you are not doing X, Y, and Z, managing your stress well enough, or getting good enough sleep, or exercising enough, when we know that's not the case. As a reminder, migraine is a chronic neurologic condition. These waves keep coming. You cannot stop the waves from coming in the ocean. But as John Kabat-Zinn said, you can learn how to surf.

Even with our best treatments for migraine, medication, neuro stimulation, behavioral, we get pretty excited when we help people reduce their attacks by 50%. And even less sometimes is enough for medications or other treatments to be approved. We get really excited if we help people reduce their attacks by 75%. And it's very rare to see eliminating attacks all together by a treatment.

Now, there are times in life when migraine attacks kind of change in frequency. We kind of have these waves. We have waves of frequency and intensity at different times of life. It may be better during pregnancy for someone, and then may be worse post pregnancy, postpartum. May be better on the weekends and worse during the week. May be better during summer, worse during the fall. Or it may be better in certain decades of later life and more intense earlier in life.

So we do have waxing and waning of migraine frequency, severity, and symptomatology. Most people notice some of that. Sometimes it's due to treatment, but a lot of times it is just the nature of migraine, and that leads to all this uncertainty. And we as humans don't like uncertainty, and migraine is a condition of uncertainty. These attacks are going to strike largely without much warning and largely

without what may seem like rhyme or reason. I think that's one reason why we all look so much for triggers and patterns.

So anything we can predict, anything we can control, anything we can change, and we do our best to use all of our data to try to do that. But anything I say today does not mean that migraine is your fault or that you are not managing it well enough. At the same time, I still want to tell you everything we've learned that can help calm this very hyperactive, responsive nervous system that is part of living with migraine. So, this is not blaming someone for not doing well enough, but we do want to also offer every strategy in the book we've got that can help we want to offer.

Lindsay Weitzel, PhD:
I can personally say that I was so sick my whole life before the age of 30, that I think most people would find it difficult to comprehend. And then when they look at me now, they're like, how much sicker were you? A lot sicker is the answer. And I exercise every day. I meditate every day. I do all these things. These are part of my toolkit. And so I understand how frustrating it can be, because people still to this day look at me and they're like, well, gosh, if you would just read a book on mindfulness, you would be better. So, I wanted to go ahead and address that elephant in the room because I know so many of us, we hear that.

Let's go ahead. I'd like to hear in your own words, can you just tell us what the role of a pain psychologist is for the person with migraine or another type of debilitating head pain?

Dawn Buse, PhD:
Absolutely. A pain psychologist, a health psychologist, there's not a whole lot of headache psychologists, but someone who specializes in behavioral therapy for migraine or other chronic illnesses, is going to do a set of techniques, education, and support. It's going to be maybe similar if you've gone to cognitive behavioral therapy before for anything in life, for depression or anxiety, or getting through a traumatic period of life.

It's going to have some very similar elements. So it's going to have the cognitive behavioral therapy element, which is looking at both thoughts and how thoughts reflect outcomes, and it really can change how we feel and how we perceive things, as well as behaviors. In migraine, there's about half a dozen behaviors that really do matter for keeping this nervous system balanced and calm as much as possible.

And that is going to be the healthy regular sleep, the nutritious diet and staying hydrated, a low inflammation diet, managing stress. Again, we cannot often control the stressful things in life that happen, but we can control how we react to them and what they mean to us.

Movement, exercise, social support. There's going to be kind of a core set of things we focus on. We're not going to focus on all of them. We're probably going to start with one area, and we're going to use cognitive behavioral techniques to really enhance success.

We're going to use stepwise goals, leveling up, looking at challenges, looking at barriers, really figuring out how to help someone optimize their adherence and their motivation. So that's going to be some of the elements of cognitive behavioral therapy.

We're also going to have elements of relaxation therapy. Relaxation therapy may include things such as diaphragmatic breathing, paced breathing, guided visual imagery. The idea here is that we are calming the nervous system.

And then in some cases, we may bring in biofeedback. Biofeedback is always valuable, but not everyone has the biofeedback equipment or the training. If you get biofeedback, it's really interesting. If you've never tried it, it's just really cool to try. So basically bio, your biology, is going to be fed back to you. You're going to get feedback in the form of a visual on the computer or printout, sounds. And you're going to be hooked up to some different monitors. So maybe muscle tension of the forehead or the jaw, the neck and shoulders. Finger temperature is how we measure circulation of blood throughout the body. We also measure relaxation. When we're in the fight, fight or freeze mode, our blood kind of comes to our major muscles, so in case we had to run away or fight, we're ready to do that. Your hands and your feet and your nose are going to get cold because they're not getting a lot of blood to them because they're not essential during that dangerous time.

So what you're going to do is in biofeedback, get hooked up to finger temperature, respiratory rate, maybe a belt around your abdomen to kind of watch your breathing, going to try to do some nice, paced, steady breathing. The muscle tension, the galvanic skin response, that's goose bumps and sweaty palms, goes up really fast, and then it kind of comes down.

So it's really interesting. You get hooked up to these different leads, and you're sitting here with all these leads on. And then I might say, Lindsay, how was your day at work today? And you might say, oh, it was okay. And then I'm going to look at the screen, I'm going to see it go [sound]. I'm going to see your GSR, your galvanic skin response, went down, and you went up, and your finger temperature is dropping down, and your muscle tension is increasing, and your breathing rate is getting rapid and shallow.

And I'm going to say, okay, let's look at how your body reacted to that question. So what's really interesting in biofeedback is you don't even have to talk to me. You can just sit and think some different thoughts and watch your physiology, watch your body respond.

And it's very helpful because sometimes we realize how much distress our body is in, even when our mind doesn't think that we're at that level of stress. Humans are able to worry about things that happened in the past, rumination, things that might even happen in the future, pre-ictal anxiety, as well as what's going on right now. We're able to worry in all sorts of different directions.

But unfortunately, those thoughts and worries have the real response on our body. They really engage the fight, flight or freeze system. And that we call the sympathetic nervous system. When that is activated, you're going to feel nervous, anxious. You're not going to get the same good blood supply. Your digestion is going to slow down. You're not getting the good deep breaths and oxygen.

So it's really important with biofeedback, you learn to notice when there's tension in your body. And you learn ways to monitor and release that tension, diaphragmatic breathing, maybe something like progressive muscle relaxation, which is a really easy exercise where we kind of go through different muscles in the body. We hold them and tense them. You would tense the bicep, and then you let it go, and feel it nice and warm. We would do that from muscles in the top of the head down to the bottom of the toes. Your whole body is going to feel nice and warm and relaxed, like warm spaghetti noodles.

These are all things that we'll do in pain psychology or headache psychology. So we're going to do some CBT, some biofeedback and relaxation, or at least body awareness and relaxation, some breathing training. You're going to learn different skills for your toolbox and you are going to learn when to apply them.

And then if you're working with an individual psychologist like myself, it's going to be very personalized. We might start to look at your migraine patterns. This could be the same if it was chronic pain, another chronic episodic condition. We're going to look at your patterns, your responses, how is it affecting work, how is it affecting school, if you are you a parent how's it affect your relationship with your children, do you have a partner, a spouse, significant other, are you dating, are you wanting to date. We can talk about all those things in the context of the impact of migraine on them.

But what's going to make this pain psychology kind of time-limited, probably 6, 8, 10, 12 sessions, probably between 6 and 12. What's going to make this different than going to a psychologist to talk about, let's just say, dating per se, or family relationships, or marital distress, or generalized anxiety, or a traumatic childhood history, PTSD, or depression. If we were going for those things, those would be the focus.

Here, we're going to teach a lot of skills still, and do a lot of work that is going to help all those things. Those things are not necessarily the focus. And you don't have to have any of those things to come to a pain psychology or a migraine psychology behavioral therapy program.

So we're not going to talk much about childhood or the past. We're going to stay pretty focused on the here and now. And it's going to be time limited. There's going to be a time when we say, you're going to learn this, you've mastered it, you're ready. Off you go. So it's going to be time limited as well.

Lindsay Weitzel, PhD:
I have a few questions then. So I bet some of the people listening are thinking, I have this app that I'm using at home for CBT, and this one I'm using for mindfulness. I'm meditating with this one, stress relief. We even have some that do biofeedback at home now. So how is this experience different? Is there a talk therapy component that helps? Will I feel effects quicker if I go into a pain psychologist and do all this? So how is the experience different from stuff that we can reproduce at home with various apps and books, etc?

Dawn Buse, PhD:
Well, there are some terrific apps out there today. There's some cool things that wearables can do. There's some classic books that cost $20 that are still top notch, like the Stress Reduction Relaxation book for $20, really teaches you a lot of things I teach you in the session.

So I'm going to say that those are all really good things because they're accessible. You do them on your own time, your own schedule. The cost is usually much more reasonable. A lot of the apps are around $10 a month, if not less, or even free. So I love that this is getting a lot more people the opportunity to try something, start to learn mindfulness, start to learn meditation, try biofeedback on your phone. That's all great. And I encourage all of that. As long as it's not too expensive, you can afford it. Really terrific. I love that people are able to explore more, start to learn to monitor their physiology, learn some of the strategies that we would teach.

If you have a chance to do an in-person or group session with an actual psychologist or other kind of mental health provider, it could be an occupational therapist, could be a social worker, could be a couple other types of providers as well who can do a top-notch job, go for it. I mean, it's the Ferrari of the biobehavioral therapies because it's going to be specialized, personalized to you, tailored to you. I'm going to hook you up with exactly the leads that you like. I'm going to ask you in your relaxation, where do you want to go? We're going to go exactly where you want to go, whether it's floating in the hot springs in Iceland or it's on a beach in Tahiti or wherever, a mountain cabin in Colorado. We're going to go wherever you want to go. It's going to be personalized. I'm going to watch your physiology change on my screen right there. I'm going to say, right there, what just happened right there? I saw a blip.

You're going to say, oh, I was worried about X, Y, and Z, and I felt the tension come back. It's going to be personalized. So, you may do a course of pain psychology, a targeted biobehavioral treatment for migraine, which may be up to maybe, as I said, up to about 12 sessions. And you may have done that a couple of years ago. And now you may maintain it with the help of the apps, the mindfulness apps, the meditation apps, the relaxation apps, the wearables. Now you've done some biofeedback. You may know when your wearable now says, ooh, your heart rate's going up or time to stand up. We already have that basis.

Now it's not always easy to find providers. There's not a whole lot of providers who have expertise in headache psychology. There are more providers around the country with expertise in pain psychology. If you go to one of the big headache centers, you might be really lucky that they actually have a multidisciplinary program where their psychologist is right in the center who works side by side with your neurologist and your physical therapist, and they all talk to each other when they're refilling their coffee. That's wonderful. There's only so many of those places in the US, and that's okay, or around the world. There's actually some beautiful centers around the world as well, but there's only so many.

If you don't have that kind of experience and you'd like to find pain psychology, headache psychology, and you can't exactly find someone in your plan who their profile says headache psychology, you can look for a couple of things. You can look for someone who's proficient in biofeedback. They're going to be able to teach you a lot of the skills. Someone who lists, as I said, pain psychology, someone who lists health psychology, can be able to teach you a lot of the skills, as well as someone who's just very strong in cognitive behavioral therapy. Those are going to be key words.

Lindsay Weitzel, PhD:
Pain psychology or biofeedback, health psychology, and what was the third thing?

Dawn Buse, PhD:
Pain, or cognitive behavioral therapy. All of those providers are going to be in the right area with the same kind of similar background. They may not have the same depth of knowledge about migraine that perhaps I might have or some of my colleagues who are really expert headache psychologists, but that's okay. You can bring the expertise about migraine. If this is the person you can find who's in your plan and available and close enough by, that's okay. I would hate to say don't go just because you can't find someone who you feel is expert enough. You're going to learn a lot from working with someone with that background.

Lindsay Weitzel, PhD:
Let me ask you a question that might be coming up for some people. Who knows what came first, the chicken or the egg, but if someone has really severe migraine, chronic migraine, it's really impacting their work, their ability to parent or whatnot, everything in their life, they've got whether it be anxiety or depression or both is really affecting them badly along with their pain, should they go to a pain psychologist? Are they going to receive help for their anxiety and depression too? Or do they need to go elsewhere first?

Dawn Buse, PhD:
The same skills and strategies that we're going to use for pain psychology, for biobehavioral treatment of migraine are going to be very similar to what is used for depression anxiety. So, there's going to be a lot of benefit for depression anxiety, quality of life, even other conditions like PTSD. There's going to be a fair amount of beneficial kind of downstream waterfall that happens because they all benefit.

Also we find that when people are successfully treated for migraine for any way, whether it is a medication, whether it's a neurostimulation, whether it is behavioral, whether it's a combination, that we do see depression anxiety reduce and quality of life improve. Now, this gets a little tricky. I am not saying that depression or anxiety is necessarily due to having migraine. And we've talked about this before in some of our interviews. They are comorbid. Comorbid means that these two conditions occur together at a higher rate than chance.

Sometimes it's that one causes the other. Sometimes this one causes that one. So unidirectional, bidirectional, or a shared underlying reason. We don't always know. In the case of migraine and depression, we know that having either one before the other means that you have a higher likelihood of the second one showing up. So, for people who had migraine, they were five times more likely than some without migraine to have depression later. For people who had depression, they were actually three and a half times more likely than some without depression to have migraine later.

But I don't mean that one is causing the other. They may have the same genetic predispositions. They both kind of have similar neurotransmitters involved in their etiology, in their pathophysiology. They both come from, kind of, shared environmental reasons. So, likely, they have a shared underlying cause. And what tends to happen a bit is when any one of them improves, the others tend to improve a bit as well. So, that's really nice.

However, let's say anxiety is to the point where someone can hardly leave their house anymore, which we call agoraphobia. They're having panic attacks. They're afraid to go out in public. It's affecting their job. They lose their job. It's affecting their marriage, their relationship. I'm going to say that's really affecting life. Please get that really treated as the target, be it with a psychologist, a psychiatrist, primary care.

Same thing, let's talk about depression. If depression right now is to the point where someone has suicidal thoughts, or even thinks they'd be better off not waking up tomorrow. Or if someone is engaging in self-harm behaviors, which are not depression, which are not suicidal gestures, they're harming oneself without the intent of suicide. That may be cutting or burning on the inner arms, the inner thighs, other kinds of self-harm behaviors.

All of these conditions are very treatable and manageable, and they don't feel like it when you're in it. They can be treated with combinations of CBT, mindfulness, biofeedback, just like we treat migraine, but that provider would focus right on those symptoms. And sometimes we'll also want to bring in a psychiatrist or primary care provider, an MD or a DO, but a physician or an NPA, nurse practitioner, psychiatric nurse, who's going to treat it with pharmacology, with medication.

So I would ask each listener to think, if this is you, what level of risk are we talking about? Should I be worried about you right now? If you're worried about yourself, and if I'd be worried about you if we had a conversation right now, please seek out care for that specifically now to start. So that's one way to think about it.

But when you think about people with migraine, you're going to think about one third are going to have depression, anxiety, or both. And as you go up to chronic migraine with headache on 15 or more days per month, it goes up to about 50 to 80 percent. So if you are listening right now and you're thinking, well, that sounds like me. I have depression. I have anxiety. You are in the majority.

However, you don't need to stay that way. We would love to help you get treated in a bunch of ways. Let's bring your migraine frequency down. Let's ramp up these kind of tools with CBT, biofeedback, mindfulness-based cognitive therapy. Let's kind of ramp up the tools. Let's think about, do you also need medication therapy. Let's get you treatment. So just because it's co-morbid doesn't mean I'm saying, oh, it's okay, not worry about it. Still treat it.

Lindsay Weitzel, PhD:
I think that's one of the things in the community we have to be careful about is not accepting it just because it's so common, and just assuming that's how everyone is going to be anxious and depressed. We don't need to accept it. There are things we can do.

Dawn Buse, PhD:
Not at all. We can do it. I don't want you to do any of this. Do not accept high frequency of migraine, do not accept impact on your life, do not accept depression, anxiety, any of this. We have the tools, the treatments to help. Just come find us because we want to help you. So, let's work on treating everything. Now, not everyone can be, as I said, 100% cured, but we can get to a better place for almost everybody.

Lindsay Weitzel, PhD:
This is an important question I think that everyone always wonders. Is the goal of pain psychology in the setting of chronic migraine or debilitating headache disorders, et cetera, do some people actually experience a decrease in the severity of their pain or their migraine or the frequency? Or is the goal to teach people coping skills and then actually getting better physically is more of something that happens at the doctor's office with medications, et cetera?

Dawn Buse, PhD:
Both those things happen. The biobehavioral therapies for migraine that have been used and studied for about the past 50 or 60 years, which again are going to include biofeedback, cognitive behavioral therapy, relaxation therapy, have very good trials. When you go in to see a psychologist, either individual

or group, they did clinical trials, they did studies of these kind of manualized anywhere between six and 12 session approaches, and did find both reduction in migraine attack frequency, as well as improvements in quality of life, improvements of coping, how you look at things, kind of better distress, higher distress tolerance, kind of lower impact, those sorts of things.

More recent studies of the mindfulness-based therapies and acceptance and commitment therapy have really found a bit more improvement in the quality of life and reduction in the disability, than necessarily the reduction in the headache day frequency. But everyone's different.

Some ways that you might reduce that headache day frequency may be that practice of relaxation, the biofeedback practice might kind of help calm the nervous system. You might get better at noticing prodromal or early warning signs, when to take your medications, being more adherent, quickly taking those medications early when you need them. In the acute phase, you might have better healthy habits with kind of maintaining consistency in sleep, diet, nutrition, all those sorts of things may affect the actual number of migraine attacks.

But then there's all these other kind of skills about how we look at things, how we perceive things, what they mean to us, that we kind of start lowering our distress about it, improving at work and school and family and relationships. It may be that we become more assertive in asking for accommodations. It may be that we educate those around us and get our needs met. There might be a way we might become more self-confident, more self-efficacious, meaning we do more things to get to better outcomes. Maybe we change our way of thinking, so reduce that catastrophizing and improve our healthy ways of thinking about things. And all of those things can reduce disability and improve quality of life.

Lindsay Weitzel, PhD:
I mean, there's so many things that even in the way people think, no longer accepting some of the stigmatizing beliefs people throw on us, stuff like that. That actually can actually, I do believe, make you feel better. So, some of the things you're saying, as you're saying them, I'm like, yes, this can really help, because there's a lot of things that just make you feel worse throughout your day if you're not careful with your own mentality. So, I love hearing you talk. Is there anything else you'd like to say?

Dawn Buse, PhD:
You mentioned stigma, and stigma is highly associated with depression, anxiety, guilt and embarrassment. Like, not that this is a chronic neurologic disease, which had a genetic predisposition, but that I'm not coping well enough. I am not working hard enough. I'm not trying hard enough. That really self kind of taking on the blame and the guilt and the ultimate responsibility for having migraine. And that is something that is incredibly common.

And we're learning more and more about stigma all the time, finding that it's really associated with worse outcomes for a lot of reasons. We find that people who experience stigma do not seek medical care at such high of rates. So while we have treatments available, if someone doesn't feel that there are treatments or that treatments would help or doesn't kind of recognize they have migraine or feels kind of guilty and that's just a personal failing and they're not getting treatment, they're not getting to better outcomes.

So, stigma is really associated with a lot of negative outcomes. So it's very important that you and I are very clear with everyone listening right now, migraine is not your fault, not a personal weakness or failing, it is a neurologic disease, and there are so many ways to improve management. Because we just want to empower every person to seek medical care, educate themselves, become a self-advocate, and whether it's through kind of self-learning and improving things, also getting to a doctor who really listens and cares and is going to help you get to optimize treatment. There's a lot of ways to get to better outcomes, but we find that stigma, self-stigma holds people back.

Lindsay Weitzel, PhD:
And I always like to say to people that don't fall into that trap, where you believe that you failed at something when it comes to mentality, and that's why you're sick or someone is sending you to pain psychology or saying that you might be helped by it. Really what it is, is that we sort of have to be superheroes at this. It's how I see it. It's almost like you have to attain almost like a Buddha brain to really be your best when you are this sick, because migraine and chronic pain is rough on your mind. And so that's why I feel these skills are so helpful. It's not because any of us are really failing in any capacity at it. And so I always try to turn that around. It's not that any of us did anything wrong to get here.

So, Dr. Buse, is there anything you'd like to add before we go today?

Dawn Buse, PhD:
Well, I'm really glad that you brought up this topic today. I think it's very common for people to hear that they're going to be referred to biobehavioral treatment, pain psychology, migraine psychology, and worry that this means either their healthcare professional doesn't believe that they have a real biologic condition, their healthcare professional is trying to pawn them off on someone else, thinks that they have mental problems and aren't coping well. I'm really glad that we had this opportunity to talk about the fact that these are data supported.

They are in the guidelines, American Headache Society, National Headache Foundation, International Headache Society. They are in the main treatment guidelines side by side with medications, neurostimulation interventions. They're right up there as main treatment approaches.

There are sometimes in life when they're the first choice, pregnancy, pre pregnancy, breastfeeding, cardiovascular challenges. There's going to be times when these are just the best way to go. And we find that also they have lasting benefits. So, most medications, when you stop them and they're out of your system, they don't continue to have the benefit. But learning these bio behavioral skills really can benefit someone for the duration of their disease for the rest of their life. So, if you have the opportunity to try biobehavioral treatment for migraine, give it a try because it can have a lot of great outcomes for you.

So thank you for letting us talk about this today. This is near and dear to my heart and very important. And I just am happy to have the opportunity to talk to the listeners today about this.

Lindsay Weitzel, PhD:
Well, thank you so much for being here with us today, Dr. Buse. And thank you everyone for listening. I hope everyone found something helpful in today's episode. And please join us again next week on HeadWise.