CHESS
Chronic Headache Education and Self-management Study

Living with chronic headaches -
Approaches to aid coping and self-management

Facilitators Training Manual

April 2017

WARWICK
CLINICAL TRIALS UNIT

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INTRODUCTION & BACKGROUND TO CHESS

Welcome to the CHESS study. In order to help put this training programme into perspective we have provided you with a brief summary of the background to the CHESS study.

Chronic headache disorders are a major cause of pain and disability. Their main impact is in young adults many of whom have both work and family commitments. The commonest chronic headache disorders are tension type (TTH), migraine, and medication overuse headaches (MOH). TTH and migraine are primary headaches. MOH is a secondary headache that can develop in people with frequent acute headaches who take analgesic, or specific anti-migraine compounds (e.g. triptans) on ≥10-15 days per month (depending on the medication).

Epidemiology and burden of the condition

Around 2-4% of the population have a chronic headache [1, 2] i.e. headaches on more than 15 days per month, for more than three months. Approximately 25-50% of those affected also have MOH, which has a prevalence of 1%.[3-5] Around 4% of primary care consultations and 30% of neurology out-patient appointments are due to headache disorders.[6-9] TTH and migraine are the second and third most common disorders globally (after dental caries of permanent teeth).[10] The annual cost of headache disorders to the UK is £5-7 billion.[11]

NICE guidance on headaches was published in September 2012.[12] Besides recommendations to consider a course of acupuncture for people with chronic migraine or tension type headache, the guideline developers did not find suitable evidence to allow recommendations on non-pharmacological treatments for people with chronic headache.

Supportive self-management programmes

The aim of self-management is to minimise the impact that a long-term health condition has on physical well-being and functioning, whilst addressing the psychological consequences of the condition. This approach to management requires the individual living with the condition to engage in behaviour change usually in conjunction with healthcare professionals.

The management of a long term condition requires a multidisciplinary approach and therefore the majority of self-management programmes encompass a biopsychosocial approach. This model acknowledges that long term conditions have physical, psychological and social implication on individuals and therefore management should focus on a combination of these factors. The model below demonstrates the close link between these core factors.

When reviewing the possible role for supportive self-management programmes the literature suggests support programmes have an established place in the management of a range of chronic diseases.[13-15] NICE did not find any relevant evidence on the use of education and self-management programmes for the treatment of chronic headaches and recommended further research in this area, hence the reason for our research.

There is an association between chronic headaches and chronic musculoskeletal pain.[16, 17] One large community study found the odds of people with chronic headache having frequent low back pain were substantially greater than those without headache.[18] Other evidence suggests chronic headaches predispose people to chronic musculoskeletal pain, and vice versa.[19] This association maybe linked to central sensitisation which may provide a common pathway for chronic headache and other chronic pain syndromes.[20, 21]

There are differences between how chronic disability arises between headaches and chronic musculoskeletal pain. Nevertheless, there is sufficient commonality that one can draw on experience from chronic pain in other areas to inform strategies to facilitate effective self-management of chronic headaches.

Headache diagnosis

Many patients with chronic headaches do not have an accurate diagnosis, or diagnoses (all three common headache types can co-exist), and receive inappropriate drug treatment.[22] Classification of headache type will be an important component of the intervention package, as it will inform advice on medication use.

There are deceptively simple diagnostic criteria for different headache types; for example, NICE headache guidance.[12] In reality, it can be challenging for a patient or non-expert clinician to decide on the headache classification. We have not identified any scientific reports testing the use of simple classification tools to stratify care for people with chronic headaches according to headache type. There are headache screening tools however these do not allow for classification of other chronic headache types. For our population of interest we have developed an approach that will allow a non-expert, to give tailored advice for people living with chronic headache.

Need for a trial

There are few existing studies of non-pharmacological treatments for headaches. These previous studies are largely uninformative because they were too small, had only a very short follow-up, did not report clinically relevant outcomes, or were conducted in different healthcare systems. There is therefore the need for a robust clinical and cost effectiveness trial.

The CHESS trial is a multi-centre randomised controlled trial comparing a group self-management and educational intervention with a relaxation control for participants living with chronic headache.

The CHESS programme and its aims

Our intervention package is derived from an existing intervention package for people living with chronic musculoskeletal pain. We have adapted this for use in people living with headache. In developing this intervention we have considered the patients' perspectives of living with headache to ensure that we fully address the important issues. We have drawn on the evidence gained from previous research in the fields of self-management, behaviour change, education and chronic headache. Using all of this material we have developed an evidence based programme with theoretical underpinnings for those living with chronic headaches.

The aim of this programme is to encourage and enable those with chronic headache to recognise unhelpful thought patterns and behaviours that contribute to their headache burden and to do something about them. That 'something' involves using psychological and physiological techniques to change perceptions and feelings about issues that influence behaviour and prevent accepting, adapting and coping with life with chronic headache.

This course is effectively a training programme to facilitate and train people to acquire lifelong skills. Those who will benefit most from this programme will be those who are ready, wanting and willing to address their health and to change. The course will be challenging for some as it requires participants to reflect about themselves and confront issues that they may or may not be already aware of.

The facilitators are crucial in the process of change and learning. Motivating participants is very much part of the process, being able to listen, being non-judgemental, having empathy and being patient are essential characteristics of the facilitators.

From the onset, there are two very important messages that must be conveyed:

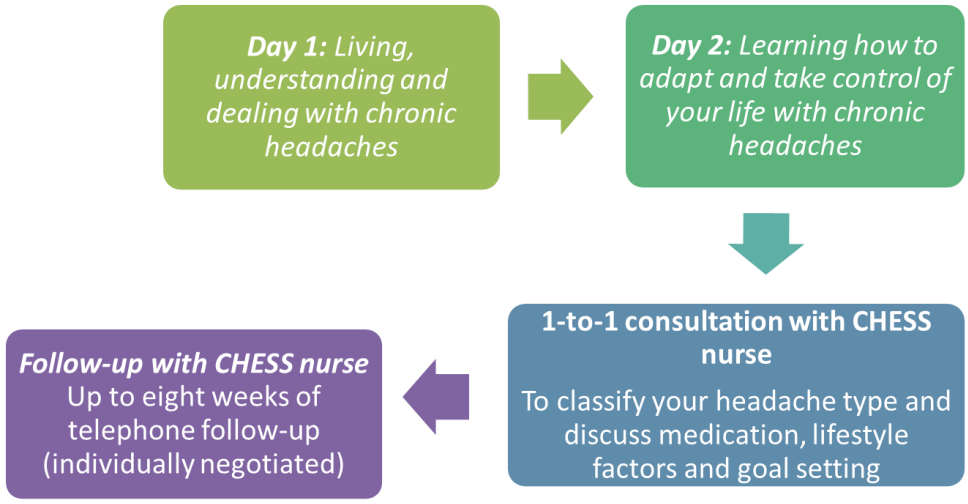
- The first is that we promise no cure but rather the programme is about helping individuals to improve the management of their headaches in order to improve their overall quality of life.
- The second message is that the effort must come from the participant; self responsibility and personal action are paramount to success.

We are not telling people what to do, but giving them information and teaching them skills should they wish to use them. Experiential learning is fundamental to the programme; it is the facilitator's role to encourage discussion, self exploration and to motivate participants to practice implementing techniques. There is evidence to suggest that belief and confidence in oneself (self efficacy) determines how well the participants respond to these types of

courses. Promoting and praising positive behaviours, thoughts and feelings will help instil confidence in participant abilities and generate and promote self confidence.

Course format and details

The course will run for two days over a two week period. Each day will run from 10.00 – 15.00. Thereafter each participant will have a one to one appointment lasting up to two hours with the research nurse to help classify the headache type, discuss medication and look at lifestyle factors and goal setting. Participants will thereafter be provided with telephone follow-up which will be individually agreed with each participant during the one to one appointment.



Each day will consist of a morning and afternoon training session, a taster activity session, and lunch.
The taster sessions provide the participant with an opportunity to try an activity that they may enjoy. The idea is to introduce and hopefully stimulate participants to take up such activities to help them manage their chronic headaches.

The course is based on discussion, reflection and experiential learning. Each facilitator will have different strengths according to the type of teaching delivery methods and topics covered in the sessions. The facilitators will have to decide in advance of the course which sessions they would like to lead. The sessions on headache mechanisms (session 3) and medication (session 15) must be led by the Nurse. Facilitators should feel free to use anonymised anecdotes and or personal observations that may illustrate different points.

The tone of the course should be uplifting, interesting and hopefully fun, using humour where appropriate to encourage enjoyment. The next section of the manual provides useful facilitation information and the basic preparation needed for each course. The manual is then laid out session by session with the aim of the session clearly stated in a blue box at the beginning of the session and the summary points listed in a pink box at the end.

Thank you for being part of the CHESS trial, we hope you enjoy the training and the experience of facilitating the courses.

With best wishes
The CHESS study team

IMPORTANT NOTES FOR RUNNING A GROUP

PRIOR TO THE SESSION

1. Facilitation of sessions: The facilitators will have to decide in advance of the course which sessions they would like to lead. The only requirement of the course is that the sessions on headache mechanisms (session 3) and medication (session 15) must be led by the Nurse.

2. Remember RED

- **R**oom - Make sure the tables and chairs are placed in a half circle arrangement, this facilitates communication, it makes it easier to make eye contact and to hear each other. This suggested seating arrangement is critically important: it should not be underestimated.
    - Lighting is very important for this population – we suggest you start the course by utilising the natural light in the room. Then at the start of the session ask the group how they would like the lighting
    - Heating is also important, make sure the room is not too hot. Again at the start of the session ask the group if the temperature is adequate
    - Remember – you will not always be able to please everyone but if you can show that you are mindful of these issues it can be helpful.
- **E**quipment - Set up the equipment and test it. Practice by actually bringing up the slides and moving back and forth through them. Also check the relaxation, mindfulness and DVD all work.
- **D**elivery - Prepare materials in advance making sure you have all the required handouts, presentations, spare paper and pens and the minute timer for the ice breaker.

Ensure arrangements for refreshments have been made (details for this will be provided by the trial team). Please note we will provide tea and coffee during the morning and afternoon breaks. Participants will be advised to make arrangements for their own lunch.

3. Audio recordings: As part of our process evaluation for the overall trial we would like to audio record each of the days. Participants have provided consent to say they are happy for the audio recordings to take place. Please therefore ensure your audio equipment is appropriately charged and ready for use on the day.

AT THE START OF THE SESSION

1. Audio recordings: Explain to the participants that the days are being recorded as part of the trial processes. Please then make sure the equipment is turned on. You may switch off the recording during the breaks and lunch but please remember to switch them back on again when the sessions restart.

2. Participant attendance: An attendance record will be provided by the research team for each course you run. Please can you make sure the record is completed and kept up to date, this again forms part of our process evaluation. If a participant does not attend, please can you inform the main research team first thing in the morning to allow us to contact the participant just in case they have forgotten.

3. Name tags: Make sure you have sufficient sticky labels for participants to write their own names and wear for the day.

DURING THE SESSIONS

1. Tips on managing the session:

- Withhold assumptions about what people do and do not know. It is okay for the facilitators and group members to ask what may be considered very basic information. Check people are familiar with terminology.

- Make the scenarios real; refer to patients in the scenario by name. When the opportunity presents itself, facilitators can ask how members would explain something to somebody else in or around the scenario. Role play

- can be very effective in this situation.

- Don't fall into the trap of always being the "Answer person." When asked a question, redirect the question to the group. This should get everyone involved and lets learners know that their peers are also a source of information. If you find yourself starting to answer lots of question or "telling" the participants something – STOP – and try asking a question instead.

- Encourage expansive thinking; try using "What if" questions, and use "And..." followed by silence.

- Facilitate reasoning. Getting the participant to share his/her thinking process without sounding threatening is helped by how you phrase the question or statement. Find non-threatening ways of asking questions for example: instead of 'why did you do that?' Try asking how someone else might explain or view X or Y?

- Use good/effective questioning and interactive techniques. For example:
    - If you want a particular person to answer a question, call the person by name
    - Alternatively, do not call people by name when asking a question that you want everyone in the group to think about
    - When you ask a specific person a question, it is quite possible that everyone else will cease thinking about an answer
    - You may ask a question and one of the participants gives a partial answer. You might say, "Could someone else add to John's answer?" or "What do others think?" or Pretend I am 'Ms. Jones' and ask me your question."

- Use silence. "Wait-time" is a period of silence (3-5 seconds) after you ask a question which gives learners time to construct an answer. Too frequently, facilitators wait less than 1-second after a question before they say something. Using wait-time after someone gives an answer is also a good strategy because it gives time for people to add to the comments of their colleagues without you asking them to do so.

- Reinforce participants' responses with positive comments:
    - Calling people by name is reinforcing especially when they have contributed something pertinent. Thank people for their contributions, be positive about productive contributions e.g. 'that's a really interesting or valuable point that you have made'
    - Attempt to get everyone involved
    - Try to ask everyone a question or get them involved in some way
    - Going systematically around the room might be too predictable but you could go back and forth across the room with your questions to be systematic but less predictable.

2. Dealing with difficult participants: Common situations that can arise in groups, and suggested ways of dealing with these situations, are detailed below.

Situation	Possible solution
One member dominates the group	Comment on the helpfulness of the dominant person but invite suggestions from others.
A member of the group is silent or rarely participates	If this person never/rarely makes a contribution, gently encourage them to participate by asking them open questions or getting them to lead the discussion on a specific point. Be aware they may be having difficulties and, if you are concerned, have a quiet word with them at a convenient break. If you are still concerned, they may need further guidance as to whether the course is appropriate for them at this stage. Give them the option of withdrawal and ask them for feedback.

The group is working well, but only half the group is contributing	Directly encourage other members to take part by asking specific open questions or get them to comment on what has been discussed so far.
The whole group is silent or hardly contributing	Do not be tempted to answer your own question! Ask if the group are having difficulties. Try to stimulate discussion with examples recalled from a previous session.
The group relies excessively on the facilitators for direction	Reassure the group of their progress and of the validity of their previous learning. Discuss with them the role of the facilitator for guidance in self learning and exploration. There are no right or wrong answers.
Two members of the group get into a heated discussion	Attempt to calm the situation down. Let each person have their say without interruptions, and take each seriously. Open the discussion up to the rest of the group.
One or two members of the groups are disruptive	Take them aside at a convenient break and ask them why this is the case (DO NOT DO THIS IN THE GROUP). Listen to what they say. Remember that some people behave in this way when they feel they are struggling with the learning process. Try to get them involved and thinking about the topic. Do not ignore them and do not become angry with them.
Poor attendance	Ask the participant the reason for absence. Discuss this privately with them. If this does not lead to a solution, refer them, or the issue, to the trial team. Check whether the participant would like details of the missed sessions. Give them the option of withdrawal and ask them for feedback.
Overly negative participant	Ask the group to comment on the negativity, challenge the negativity as part of the process of learning. Simplify the negativity, by illustrating 2 options available, staying negative and miserable or changing and perhaps finding some positivity and improving quality of life, ask the question can changing be worse than the way you are?

(Section adapted with permission from the COPERS study)

END OF THE SESSIONS

1. Summarising: It can be really helpful to summarise at the end of a session/discussion or day. One way to do it is to either do it yourself or you can ask the participants to provide a summary in a very succinct fashion (e.g. complete essence of the discussion in two minutes). Or you can ask each person to express one really important thing he/she learned. Another way to conduct a summary is to read or show the participants the aims and ask them if they feel that they accomplished them as a result of participating in the discussion.

2. Personal reflections: We encourage personal reflection from facilitators whereby we ask you to send us a daily reflection email to chess@warwick.ac.uk recording your thoughts and feelings about the sessions, noting things that went well and where things could have gone better. Your email will help us support you if you are experiencing any difficulties with your group.

If at any time you need to speak to a member of the CHESS team, please call Ms Kimberly White on 02476 151 634 who will be able to direct your query to the relevant person.

FACILITATION SKILLS FOR GROUPS

Reasons for using small groups to foster learning

- Learners gain a sense of ownership of the learning process
- Helps learners build their own knowledge. Knowledge built is knowledge understood
- Provides an environment for learners to practice skills in a safe environment so that skills will be more rehearsed when applied in the "real" setting
- Provides an opportunity to learn effective group process and be part of a team (a "learning team")
- Provides opportunities for enhancement of communication skills
- Provides opportunities to give and to receive feedback
- Provides opportunities for learners to learn from each other rather that the "experts" who sometimes cannot explain content at the level needed by the learner
- Helps learners understand others' points of view
- Provides a supportive environment
- Provides an opportunity to learn by teaching/sharing.

(Adapted from Fostering Learning in Small Groups by Jane Westberg and Hilliard Jason [23])

Required skills and behaviour for good facilitation

- Accurately listening to, observing and remembering/recording behaviour and conversation
- Asking questions that facilitate and improve group process skills
- Diagnosing and intervening when ineffective behaviours occur
- Providing feedback without creating defensive reactions
- Accepting feedback without being defensive
- Providing support and encouragement
- Showing patience
- Showing consistency
- Identifying when group has acted inconsistently with their values/ground rules
- Helping group analyse when things go well
- Helping group analyse when things go wrong
- Evaluating group and individual group members.

(Section adapted with permission from the COPERS study)

ADVERSE AND SERIOUS ADVERSE EVENTS

Our experience across multiple studies of group interventions is that adverse events that are directly attributable to the intervention are rare. This includes events during the session, e.g. severe psychological disturbance, or a fall during travel to and from the venue. We must manage any suspected adverse events during group or one-to-one sessions in line with Warwick CTU's standard operating procedures.

An Adverse Event/Serious Adverse Event is any event that takes place on the way to, during, or on the way home from the intervention course. This includes the two days of the group course and the one to one nurse appointment.

Adverse event (AE)

An AE is: "Any untoward medical occurrence in a patient or clinical investigation participant taking part in health care research, which does not necessarily have a causal relationship with the research". An adverse event can be any unfavourable and unintended sign, symptom, or disease that occurs during the time a participant is involved in the trial whether or not it is considered to be related to the intervention.

Serious Adverse Event (SAE)

An SAE is: Any untoward and unexpected medical occurrence that:

1. Results in death
2. Is immediately life-threatening
3. Requires hospitalisation or prolongation of existing inpatients´ hospitalisation,
4. Results in long-term or significant disability or incapacity,
5. Is a congenital anomaly or birth defect
6. Requires medical intervention to prevent one of the above, or is otherwise considered medically significant by the investigator.

Those events that do not immediately fall into one of the above categories, but that jeopardise the participant, or require intervention to prevent one of the outcomes listed above, should also be considered serious.

Important note: "Serious" and "severe" are not the same

- "Serious" refers to a specific definition for the outcome of an event (see above)
- "Severe" refers to the intensity of a reaction (e.g. mild, moderate, severe)
- For example, it is possible to have a "severe" headache, but the headache itself is not a "serious" adverse event. The term 'life-threatening' in the definition of a serious adverse event refers to an event in which the participant was at risk of death **at the time of the event**. It does not refer to an event which, hypothetically, might have caused death if more severe.

Examples of Adverse event (AE)	Examples of Serious Adverse Event (SAE)
A participant becomes distressed or angry during the CHESS course. Participant was sufficiently consoled away from the group. **Adverse Event> Reportable > call study team at the end of day to provide details> relevant follow up by study team/facilitator.**	A participant slips on the way home from the course and breaks their ankle, they attend A&E. **Serious Adverse Event> Reportable> call study team for support immediately if required or at the end of the day to provide details> relevant follow up by study team/facilitator.**
A participant becomes distressed or angry during the CHESS course. Participant was advised to make an appointment to discuss further with their GP and did not attend for the rest of the day. **Adverse Event> Reportable> call study team at the end of day to provide details> relevant follow up by study team/facilitator.**	A participant goes shopping on their way home from the course, they slip and are injured, and they attend A&E. **Not reportable.**

If in doubt contact the CHESS Study team on 02476 151 634 a member of the team will be able to provide support and advise on the relevant reporting required.

Reporting an AE or SAE

Contact the study team following an adverse event or serious adverse event at your earliest opportunity. Serious Adverse Events should be reported to the study team within 24 hours of the facilitator being made aware of the event.

- In the first instance telephone the study team on 02476 151 634. A member of the team will confirm whether or not this is reportable. If the event is reportable the study team will take all the relevant information to be able to complete Part A of the Adverse Event CRF or the Initial SAE CRF.

- Depending on the nature of the event and when it took place either the study team or the facilitator will contact the participant to follow up on the event and confirm the outcome of the event. Following this contact Part B of the Adverse Event CRF or the follow up SAE CRF should be completed.

What to do if a participant gets distressed during the group session

1. One of the facilitators accompanies the participant to a more private space outside the meeting room e.g. kitchen.

2. The facilitator's role in this instance is to calm the person and listen to ascertain the problem. The facilitators must stay with the participant until they are satisfied that an appropriate course of action has been decided upon and implemented.

3. If the person has calmed/collected themselves, ask them if they wish to re-join the group at the start of a new session or if they would like to withdraw from the programme for the rest of the day, or completely.

4. For distressed participants who *do not* express suicidal ideas, calling the Samaritans (116 123) or NHS Direct (111) may help to get appropriate advice.

5. If the facilitator has any concerns about a participant they fear may be at risk of suicide (or very severe depression) they should contact the participants GP (take details from the participant if they are able to provide these, alternatively please call the research team on 02476 151 634).

6. The facilitator can contact the participant's GP to inform of the situation if they have safety concerns or if there is chance of significant harm to the participant or to others.

7. If the participant cannot be left alone at all and the situation is deemed an emergency, the facilitator should call 999 and stay with the participant until an ambulance arrives.

8. Listen to the participant- if they would like to contact a family member to help them in this situation or take them home, the facilitator can make a call to the family member.

9. Contact the study team following an adverse event or serious adverse event and follow guidance as detailed above for reporting of these events.

CHESS CONTACT NUMBERS

In an emergency please call XX in the first instance using the details below. Should she not be available we have provided the contact details of other members of the CHESS team at the Warwick and London sites.

Name	Contact for	Contact details	Location

COURSE OUTLINE

Day	Modules	Content of sessions
1. Living, understanding and dealing with chronic headaches	1. Introduction to the course and each other	**Session 1**: Welcome and introductions **Session 2**: Course overview
	2. Understanding chronic headaches and acceptance	**Session 3**. Headache information and mechanisms **Session 4**. Acceptance of chronic headaches
	Taster activity – Relaxation and breathing	
	Lunch	
	3. Mind, body and pain link	**Session 5**. Impact of thoughts, mood and emotions on headaches **Session 6**. Headache cycle and breaking the cycle
	4. Dealing with unhelpful thought patterns	**Session 7**. Unhelpful thinking patterns: recognising and finding alternatives
	5. Summary	**Session 8:** Summary and reminders from day 1
2. Learning how to adapt and take control of your life with chronic headaches	1. Reflections	**Session 9**. Reflections from Day 1
	2. Back to basics	**Session 10**. Identifying barriers to change and exploring problem solving and goal setting **Session 11**. Lifestyle factors and impact on headaches
	3. Making headaches more manageable	**Session 12**. Managing stress and anxiety **Session 13**. Manging sleep better **Session 14**. Mindfulness and relaxation for headaches
	Lunch	
	Taster activity – Mindfulness practice	
	5. Treatment options	**Session 15**. Medication management
	6. Communication – explaining your headaches to others	**Session 16**. Relationships and communication with family, carers and friends **Session 17**. Communicating better with Health Professionals
	7. Future management	**Session 18**. Managing setbacks – what to do when things don't go to plan
	8. Summary	**Session 19**. Summary of course
3. One to one session with nurse	Session covers: • Classification assessment with headache diary • Discussion around medication • Lifestyle factors and personalised goal setting.	

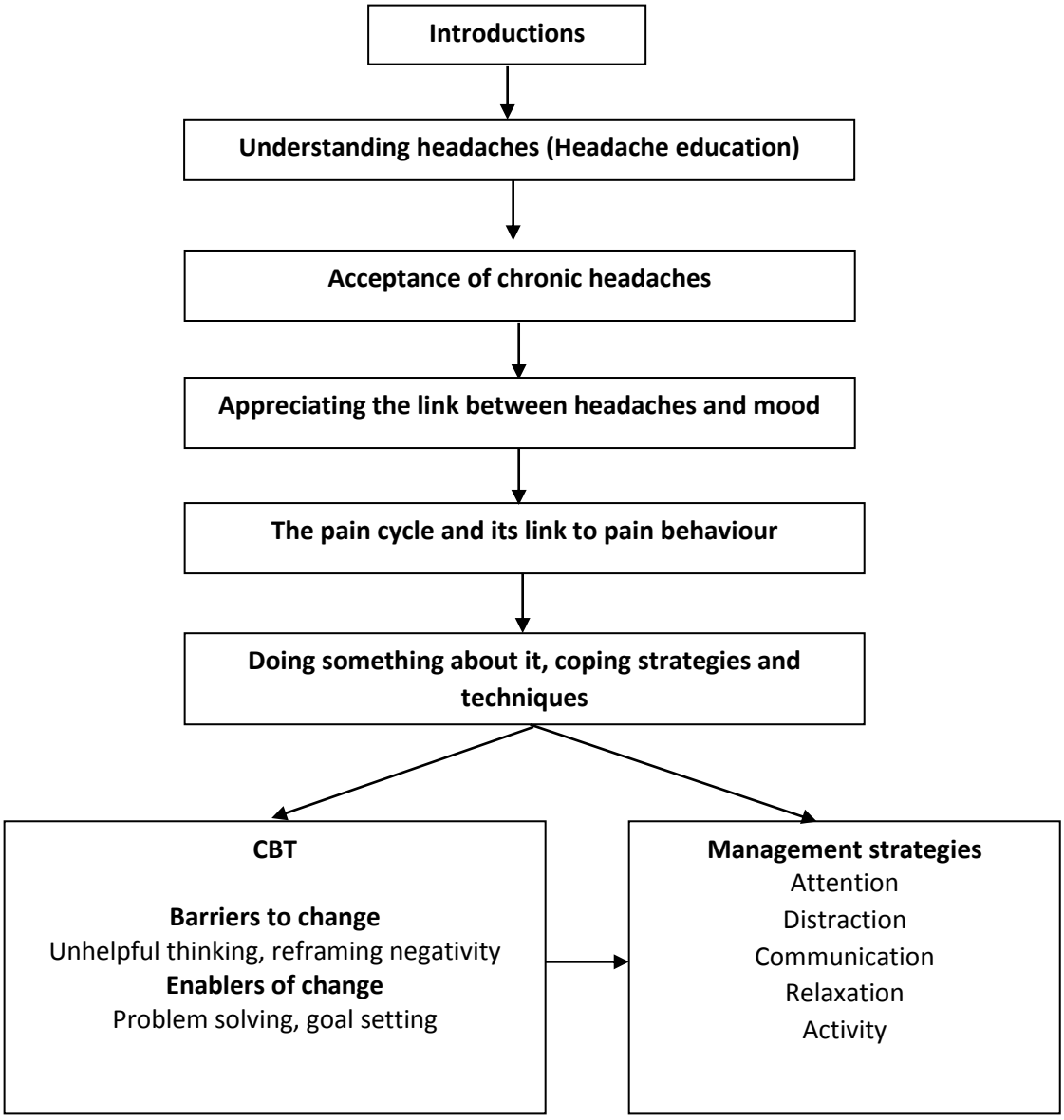
The aim of the course is to encourage and enable those with chronic headache to manage and cope with their pain better, to improve their quality of life despite their headache.

This is promoted by the use of facilitated learning which forms the foundation of this programme. We encourage participants to identify unhelpful thought patterns that may contribute to their headache burden. We educate participants on psychological and physiological influences and promote behaviour that is more accepting and adapting to life with chronic headaches.

COURSE AIM

Overview of the learning journey

(Adapted with permission from the COPERS study)



Day 1 - Living, understanding and dealing with chronic headaches

Aim:

- Introduce aims of the course, concepts of group work, increase understanding of chronic headaches and reasons for it. Introduce concept of acceptance and need for self-management and to recognise and understand how thoughts, mood and emotions can have an implication on headaches.

Learning outcomes:

- Be aware of the underlying mechanisms influencing headaches and feel confident that they can describe this to others
- Be able to accept the long term nature of chronic headaches and appreciate the need for self-management strategies
- Be able to identify the link between their own thoughts and beliefs and how this can related to mood
- Be able to identify negative and unhelpful thoughts and behaviours and the link between these and chronic headaches.

Delivery methods:

Group introductions, presentation, facilitated discussions, exercises, taster activity.

Session number	Title	Duration (minutes)	Timing
1	Welcome and introductions	20	10:00-10:20
2	Course overview	10	10:20-10:30
3	Headache information and mechanisms	50	10:30-11:20
	Break	10	11:20-11:30
4	Acceptance of chronic headaches	45	11:30-12:15
	Taster activity – Relaxation and breathing	15	12:15-12:30
	Lunch	30	12.30-13:00
5	Impact of thoughts, mood and emotions on headaches	30	13:00-13:30
6	Headache cycle and breaking the cycle	30	13:30-14:00
	Break	10	14:00-14:10
7	Unhelpful thinking patterns: recognising and finding alternatives	40	14:10-14:50
8	Summary and reminders from Day 1	10	14:50-15:00

Day 1 – Session 1	
Title: Welcome and introductions	**Time: 10:00-10:20**

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Facilitator notes:

- *We would suggest starting the session utilising the natural light in the room and making sure the temperature is not too hot. At the start of the session, just check with the group what they prefer. Just remember you won't be able to please everyone but showing you are mindful of these factors should be helpful.*
- *We are trying to encourage participants to communicate and feel comfortable in a group environment.*
- *Do not be surprised if patients are tempted to talk at great length about their headaches – you may wish to use the egg timer to keep to time during the introductions.*
- *The participants will have to speak publicly and disclose personal details to strangers and some people will be very nervous. It is the facilitator's job to put the group at ease and make the environment/ set up and atmosphere as informal and non-threatening as possible. Circular seating arrangements, relaxed body posture and tone of voice will help.*
- *If some participants choose only to disclose their name, this is acceptable as not all participants will want to engage at the outset. The facilitator's role in these instances would be to gently encourage participation throughout the rest of the course.*
- *It is important to identify what people's expectations are at the onset – remember we are not providing a cure for headaches.*
- *In order for participants to gain the most from the course they need to engage, participate and take responsibility.*

- **Display** the hello and welcome slide.

  (SLIDE 3)

- **Provide** the group with sticky labels for them to write their name on (they can put whatever name they prefer to be called).

- **Introduce** yourselves as course facilitators and go through necessary housekeeping.
  - Check room if the group are happy with the room lighting and heating.

- **Ice breaker** – (use the 1 minute egg timer for time keeping if required). Start with yourself as facilitators to introduce yourself and tell the group why you are here and what you wish to achieve. Go round the group, after each participant has had their turn make sure you are positive, supportive and encouraging of their response.

  (SLIDE 4)

  - On flipchart **write down** what participants says about what they wish to achieve from the programme for future reference
  - Some people may be very negative, saying things like "I doubt you can do anything to change my headache", "I'm not expecting anything". Make a note of these to use later as examples of negative and or unhelpful thoughts. With these participants, just thank them for being open and honest and coming along and trying out the course and ask them to keep an open mind and hope they will enjoy the course

- **Talk about** the need for “ground rules” and **ask** the group to suggest some. Use the flip chart to record suggestions.

Examples:

- Confidentiality (if this is not mentioned please stress the importance)
- Mobiles off/on silent
- Try to join in
- Listen
- Think about others
- Respect
- Agree to sometimes disagree
- Be honest and open
- If you need a break ask
- Don’t interrupt
- Be punctual
- Low lighting and temperature.

Day 1 – Session 2	
Title: Course overview	**Time: 10:20-10:30**

Aim: Introduce aims of the course and the concept of group work.
Rational: Managing expectations.

Facilitator notes:

- *Participants should be advised of the overall aim of the course as well as the aim of day 1 to help set the scene. Aim of day 2 to be presented on the second day of the course.*
- *One to one session – The nurse facilitator needs to have set aside time to offer participant a one to one appointment. These should be arranged at some point during the two days with each individual participant (time has been allowed a the end of day two but if required this can be done at any point in breaks over the two days). Once appointments have been booked, please provided the participant with a booking card, complete with appointment details.*
- *Ongoing telephone support post intervention – Participants should be offered telephone follow-up for up to eight weeks. Participants who maybe withdrawing from medication may require more support than others but the frequency of these follow-up calls should be individually negotiated and agreed with participants during the one to one session.*

➢ **Explain** the overall aim of the course

- *The overall aim of the course is to encourage and enable those with chronic headache to manage and cope with their pain better, to improve their quality of life despite their headache.*

➢ **(SLIDE 5)**

➢ **Explain** how this will be achieved:

- *Through facilitated learning*
- *By encouraging discussion*
- *Identifying unhelpful through patterns and behaviours*
- *Education on the physiological influences*
- *Education on the psychological influences*
- *Promotion of behaviour that is more accepting and adapting to life with chronic headaches.*

➢ **(SLIDE 6)**

➢ **Detail** the structure of the overall programme:

- Two days of group sessions:
  - Day 1 is all about - Living, understanding and dealing with chronic headaches
  - Day 2 is all about – Learning how to adapt and take control of your life with chronic headaches.
- The two days will be followed by a one to one consultation with the CHESS nurse where the headache will be classified and medication, lifestyle factors and goals will be discussed (appointments to be arranged with each person)
- Telephone follow-up for up to eight weeks will be provided by the CHESS nurse (this will be individually negotiated with each participant).

Reminder for participants – to continue with headache diary and bring to the 121 consultation

➢ **(SLIDE 7)**

➢ **Detail** the resources they will gain by the end to take away and use:

- *course handouts*
- *a relaxation CD*

- *a mindfulness CD*
- *an educational DVD.*

➢ **(SLIDE 8)**

➢ **Explain** the aim of day 1
- *To increase understanding of chronic headaches and reasons for it*
- *To introduce concept of acceptance and need for self-management*
- *To recognise and understand how thoughts, mood and emotions can have an implication on headaches.*

➢ **(SLIDE 9)**

Day 1 – Session 3	
Title: Headache information and mechanisms	**Time: 10:30-11:20**

Aim: To increase understanding of chronic headaches and reasons for it.
Rational: Information and education to increase awareness.

Facilitator notes:

- *Here the group will question their own knowledge and beliefs about headaches – this will get them to reflect on what they have been told and experienced in the past – As a facilitator you want to keep the discussion focused, allow for personal narrative but not too much and do not let few participants dominate.*
- *If you have time left in the session then you could play part of the DVD but this is not necessary.*
- *Please do ask all participants to watch the DVD between now and the next session to help consolidate learning and highlight any areas that are unclear and require clarification.*

PART 1 – Headache is a common problem

- **Ask the group** - How common do they think chronic headache is? **Inform them:**
  - Around 2-4% of the population have chronic headache (headaches on more than 15 days per month, for more than three months).

- **Advise the group** - the most common headache disorders included:
  - Migraine
  - Tension type headache
  - Medication overuse headache.

(Please note that these will be covered in more detail as you go through the session)

PART 2 – Different types of headaches and there features

1. MIGRAINE

A. What is migraine?

- **Ask the group –** Use the open question 'what is a migraine?' **Write** answers on a flipchart.

- **Talk** through the following points presented on **SLIDES 10 & 11**
  - *A migraine is more than 'just a headache' and can affect people in different ways*
  - *It is a complex neurological condition affecting the whole body but it is not life threatening*
  - *Migraine sufferers have an unusually sensitive nervous system which is highly sensitive to changes*
  - *This can mean changes in the environment other people do not notice can cause recurrent painful headaches*
  - *They cause headaches linked with associated symptoms such as nausea, vomiting, sensitivity to light, noise and movement and visual symptoms*
  - *Migraine can be episodic (infrequent attacks) or chronic (symptoms occurring on more than 15 days a month for over three months).*

- **(SLIDES 10 & 11)**

B. Who gets migraine?

- **Ask the group –** Use the open question 'who gets migraine?' to generate answers.

- **Talk** through the following points presented on **SLIDES 12**
  - *Anyone can get migraine - As many as 12% of the population suffer*

- *Women are at least three times more likely to have migraine than men*
- *Migraine usually begins in early age but often does not become problematic until much later*
- *Migraine tends to improve with older age*
- *Pregnancy and menopause can both affect migraines.*

➢ **(SLIDE 12)**

C. What are the features / characteristics of a migraine?

➢ **Ask the group –** Use the open question 'what do they think are the features or characteristics of a migraine? **Write** answers on a flipchart.

➢ **Talk through** the table below which is on **SLIDE 13.**

➢ **(SLIDE 13)**

Headache feature	Migraine
Pain location	Unilateral or bilateral
Pain quality	Pulsating or throbbing
Pain intensity	Moderate or severe
Effects on activity	Aggravated by, or causes avoidance of, routine activities of daily living
Other symptoms	Unusual sensitivity to light and/or sound or nausea and/or vomiting **Aura (act like warning signals)** Symptoms can occur with or without headache and: ➢ are fully reversible ➢ develop over at least 5 minutes ➢ last 5–60 minutes. Typical aura symptoms include visual symptoms such as flickering lights, spots or lines and/or partial loss of vision; sensory symptoms such as numbness and/or pins and needles; and/or speech disturbance.
Duration of headache	4–72 hours in adults
Frequency of headache	15 days or more per month for more than 3 months (less than 15 days per month it is episodic migraine)

Adapted from - 'Headaches' (NICE clinical guideline 150), available from www.nice.org.uk/CG150

D. Stages of a migraine attack

➢ **Talk through** the stages using the details below (brief descriptions on **SLIDES 14 & 15**).

➢ **(SLIDES 14 & 15)**

➢ There are four stages of a migraine attack:

- **Prodrome** – *the symptoms occurring hours to days before the headache.* Symptoms may be subtle including mood change, fatigue, food cravings, neck stiffness, irritability and hyperactivity.
- **Aura** – *the majority of people do not suffer this stage and have migraine without aura.* Auras are usually visual (blind spots, flashing lights, zig-zag lines) but can involve sensory (pins and needles or numbness of the face or limbs), motor (weakness of the limbs), speech (slurred, mixing up words) or cognitive (slowed or mixed up thinking) disturbances. Symptoms begin gradually and commonly last for minutes up to an hour. Some people may get a mixture of aura symptoms during a single attack.
- **Headache** – *untreated, severe headaches can last hours to days. The duration and frequency of headaches varies between sufferers.* During this phase people complain of:
  - Severe throbbing headache that is often on one side of the head but that may move
  - Sensitivity to light, noise, smells and movement
  - Nausea and vomiting
  - Neck pain or stiffness (occurs in approximately 80% of patients)
  - Diarrhoea
  - Dizziness or faintness.

- **Postdrome/Resolution** – *the headache slowly fades away over hours or days.* Some sufferers find an attack will stop suddenly if they vomit or if they sleep. In fact, many sufferers find a few hours sleep is the best treatment for their migraines. Even though the headache may have gone people can feel unwell and washed out for days after an attack.

E. What are the underlying biological mechanisms of a migraine?

- **Ask the group –** Use the open question 'what do they understand is the underlying biological reason for a migraine? **Write** answers on a flipchart.

- **Talk through** the points below:
  - The underlying cause is still unknown but research has greatly improved our understanding of migraine
  - Migraine is a disorder of how sensory information such as light, pain or sound, are dealt with by the brain. Migraine brains can be thought of as having an overactive pain system due to errors in the channels on the lining of the nerves. At the start of an attack, chemical changes occur in the part of the brain called the brainstem. These changes create a cycle where the brain responds abnormally to the normal signals coming from its own coverings and blood vessels. This results in the typical migraine symptoms of pounding headache and sensitivity to light, noise and movement
  - Migraine aura occurs when a spreading wave of electrical activity travels over the outer layer (cortex) of the brain
  - Research confirms that there is a genetic role in migraine. Genes are the instructions within you that tell your body how to work and what to do. Genes are inherited from your parents and this explains why headaches run in families.

- **(SLIDE 16)**

2. TENSION TYPE HEADACHE (TTH)

A. What is TTH?

- **Ask the group –** Use the open question 'what is TTH?' **Write** answers on a flipchart
  - In essence this is the opposite of a migraine headache.

B. What are the features / characteristics of a TTH?

- **Ask the group –** Use the open question 'what do they think are the features or characteristics of a TTH? **Write** answers on a flipchart.

- **Talk through** the table below which is on **SLIDE 17.**

- **(SLIDE 17)**

Headache feature	Chronic tension type headache
Pain location	Bilateral
Pain quality	Pressing/tightening (non-pulsating)
Pain intensity	Mild or moderate
Effects on activity	Not aggravated by routine activities of daily living
Other symptoms	None
Duration of headache	30 minutes – continuous
Frequency of headache	15 days or more (less than 15 days it is episodic tension type headache)

Adapted from - 'Headaches' (NICE clinical guideline 150), available from www.nice.org.uk/CG150

C. What are the underlying biological mechanisms of a TTH?

- **Ask the group –** Use the open question ''what could be the underlying biological mechanisms of a TTH?
  - In essence the answer to this is unclear as it is not very well understood.

3. MEDICATION OVERUSE HEADACHE

- **Ask the group –** Have they come across the concept of MOH? Allow for a general discussion around this point.

- **Talk through** the points below presented on **SLIDES 18, 19 & 20**:
  - *We will be discussing this in more detail on day 2 when we look at medication management therefore not to worry about it*
  - *Doctors are not all aware of this concept and they are only just getting to grips with the idea of MOH*
  - *MOH is the notion that people can develop headaches as a consequence of regular overuse of acute or symptomatic headache medication*
  - *This overuse will prevent frequent headache improving because it blocks the useful effects of headache preventives and is a key factor in patients having untreatable headache*
  - *If you have MOH, it's not your fault*
  - *The concept of MOH can be difficult and for some it may be upsetting*
  - *It is important to note that it is not an addiction*
  - *We are going to, during the course of this programme, find out where you are with regards to medication and help you if you have MOH*
  - *The aim is to look forward to a life without so much medication*
  - *The suggestion for people with MOH would be to stop the medication for 1-2 months and then restart but limit the medications to 10 days or less a month. If this is not possible then a reduction in medication to 10 days or less a month would be a good starting point.*

(SLIDES 18, 19 & 20)

PART 3 – What are the triggers?

- **Ask the group –** What triggers their headache? **Write** answers on a flipchart.

- **Talk through** the points below:
  - Some people may be able to identify factors that bring an attack on. It is often necessary for more than one trigger to be present to cross the "attack threshold" and cause an acute attack. The final trigger is usually obvious but the others are just as important.
    - For example, drinking a glass of wine does not always bring on a headache. However, if you drink a glass of wine on an empty stomach after having had a particularly stressful day having had drunk lots of coffee to keep you going – you are far more likely to notice an attack. It is the **combination** of stress, caffeine, hunger and the alcohol that is important, not the glass of wine on it's own.
  - The most common triggers for migraine are:
    - **Lack of food** – missing meals will result in a drop in blood sugar that can make an attack more likely
    - **Changes in sleep pattern** – too little or too much sleep (such as a weekend lie-in)
    - **Hormonal changes in women** – certain contraceptive pills, stages of the menstrual cycle, pregnancy and menopause will affect migraine
    - **Stress** – both periods of high stress and the relaxation after stress (first few days of a holiday)
    - **Over exertion** – both physical and mental
    - **Environmental changes** – bright lights, loud noises, weather changes (hot or humid weather).

(SLIDE 21)

PART 4 – What can you do to help yourself?

- **Ask the group –** What can they suggest might help them manage headaches more effectively? **Write** answers on a flipchart.

- **Talk through** the points below **(SLIDE 22)**:
  - Keep a headache diary - Keeping a diary can help you identify prodromal symptoms and triggers and also help doctors decide on your treatment. If you can identify triggers and then remove or modify a number of these you may be able to help your headaches. For a short time period, for each attack try to record:
    - The date
    - The time the attack started
    - The duration of attacks
    - The symptoms present and their timing in relation to the headache
    - What treatment was taken and when
    - The effect of treatment
    - Any trigger factors present or that may have built up.

  - Identify and modify triggers - Once you have recorded a number of attacks you may have a better idea of headache triggers. You can then try to identify triggers which you can do something about (missing meals, dehydration, erratic sleep, limit intake of alcohol). Modify as many suspected triggers as you can.

  - Take treatment early - During a migraine attack the gut shuts down and drugs are not absorbed well. This means pain killers will not be as effective. It is important to take acute migraine drugs as early as possible in the attack.

  - Balanced lifestyle - Try and maintain a regular and balanced lifestyle (more about this later in the course).

(SLIDE 22)

HOME TASK – Encourage the participants to watch the DVD before the next session to help consolidate discussions and messages from this session. Suggest that the DVD can be watched with family/friends/careers should the wish to do so.

- **Ask them to note any questions they may have from the DVD and to bring these on day 2 of the course.**

(SLIDE 23)

Summary

1. We are aware of features of different types of headaches which can help to distinguish between migraine and tension type headaches.

2. Some people do get triggers and by being aware of these you may be able to modify them.

3. There are lifestyle changes that can help manage headaches, which we will cover as we go through the course.

BREAK (11:20-11:30)

Day 1 – Session 4	
Title: Acceptance of chronic headaches	**Time: 11:30-12:15**

Aim: To introduce the concept of acceptance and need for self-management.
Rational: Principles of acceptance therapy.

Facilitator notes:

- *Some members of the group will take the story literally. If discussion gets too heated e.g. I'd physically drag him out or I would punch him" explain the analogy to the group and ask them to reflect on this.*

Part 1 – Case study of Lisa

- **Suggest** to the group - Headaches cause the physical sensations and pain but it can be the struggle to manage this pain that causes the overall distress
  - **Ask them** - What are their thoughts on this?

- **Describe or read** the following story about the street party to the group.

- **(SLIDE 24)**

Case study - Lisa

A woman has a street party, so she invites everyone who lives in the street to come to her house, except, she doesn't invite the 'pain in the neck' guy who lives next door but one. He's loud, smelly and obnoxious. She hopes that he doesn't get to know about the party.

But on the evening of the party he arrives at her house and lets himself in, he is loud and has rude manners. She asks him to leave but he won't go, she threatens him with the police but he says "this is a street party and I live in the street".

She doesn't know what to do so she says nothing else, but she follows him around to check on him and his behaviour. She gets increasingly agitated and upset by his presence as she feels he is ruining her party.

He still refuses to leave. She finds it hard to focus on her guests because she is constantly aware of his presence, she gets more and more upset and miserable, in the end she can't bear him in her house or watching him talk to her neighbours anymore, she withdraws to her bedroom crying and misses the party.

Part 2 – Balancing what you can and cannot control

- **A**
  s

Examples:

- She should have thrown him out….but she can't
- She should have got someone else to throw him out
- Could have called the police….but what good would that do? He may just come back
- It's a bit like headaches, they can be there a lot of the time causing anger and frustration, but that doesn't make them go away
- Headaches can cause upset and withdrawal therefore people miss out on things.

oup to discuss the way she handles the issue?

- **Ask** the group to relate this to their headaches as an uninvited and unwanted guest and how to deal with t
h

Examples:

- She could have tried to ignore him
- Others don't seem to be bothered by him why is she getting so upset
- If he's not talking to her, it's not really her problem, let other people deal with him
- If people ignore him he might just disappear into the background and go home
- Headaches just go away/home
- Yes but getting uptight about it doesn't help anyone….this is easier said than done
- But what's the alternative, get on with it or get so upset and stressed it makes the headaches worse and then she misses her party
- We can't control other people….just like we can't always control the headaches
- But does that mean we let it rule our lives?....if you can't control it, do you let it get to you or carry on in some way and try your best to manage?

- I
scuss the idea with the group that Lisa could not control her guest so she would have to learn to get on with him in one way or another.

Summary

1. Acceptance – Can be difficult to accept that the headaches are unlikely to go away, they will exist in some form as we do not have a cure.

2. Acceptance can be less stressful than trying to find a cure. We have to remember there are some things we do have control over and other things we do not.

3. Question - For things we do not have control over is it worth battling with them?

4. Important to learn as much as possible about your headaches in order to understand them and best manage them.

5. The next session will focus on developing an understanding of the relationship between emotions and mood, and headaches.

TASTER ACTIVITY – PROGRESSIVE MUSCLE RELAXATION AND BREATHING (12:15 – 12:30) – SEE PAGE 81 OF HANDBOOK FOR SCRIPT (DISPLAY SLIDE 25)

Please provide all participants with a copy of the relaxation CD to take away

LUNCH (12:30-13:00)

Day 1 – Session 5	
Title: Impact of thoughts, mood and emotions on headaches	**Time: 13:00-13:30**

Aim: To start to introduce the concept that pain and mood are linked and that mood can have an influence on headaches.
Rational: Understanding emotional consequence.

Facilitator notes:

- *We usually think of the headache first as a cause then the emotion as an effect. The idea of this session is to shift participants thinking to consider that a person's emotional state can influence their pain perception i.e. feeling low could result on more pain perception.*

PART 1 – When is your headache bad?

- **Ask** each participant to consider the last time their headache felt really bad, and then ask them to consider:
  - The circumstances at that time – what had been happening in their life at the time
  - Triggers that exacerbated the headache
  - Thoughts at the time of the headache
  - Emotions and feelings at the time of the headache
  - The impact this had on mood at the time and shortly after the headache.

(SLIDE 26)

Examples:

- Bad when haven't had enough time to drink and eat properly in the day because of work
- Worse when have overdone it and not slept very well
- Headache is always worse when feeling stressed
- During menstrual periods
- When noise levels are high
- When lighting is bad
- Thoughts – 'leave me alone', 'don't speak to me', negative thinking
- Emotions – sadness, guilt (especially if letting people down), anger, frustration, fed-up
- Mood – low mood, lack of motivation, low self-esteem.

- **Record** on a flip chart (If the group is large enough split them into two groups and let them do the tasks in their groups with a facilitator for each group, reconvene and discuss as a whole).

PART 2 – When is your headache 'not so bad' or 'bearable'?

- **Ask** each participant to think about the last time their headache wasn't so bad, and then ask them to consider:
  - The circumstances at that time – what had been happening in their life at the time
  - Triggers that exacerbated the headache
  - Thoughts at the time of the headache
  - Emotions and feelings at the time of the headache
  - The impact this had on mood at the time and shortly after the headache.

- Some will find this hard as they may be reluctant to admit that their headache is not always severe, but they have to be realistic and accept if it can get really bad there must be times when it is not so bad.

(SLIDE 27)

Examples:

- When away on holiday, you don't have the same stresses that might aggravate headaches
- When doing things of enjoyment, can get really absorbed and forget about the headaches
- When trying to overcome guilt and not be too harsh on yourself
- Thoughts – 'I can cope', more positive, optimistic
- Emotions – less guilt (as less impact on others)
- Mood – manageable mood, not so bad.

- **Record** on a flip chart (If the group is large enough split them into two groups and let them do the tasks in their groups with a facilitator for each group, reconvene and discuss as a whole).

- If there are no forthcoming narratives use the example (Peter's holiday) below and ask them to discuss the way the headache seems worse or better with different moods.

(SLIDE 28)

- **Ask** the group to consider the differences in his perception of headache in the different environments.

Case study – Peter's holiday

On holiday Peter's headache is manageable he does not have the usual chores to do and therefore does not get distressed. He sleeps better and eats well. At home his headaches are severe and debilitating. All the household chores are difficult, the children are demanding and he is conscious about not overburdening his wife because she works full time in a stressful job.

PART 3 – Link between emotion and headaches

- **Compare** the content on each flip chart for the above exercises and **discuss**
  - Initially the group may argue cause and effect i.e. chicken and egg scenario
  - **Explore** with the group the idea of thinking about the emotion first then the pain:
    - Feel good = headaches manageable / Feel bad = bad headaches **RATHER THAN** Headache OK = feel good / Headache terrible = feel bad.

(SLIDE 29)

	Scenario 1	***Scenario 2***
Thinking of pain first	*No headache = feel good*	*Terrible headache = feel bad*
Thinking of emotion first	*Feel good = Headaches more manageable i.e. less intense, less severe, shorter duration*	*Feel bad = Headaches more intense, severe and possible longer duration*

Summary

1. Mood and pain are linked.

2. Mood can have an impact on headaches. If mood can be better controlled then this may help to manage headaches.

3. The next session will focus on the pain cycle in which it is possible to see how headaches and mood can have an effect on behaviour and lifestyle.

Day 1 – Session 6	
Title: Headache cycle & breaking the cycle	**Time: 13:30-14:00**

Aim: To explain the pain cycle individuals can get stuck in due to the unhelpful things we do, and explore the strategies that can be used to help break the cycle.
Rational: Education and shaping knowledge, based on the fear avoidance model.

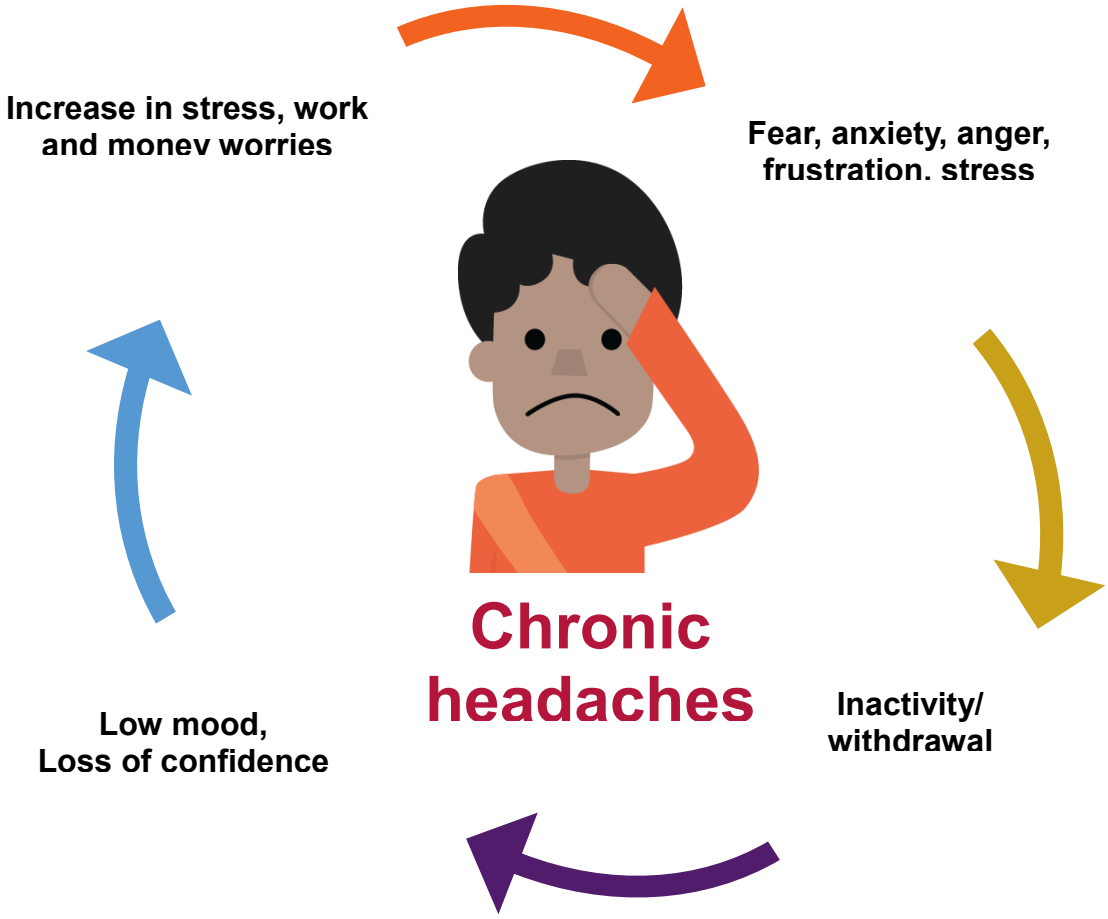
Facilitator notes:

- *Negative thoughts and negative emotions go together; negative emotions make pain far harder to deal with as these affect our behaviour.*
- *Sometimes we resort to coping behaviours that aren't that helpful. For example, shouting at those around us who don't deserve it, withdrawing socially, comfort eating.*
- *What are negative emotions? For example, feeling really sad when someone has died is not a negative emotion but feeling intensely sad all the time would be a negative emotion.*

PART 1 – Headache cycle

- **Show** the group the persistent headache pain cycle, and explain the vicious circle.

- **(SLIDE 30)**



- **Ask** the group to generate a list of unhelpful things that people might do that keep them in the cycle (focus here is on unhelpful coping strategies). **Write** answers on a flipchart.

Examples:

- Negativity
- Worry about stigma
- Lack of support
- Isolation – not sharing feelings
- Doing nothing
- Feeling a lack of purpose
- Accepting you're in this cycle for good
- Panic / Fear
- Stress – life and work related
- Money worries
- Insecurities
- Too much time alone to worry about things
- Moaning
- Drinking too much alcohol/caffeine
- Poor diet or not eating/hydrating regularly
- Overdoing things to play catch up
- Doing little or no physical activity
- Setting unrealistic targets
- Getting angry and frustrated
- Irregular sleep patterns.

PART 2 – Recognising depressive symptoms and how they can keep you in the pain cycle

- **Give** the group the depressive symptom list ***Handout 1 (Page 62)*** and display **SLIDE 31**.

(SLIDE 31)

- Let each individual consider the content of these handouts at home, ***if they are worried that the symptoms listed overwhelm their lives, then advise them to consider seeing their GP.***

PART 3 – Breaking the headache cycle

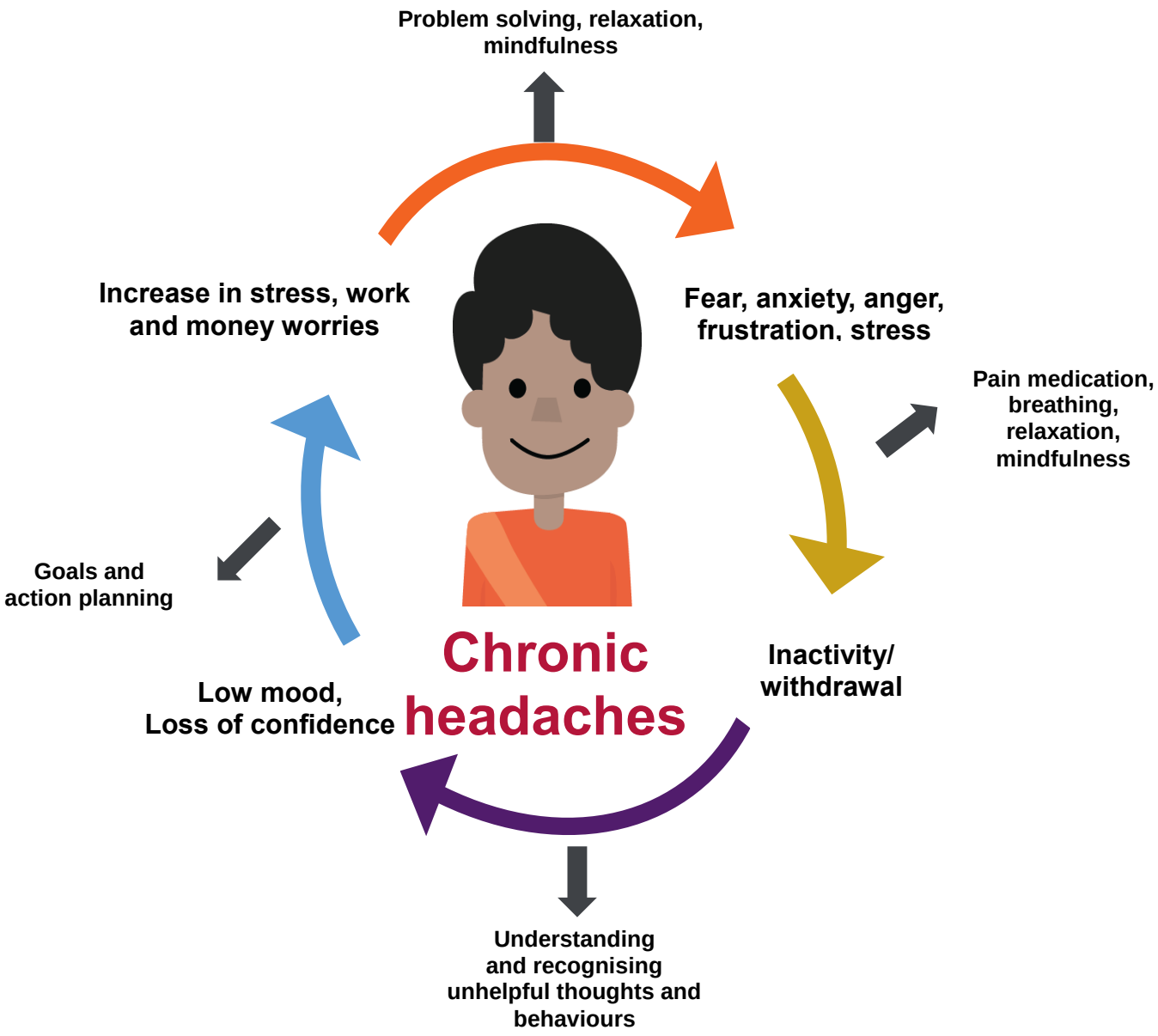
- **Ask** the group what they could do to break the headache cycle. Use the flip chart to record their ideas. **Write** answers on a flipchart.

Examples:

- Rewarding yourself
- Doing small things
- Setting goals
- Doing enjoyable activities
- Taking time out – making 'me time'
- Recognising unhelpful thoughts and behaviours
- Explore stresses and possible means to manage

- After the discussion, **show** the headache cycle with the escape routes on it **(SLIDE 32).** Give them ***Handout 2 (Page 63)***. It should summarise much of what they said in the session.

(SLIDE 32)



Summary

1. You can see how it can be easy to get stuck in such a cycle. There is no magic cure but there are lifestyle changes than can help to improve your quality of life.

2. Learning how to control and conquer emotions as well as challenge unhelpful thought patters will help you to deal with headaches better.

BREAK (14:00-14:10)

Day 1 – Session 7	
Title: Unhelpful thinking patterns: recognising and finding alternatives	**Time: 14:10-14:50**

Aim: To
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Facilitator notes:

- *Unhelpful thoughts stop people doing positive things and achieving goals therefore ability to recognise these can help people make more realistic assessments.*
- *The group may ask what has all this got to do with my headaches? If they haven't asked this question yet, ask the group to figure it out. The scenario below may help the group answer this question (you also need to encourage the group to think back to the pain cycle and recall the things that keep them going round in circles).*
- *It can be useful following this session to ask the group and you as facilitators to listen out for any unhelpful 'speak.'*

PART 1- Unhelpful thinking patterns

- **Give** the group ***Handout 3 (Page 64)*** and display **SLIDE 33**, typical unhelpful/negative thoughts and thinking.
  - **(SLIDE 33)**
- **Read** the titles out and see if they are personally familiar with any of the examples. **Ask** people to suggest example and **write** these on a flipchart.
- If the group is large enough, split into 2 groups. **Give** each group 5 of the unhelpful thought "flash cards" and ask them to think of examples to feedback to the group. **Write** these on a flipchart.

PART 2 – Recognising unhelpful thinking patterns

- **Read** the scenario and pause at each (*) asking the group if they can recognise what kind of negative thought Sam is having.
  - **(SLIDE 34)**
- Sometimes more than one unhelpful thought can be applied.
- **Encourage** the group to **use** the "flash cards" to hold up.
- **Ask** the group to keep an ear out for group members (including the facilitators) vocalising unhelpful thoughts throughout the rest of the course.
- As a facilitator ensure you are **listening out** for unhelpful thinking in the group and highlight as an example.

Case study - Sam's morning

Soon after waking up Sam gets a really bad headache. He is trying to get ready to go to work but the pain is excruciating and he knows it's going to be a bad day because they always are. **(*) Predicting/Catastrophising** Sam decides to call into work to say he has a headache and goes back to bed.

Eventually he gets up to make a cup of coffee and take some tablets. Sam feels low as he is worried about what people at work will think and he feels he should be just getting on with it and not wasting time. **(*) Shoulds/Musts** He is worried that he could lose his job because he is always calling in sick with his headaches and if that happens there is no way he can afford the house which he is worried he will lose **(*) Catatrophising**.

Whilst making the coffee he notices all the mess in the living room, he feels useless that he can't even keep the house tidy **(*) Mountains and molehills/Black and white thinking** Sam notices his calendar on the wall which shows a friends 40th birthday party on the weekend, which is four days away. He begins to worry that this headache will not have gone and that he should call him and cancel just in case. **(*)Emotional reasoning / Mountains and Molehills**. Sam is worried his friends will think that he is just making excuses and he will not understand and therefore will stop speaking to him **(*) Mind reading.**

Sam spends a large part of the day worrying and going over and over what to do about the birthday party and in what manner not to upset his friend **(*) Mental filter/rumination**. Sam feels life is so unfair and he just doesn't know what he has done to deserve this? **(*) Critical self.**

PART 3 – Finding alternative more helpful thoughts

- **Give** the group ***Handout 4 (Page 65)*** and display **SLIDE 35** alternative ways of thinking about each of the unhelpful thoughts highlighted earlier.

(SLIDE 35)

- **Ask** the group to suggest what questions they can ask to challenge unhelpful thoughts – **Write** these on a flipchart and discuss before giving out ***Handout 5 (Page 66).***

- **Ask** the group to consider the scenario again, unemotionally:
  - Were Sam's emotions rational?
  - Was Sam useless?
  - Was his friend really likely to react in such a way?
  - Will his friend stop speaking to him?
  - What would be the alterative view point?

PART 4 – Changing from CAN'Ts to CANs – moving from what you can't do to want you can do

- **Use** the examples from part 1 to explore how some of the unhelpful statements can be converted to more positive statements. Below are a couple of examples that might be helpful.

- **Remind** the group that this is a skill and requires practice, the use of questions will help them to reframe unhelpful thoughts to more positive ones.

Examples:

- ***Unhelpful thought*** *– "I just cannot cope with my headaches"*
- ***More helpful alternative*** *– "I know it can be difficult but I am trying to get on with things the best I can"*

- ***Unhelpful thought*** *– "I have no control over my life because these headaches have taken over"*
- ***More helpful alternative*** *– "It can be difficult to plan things because of the headaches but I am trying to minimise the things that trigger my headaches so that I can try and enjoy activities I want to be part of"*

Summary

1. Unhelpful/negative thoughts have an impact on mood and behaviours and can keep people in the pain cycle, preventing them from escaping.

2. Identifying unhelpful/negative thoughts is a first step – **RECOGNISE**. Stress that practising is important. The more conscious you are of identifying barriers (such as 'can't' statements), the more chance you have of doing something about them.

3. To do something about them you will need to **QUESTION** these thoughts – are they rational?

4. You will then need to **REFRAME** these thoughts which involves changing the unhelpful thoughts to more positive alternatives. The use of questions can help with this process.

5. Remember how you think can affect how you feel and subsequently how you behave.

Day 1 – Session 8	
Title: Summary and reminders from day 1	**Time: 14:50 -15:00**

Aim: To clarify learning from day one and provide a reminder for things to do before day 2.
Rational: Embedding learning.

- **Remind** the group that the main aims of the day were:
  - *To increase understanding of chronic headaches and reasons for it.*
  - *To introduce the concept of acceptance and need for self-management*
  - *To recognise and understand how thoughts, mood and emotions can have an implication on headaches.*
- **(SLIDE 36)**

- **Ask** them if they have any questions

- **Encourage** the participants to:
  - Watch the DVD before the next session to help consolidate discussions and messages from this session. DVD can be watched with family/friends
  - Look through the material from day one ahead of the next session to identify any areas they feel unclear about. **Ask** them to write any questions down and bring them to the next session
  - Continue to keep the paper headache diary which will be needed for the one to one consultation.

- **Give out** relaxation CD and instructions and **encourage** them to have a go.

- **Remind** them of the date and time of day 2.

- Thank participants for their attention.
- **(SLIDE 37)**

Day 2 – Learning how to adapt and take control of your life with chronic headaches

Aim:

- To identify strategies that can be implemented to help with the management of chronic headaches which includes preventative strategies.

Learning outcomes:

- Be able to break down issues into manageable chunks and set simple, measurable, achievable, realistic goals within a suitable time frame
- Be able to apply back to basics strategies to implement basis lifestyle changes
- Recognise the importance of and learn strategies to manage stress, anxiety and sleep more effectively
- Feel confident in being able to communicate efficiently with health care professionals and family members while at the same time learning to moderate ones expectations
- Understand the importance of managing setback and recognise strategies to help achieve this.

Delivery methods:

Presentation, facilitated discussions, exercises, taster session, role play

Session number	Title	Duration (minutes)	Timing
9	Reflections from day one	10	10:00-10:10
10	Identifying barriers to change and exploring problem solving and goal setting	30	10:10-10:40
11	Lifestyle factors and impact on headaches	20	10:40-11:00
	BREAK	10	11:00-11:10
12	Managing stress and anxiety	25	11:10-11:35
13	Managing sleep better	25	11:35-12:00
14	Mindfulness and relaxation for headaches	15	12:00-12:15
	Taster activity – Mindfulness practice	15	12:15-12:30
	Lunch	30	12:30-13:00
15	Medication management	30	13:00-13:30
16	Relationships and communication with family, careers and friends	20	13:30-13:50
17	Communicating better with Health Professionals	20	13:50-14:10
	BREAK	10	14:10-14:20
18	Managing setbacks – what to do when things don't go to plan	25	14:20-14:45
19	Summary of the course and arrangement of 121's	15	14:45-15:00

PLEASE NOTE: If a participant has failed to attend day 1 of the course and the research team have not been able to contact them to rebook them they may turn up to day 2. If so advise that the material may not make sense as they have not attended day 1. Encourage them to consider attending a day 1 in the future and offer to contact the research team to arrange that for them at the end of the day. If however, they wish to stay then allow them to do so.

Day 2 – Session 9	
Title: Reflections from Day 1	**Time: 10:00-10:10**

Aim: To understand and empathise with the group and ascertain current thoughts.
Rational: Improving bonding and group cohesion.

Facilitator notes:

- *Some participants maybe tempted to take over, as a facilitator it will be your role to try and give everyone the opportunity to feedback and reflect on their experience from day 1.*

Welcome back

➢ **(SLIDE 38 & 39)**

General discussion

➢ **(SLIDE 40)**

- **Ask** the group if they have any question about the first day of the course
- Have they had any issues or problems?
- Are there any positives? Would anyone like to share these?
- Was there anything that made more of an impression than anything else?

Aim of day 2

- **Inform** the group that the aim of day 2 is to:
  - *To identify strategies that can be implemented to help with the management of chronic headaches which includes preventative strategies.*

➢ **(SLIDE 41)**

Day 2 – Session 10	
Title: Identifying barriers to change and exploring problem solving and goal setting	**Time: 10:10 -10:40**

Aim: To get participants to think about future goals and explore these by identifying possible barriers, potential solutions and develop an associated action plan.
Rational: Goals and planning, theory of planned behaviour, theory of reasoned action, based on CBT principles.

Facilitator notes:

- *There is some evidence to suggest for people with long-term conditions who plan activities they are more likely to succeed.*
- *An individual's intention to perform a behaviour combined with the confidence they have in being able to succeed (self efficacy) has an impact on their actual willingness to engage.*
- *Goal setting is one way of escaping the pain cycle as discussed in session 6 on day 1, and encourages people to engage in positive behaviours.*

PART 1 – Background to problem solving and action planning

- **Explain** the problem solving steps (detailed on **SLIDE 42**):
  - *Identify and clearly define the challenge/problem/barrier*
  - *List a range of potential solutions – you can be creative*
  - *Highlight the advantages and disadvantages of each of these possible options*
  - *Select one of the options from the list as a goal*
  - *Implement using a S.M.A.R.T goal approach*
  - *Reflect on the experience*
  - *Tweak goal if needed.*

(SLIDE 42)

PART 2 – Background to SMART goal setting

- **Ask** group if they know what S.M.A.R.T goals are? **Explain** the S.M.A.R.T process
  - *S - Specific*
  - *M - Measureable*
  - *A - Achievable*
  - *R - Relevant*
  - *T – Timebound.*

(SLIDE 43)

- Give out S.M.A.R.T goal setting sheet ***Handout 6 (Page 67).***

PART 3 – Group exercise

- **Use** the pre-printed table provided - **Ask** the group to talk you through each column on the table for the identified problem of '*Finding it difficult to find the time to eat and drink water regularly due to being very busy and stressed at work*'. Below are some answers to help you.

Identify issue or problem	Brainstorm potential Solutions	Advantages/ disadvantages	Choose a solution	Set as a S.M.A.R.T goal **(Complete last after one solution is selected)**
Finding it difficult to find the time to eat and drink water regularly due to being very busy and stressed at work	*Have a bottle of water to hand to sip on* *Replace coffee and tea with water* *Try and set reminders to take breaks and eat* *Carry food on you* *Plan your work to make time in the day to take break* *Make juices with fruit and veg*	*Might help with headaches* *Might make me more productive* *I might get more behind on my work* *Might turn to convenience food so would put in weight* *Have to carry water bottle around* *Might need toilet more, can't keep taking breaks* *Can make you more organised*	*Have a bottle of water to hand to sip on* *Make juices with fruit and veg so healthy*	***Specific** – Yes* ***Measurable** – A litre bottle per day* ***Achievable** - Try to do this 3 times in the first week, 5 times in the second week. If feeling stressed with work try doing some breathing/relaxation. Or try drinking dilute juice instead.* ***Relevant** – Yes* ***Time bound** - Try for two weeks*

PART 4 – Personal goal setting

- **Encourage** them to start to think about setting some realistic goals by choosing something that they have the power to change – remind them of the case study of Lisa.

- **Ask** them to use ***Handout 7 (Page 68)*** to write any goals they have (if there is time ask them to look at this in the session, if not this will form part of the **HOME TASK**).

- **REMIND** them to bring this sheet with them to the one to one nurse consultation.

PART 5 – Pacing for goal setting

- **Ask** the group:
  - What is pacing?
  - And why is it important for people with chronic headaches?
    - Idea is to prevent boom/bust cycle – especially when playing catch-up in the home or work environment
    - Try not to get stuck in this cycle
    - Aim for a more balanced, planned approach with problem solving skills to hand when needed
    - Remember to think about pacing when looking at setting SMART goals.

- **(SLIDE 44)**

Summary

1. Small steps can take you a long way – If you have a large goal break it down.

2. Goals need to be things you want to do as the only person who can change things and make things happen is yourself, we can't expect others to do it for us.

3. Make sure pacing is adopted to prevent overdoing activity and causing headaches.

Day 2 – Session 11	
Title: Lifestyle factors and impact on headaches	**Time: 10:40 – 11:00**

Aim: To learn about the importance of lifestyle change by being aware of triggers.
Rational: Education and shaping knowledge.

Facilitator notes:

- ❖ *Some participants may feel this is all common sense and is not anything new, however it is an opportunity for them to think about these factors in light of their headaches and possibly as a future goal.*
- ❖ *Managing expectations is important in this session; it's not possible to expect miracle cures after making such lifestyle changes but changes in frequency of headaches maybe more realistic.*

PART 1 – Lifestyle factors

- ➢ **Inform** the group that headaches may be triggered or worsen with certain types of foods, activities, medications, or stress. (Remind the group that triggers were discussed on day 1).

- ➢ **Ask** the group - What changes could people make to their lifestyle that may have an impact on their headaches? **Write** these on a flipchart.

- ➢ **Give** the group ***Handout 8 (page 69)*** and have a look at the suggestions made.

➢ **(SLIDE 45)**

Get Regular Sleep	• *Go to bed and wake up at regular times each day, even at weekends* • *Do not sleep excessively on the weekends and too little on the weekdays* • *Most adults need approximately 6-8 hours of sleep per night* • *Try to avoid shift work or stick to the same shift all the time.*
Eat Regular Meals	• *Low blood sugar can trigger a headache* • *Eat regular meals three times each day* • *Ensure you have a balanced diet including protein, fruits, vegetables and carbohydrates.*
Get Moderate Amounts of Routine Physical Activity *Give out* ***Handout 9 (Page 70 & 71)***	• *Moderate physical activity (enough to raise your heart rate) three to five times each week will help reduce stress and keep you physically fit* • *Too much physical activity or inconsistent patterns of activity may trigger headache.*
Drink Plenty of Water	• *A normal adult should drink plenty of water throughout the day (at least 2-3 litres per day)* • *Dehydration may cause headaches*

Limit Caffeine, Alcohol and other Drugs	• *Caffeine is a stimulant and caffeine withdrawal may cause headaches when blood levels of caffeine fall* • *Excessive caffeine can lead to a worsening of headache and even cause chronic daily headaches* • *Alcohol may be a trigger for headaches* • *Regular painkillers (especially codeine containing drugs) will lead to a gradual worsening of headache and stop anti-migraine drugs from working (medication overuse headache).*
Reduce Stress	• *Stress may lead to an increase in headache* • *Relaxation and stress management may help reduce headaches.*

- **Ask** the group - Are there any other triggers and suggestions for lifestyle change that anyone has adopted? **Write** these on a flipchart.

- **Ask** the group - What might be the barriers to change? And what can they do to help break these? **Write** these on a flipchart.

PART 2 – Managing expectations

- **Ask** the group what they would expect to achieve from modifying lifestyle factors. **Write** these on a flipchart.

- Key points to **emphasise** to the group about managing their expectations:
  - *Be realistic about what to expect from lifestyle changes*
  - *Aiming to reduce how often you get headaches is a sensible expectation but wanting to be headache free for life is not*
  - *Lifestyle changes can be difficult as it is often difficult to break routines*
  - *For some of the major changes you may need can take a lot of time, energy and support. However, if you strive to make changes they can lead to an improvement in your quality of life.*

(SLIDE 46)

Summary

1. Basic lifestyle management may help with headache management. These are lifestyle factors that can have a positive impact on your general health and wellbeing.

2. Keep a headache diary – may help identify modifiable triggers.

3. It is important to strike a balance between lifestyle factors and drug treatment. Therefore in the case of migraine it's important to take treatment early.

4. Pacing is an important skill to adopt especially during periods after headaches to prevent overdoing activities and getting stressed.

5. Remember to be realistic and manage expectations.

BREAK (11:00-11:10)

Day 2 – Session 12	
Title: Managing stress and anxiety	**Time: 11:10-11:35**

Aim: To understand the link between stress, anxiety and headaches, and look for strategies that may help manage this better.
Rational: Regulation and reducing negative emotions.

Facilitator notes:

- *During the session, encourage participants to refer back to previous sessions to make connections to aid understanding about the link between stress, anxiety and headaches.*
- *Make reference to unhelpful thinking patterns and how these might increase stress and anxiety.*

PART 1 – What is stress and anxiety?

- **Ask** the group if they know what stress is – **write** suggestions on flipchart.

Examples:

- When something is overpowering
- Feeling pressure
- When you can't see the end
- When you feel you can't finish something
- Irritation.

- **Ask** the group if they know what anxiety is – **write** suggestions on flipchart.

Examples:

- It's like when you go to new places
- It's how you feel inside
- It's when you have a nervous feeling.

- **Explain** the following definitions:
  - **Stress** – the feeling of being under too much mental or emotional pressure which one feels they are unable to cope with
  - **Anxiety** – a feeling of unease, worry or fear.

PART 2 – When does stress and anxiety become problematic for people with chronic headache?

- **Remind** the group of the following:
  - That we all experience stress and anxiety in our lives
  - How this stress and anxiety is managed is important. For some it can become over bearing preventing them from functioning

- Stress and anxiety have been associated as triggers of headaches for some people (**Reflect** back to discussion on triggers during day 1 session 3)
- Stress and anxiety can cause a number of symptoms
  - **Ask** group to come up with what happens to us physically, emotionally, behaviourally and cognitively when we feel stressed or anxious (**write** them on a flipchart).

➢ **(SLIDE 47 & 48)**

Physical symptoms	***Emotional symptoms***	***Behavioural symptoms***	***Cognitive symptoms***
Increased heart rate	*Low mood*	*Increase alcohol/smoking*	*Poor concentration*
Sleep problems	*Irritable*	*Loss of weight/weight gain*	*Low confidence*
Headaches	*Fearfulness*	*Crying for no reason*	*Ruminating thoughts*
Changes in appetite			*Worry about the future*
Frequent urination			*Memory problems*
Sweating			

PART 3 – What can you do to help manage stress and anxiety?

➢ **Ask** the group to come up with stress and anxiety management techniques (**write** them on a flipchart).

Examples:

- Distraction
- Exercise
- Fresh air
- Word search / crosswords
- Music
- Mindfulness
- Communicate
- Delegate
- Time management
- Alcohol
- Smoking
- Indulging in food.

➢ **Highlight** any strategies the group have come up with that may not be helpful i.e. drinking alcohol, smoking, indulging in food – And discuss.

➢ **Explain** to the group:
- There is not always something you can do to prevent stress but there are various strategies to help manage stress more effectively
- Spotting early signs of stress is key – (they might recognise some of the symptoms mentioned in part two as signs).

➢ Give them ***Handout 10 (Page 72).***

Summary

1. Stress is a known trigger for headaches.

2. Stress is difficult to avoid but becoming aware of the early symptoms can help.

3. Stress can be presented with physical, emotional, cognitive and behavioural symptoms.

4. There are several strategies to help manage stress but the first aspect is recognising the symptoms of stress and anxiety.

Day 2 – Session 13	
Title: Managing sleep better	**Time: 11:35-12:00**

Aim: T
improv
Ration

Facilitator notes:

- ❖ *During the session, encourage participants to refer back to previous sessions to make connections to aid understanding about the link between sleep and headaches.*
- ❖ *Make reference to unhelpful thinking patterns, thoughts and beliefs which can have an impact on sleep and people getting stuck in a vicious cycle.*

PART 1 – Background to sleep

- ➢ **Explore** with the group
  - How much sleep is needed?
    - Remember everyone is different – and the amount of sleep needed can vary from person to person
  - How is sleep regulated?
    - Our sleep is regulated by an internal body clock – this body clock is influenced by many factors including light, time of day
  - **Reflect** back on discussion during day 1 session 3 - whereby poor and disturbed sleep can be a triggers of headaches for some people.

- ➢ **Ask** the group what factors can have an influence on our sleep? **Write down** suggestions on flip chart.

Examples:

- Stress
- Lighting
- Heating
- Noise
- Comfort of the bed
- Worry (including worry about not getting to sleep)
- Using technology in bed – phones, iPads etc.

PART 2 – What impact can thoughts have on sleep?

- ➢ **Remind** the group:
  - Your beliefs and misconceptions about sleep can have an impact on your sleep quality
  - By changing these beliefs and perceptions it can be possible to improve sleep and any unhelpful associations. **Ask** them to consider:
    - Are their expectations realistic?

- What could be the possible cause of sleep disturbance?
- Try not to worry about sleeping
- Try and stay calm and relaxed
- If they are having unhelpful thoughts, recognise and challenge these thoughts – As discussed on day 1.

PART 3 – What to do and what to avoid

- **Advise** the group:
  - Sleep hygiene are common sense strategies and lifestyle practices that can have an impact on your sleep.

- **Ask** the group what these could be, **write** them on a flipchart.

- Go through **SLIDES 49 & 50**
  - Try to:
    - Have a set bedtime and rise time
    - Make sure lighting and temperature is comfortable
    - Engage in some exercise
    - Have a winding down bedtime routine
    - Make sure the room temperature is comfortable
    - Use the bedroom for sleeping and sex
    - Leave the bedroom if can't fall asleep easily
    - Do some relaxation or mindfulness
    - Write down any worries, concerns, or troubled thoughts and deal with in the morning – keep notepad by the bed.

  - Try to avoid:
    - Napping during the day
    - Intake of caffeine, alcohol and nicotine all act as stimulants so should be avoided before bedtime
    - Engaging in strenuous exercise close to bedtime
    - Clock watching when you cannot sleep
    - Eating too late in the evening.

(SLIDE 49 & 50)

- **Give out *Handout 11 – Page 73*.**

- **Suggest** – for some keeping a sleep diary can be a useful way of monitoring sleep pattern.

Summary

1. Poor sleep can be a trigger for headaches therefore trying to maintain a good sleep pattern can be helpful.
2. Applying the basic principles of sleep hygiene can be useful.
3. Recognising unhelpful thought patterns and associations and challenging these can also help.

Day 2 – Session 14	
Title: Mindfulness and relaxation for headaches	**Time: 12:00-12:15**

Aim: T
Ration

Facilitator notes:

- The idea of this session is to introduce the concept of mindfulness as a tool for managing chronic headaches.
- Some participants maybe interested in the difference between mindfulness and relaxation. We have therefore included a section on this, which will allow participants to reflect back on the progressive muscle relaxation they practiced on day 1 in comparison to the practice they will do in this session.
- Some maybe resistant to trying and that is ok but just remind them that it is another tool in the tool box should they wish to have a go. They could also be encouraged to just listen to the CD without actually doing what is being suggested to familiarise themselves.
- There is a detailed information sheet on Mindfulness – it would be helpful to familiarise yourself with the background material to help you deliver this session.

PART 1 – What is mindfulness and why might it be helpful?

- **Ask** the group to tell you what they know about mindfulness - **Write** these up on a flipchart.

- **Explain** what mindfulness is **(SLIDE 51)**
  - *"Mindfulness is the awareness that emerges through paying attention on purpose, in the present moment and non-judgementally to things as they are" (*Williams, Teasdale, Segal and Kabat-Zinn).

(SLIDE 51)

- **Explain** that:
  - It can be viewed as exercise for the mind – where you are not being judgemental, rather you are seeing things as they are in the present moment
  - It can change the brain in a positive way
  - It can improve cognitive and emotional control as well as resilience
  - It is NOT a passive relaxation technique - you are active in mindfulness, the purpose is not to fall asleep but feeling relaxed is a nice side effect
  - Its NOT about emptying your mind.

- **Ask** the group why might mindfulness be helpful? - **Write** these up on a flipchart.

Examples:

- Improves mood
- Helps with stress and anxiety
- Helps manage anxiety
- Can be calming and relaxing
- Helps 'shut out the clutter'
- May help with physical conditions and general wellbeing
- Allows us to come off automatic pilot and see experience as they are rather than as we think they are
- Remember – we cannot change our experience but we can change how we relate to them
- Better self-knowledge
- Clarity of thoughts.

PART 2 – What is the difference between mindfulness and relaxation?

- **Ask** the group to tell you what they think the difference might be - **Write** these up on a flipchart.

- **Advise** the group:
  - In relaxation you can be more passive
  - People often know what they can do to relax (e.g. read a book, listen to music)
  - In the last session we tried a tense and release relaxation where we tried to relax muscles through a two-step process of tensing specific muscle groups then releasing the tension to notice how the muscles feel when relaxed
  - In mindfulness practice we would just be noticing and paying attention to these muscles groups in a non-judgemental manner.

PART 3 – Mindfulness CD

- **Give** out **Mindfulness CD and information sheet.**

- **Ask** participants to have a read of the sheet and have a go at the mindfulness at home.

- As part of the taster activity next **ask** participants to put themselves in a comfortable position. **Ask** the group to make sure all mobiles are switched off or put on silent.

- **Play** a track from the CD based on the time you have remaining before the next session.

- **Ask** the group how they found the practice
  - **Remind** them that it does take regular practice to start noticing any benefits.

Summary

1. Mindfulness is a state allowing you to be in the present moment. It takes practice and requires the mind to be trained.

2. Mindfulness works on the stress response and therefore can act as a great way of managing stress which we know is a trigger for headaches.

TASTER ACTIVITY – MINDFULNESS (12:15-12:30) – SEE PAGE 84 OF HANDBOOK FOR DETAILS OF TRACKS ON THE CD (DISPLAY SLIDE 52)

(Please provide all participants with a copy of the mindfulness CD to take away as well as the handout)

LUNCH (12:30-13:00)

Day 2 – Session 15	
Title: Medication management	**Time: 13:00-13:30**

Aim: T
Ration

Facilitator notes:

- *The idea of this session is to inform the group about the different drug management strategies for acute and preventative treatment of headaches.*
- *The session is not about diagnosing, but rather to get the participants to think about their own medication management and possibly enable them to identify any medication overuse.*
- *This session should be 'food for thought' allowing them to have a more personalised discussion with the nurse during the one to one consultation where they will have their headache classification and diary to reflect on.*
- *The idea is to empower patients to take control of managing their headaches – we are not here to recommend specific treatments. All change in medication will need to be done by the participants GP.*

Part 1 – What medication have the group tried?

- **POSTERS** - Put up the pre-printed posters showing the different drug groups used in the management of chronic headaches. **Ask** participants to mark which ones they use or have used.

Part 2 – Treatment falls into two main groups 'acute' and 'preventative' treatment

- **(SLIDE 53)**

1. Acute treatment

- **Inform the group**:
  - These drugs are ONLY taken when a headache attack occurs

- They include simple over the counter medicines which can be effective if taken early in an attack in combination with an anti-sickness drug
- GPs can prescribe stronger pain killers called Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) or migraine specific pain killers called Triptans
- Opiates or mixed analgesics should not be taken for migraine
- All acute medications must be limited using the following otherwise they can cause medication overuse headaches (**Reflect** back on the discussion during day 1 session 3):
    - If on paracetamol or NSAIDs - a maximum of 15 days a month
    - If on Triptans or opiods – a maximum of 10 days a month or they will cause medication overuse headache and worsen the migraine
    - **Key point – it's not the dose that is important it is the actual number of days the medication is taken on.**

This table is included for your reference and information only – you are not expected to go through each of the drugs under the categories with dosage during the session.

Type of drugs	Drugs used with dose
Non-specific treatments for headache	• Paracetamol 1 g
Non-steroidal anti-inflammatory drugs (NSAIDs)	• Aspirin 900 mg • Ibuprofen 400-800 mg • Naproxen 500mg
Specific treatments for migraine – Triptans	• Sumatriptan 50-100 mg orally; 20 mg nasal spray or 6 mg subcutaneous injection • Rizatriptan 10 mg tablet or wafer • Zolmitriptan 2.5-5 mg tablet or melt • Almotriptan 12.5 mg • Eletriptan 40-80mgs • Frovatriptan 2.5mg • Naratriptan 2.5 mg
Opioids	• Codeine • Tramadol
Prokinetics (anti sickness drugs)	The above treatments are improved when also taking one of the following anti sickness drugs: • Domperidone 10mgs • Metoclopramide 10mgs

*Table adapted from Miller and Matharu (2014) – [24]

2. Preventative treatment (or prophylactic treatment)

- **Inform the group**:
    - These drugs are used if you are having very frequent attacks (headaches on ≥5 days per month) that interfere with your ability to function or if acute medication does not work for you

- The aim is to reduce the frequency of attacks
- The drugs must be taken every day for at least 3-4 months to have an effect and if successful need to be continued for at least 6 months
- The doses often need adjusted during this time
- The effectiveness of drugs differ between sufferers and this combined with side effects mean you may need to try a number of different drugs before you find the one for you
- Preventative drugs **DO NOT** cure migraines and will not leave you completely headache free but should reduce attack frequency by at least 30%
- Drugs used include anti-depressants, anti-epileptics, beta-blockers, serotonin modulators, angiotensin modulators and metabolic enhancers (nutraceuticals).

➢ **Inform the group** that the following are the drugs recommended by the National Institute for Health and Care Excellence (NICE):

- Topiramate (anti-epileptic)
- Propranolol (beta-blocker)
- Amitriptyline (anti-depressant)
- Riboflavin (Vitamin B2).

This table is included for your reference and information only – you are not expected to go through each of the drugs under the categories with dosage during the session.

Type of drugs	Drugs used with dose
beta -blockers	• Propranolol 40-120mg twice daily* • Metoprolol 100-200mg daily
Anti-epileptic agents	• Topiramate 25-200mg daily* • Valproate 600-1000mg twice daily
Anti-depressants	• Amitriptyline 10-75mg nocte* • Nortriptyline 10-75mg nocte
Serotonergic modulators	• Pizotifen 0.5 to 3mg daily
Angiotensin-based modulators	• Lisinopril 10-20mg daily • Candesartan 8-32mg daily • Telmisartan 20-80mg daily
Nutraceuticals	• Riboflavin 400mg daily* • Co-enzyme Q10 30-600mg daily • Magnesium 600mg daily
Acupuncture*	

*Table adapted from Miller and Matharu (2014) – [24]

Part 3 – Medication overuse headaches (MOHs)

➢ **Remind** the group of the core messages from day 1 session 3 presented on **SLIDE 54.**

➢ **(SLIDE 54)**

- *Doctors are not all aware of this concept and they are only just getting to grips with the idea of MOH*
- *MOH is the notion that people can develop headaches as a consequence of regular overuse of acute or symptomatic headache medication which prevents headaches improving*
- *If you have MOH, it's not your fault*

- *It is important to note that it is not an addiction.*

➢ **Inform the group:**

- Acute medication can be useful for when you have attacks but more recently it has come to light that too much medication can be problematic.

- MOH is a headache occurring on 15 days or more per month developing as a consequence of regular overuse of acute or symptomatic headache medication on 10 or more, or 15 or more days per month, depending on the medication, for more than 3 months.
    - All acute medications must be limited to a maximum of 10 – 15 days a month (depending on the acute treatments used) or they will cause medication overuse headache and worsen the migraine.

- If acute or symptomatic headache medication (not preventative medication) is taken on 10 or less days per month then it is not classed as MOH.

- Medication overuse will prevent frequent headache improving because it blocks the useful effects of headache preventives and is a key factor in patients having untreatable headache.

- Evidence from a Danish study shows:
    - 93 out of 100 patients will be the same or better when taking less medication
    - Nearly half of the patients will be better and not need prophylactic drugs.

➢ **(SLIDES 55 & 56)**

- If medication overuse if not addressed people often find the severity of their headaches get worse and they require more medication.

➢ **(SLIDE 57)**

➢ **Acknowledge to the group that:**

- The concept of MOH can be difficult and for some it may be upsetting
- The aim is to look forward to a life without so much medication
- The suggestion for people with MOH would be to stop the medication for 1-2 months and then restart but limit the medications to 10 days or less a month. If this is not possible then a reduction in medication to 10 days or less a month would be a good starting point
- There will be an opportunity to reflect on headache type and MOH at the one to one consultation therefore it is important to keep the headache diary to get a good idea of headache patterns and medication use.

Summary

1. There are different treatment options available for acute and preventative management of headaches.

2. Individuals should be mindful of medication overuse headaches.

Day 2 – Session 16	
Title: Relationships and communication with family, carers and friends	**Time: 13:30-13:50**

- **Ask** the group what challenges they face when communicating with family members? (these maybe related to children, partner not listening, getting angry, frustrated) - **Write** these on a flipchart.

Ai
Ra

Examples:

- People don't always understand how bad it is
- Headaches are not visible so hard
- People don't always take it seriously
- You sometimes get the feeling of 'oh here she goes again.'

PART 1 – A talks, B listens

- **Ask** the group to get into pairs. One person is A, the other is B.
- **Ask** person A to describe an activity or hobby of interest that they like doing or used to like doing to person B for 2 minutes. Person B must listen without interrupting.
- After 2 minutes ask person B to recount back to person A what they have heard. Person A must now listen without interrupting then reports how accurately B was listening.
- **Observe** person B's body language for attentive listening.

(SLIDE 58)

PART 2 – B talks, A listens

- Now **ask** person B to describe an activity or hobby of interest that they like doing or used to like doing to person A for 2 minutes. Person A must listen without interrupting.
- After 2 minutes **ask** person A to recount back to person B what they have heard. Person B must now listen without interrupting then reports how accurately A was listening.
- **Observe** person A's body language for attentive listening.

(SLIDE 58)

PART 3 – Discussion

- **Ask** the group the following questions
  - How did it feel to actively listen?
  - How did it feel to be listened to?
  - How did it feel to hear someone describing your thoughts in their terms?
- **Ask** the group to consider when was the last time they had a conversation with a specific purpose and really listened to the responses without interjecting or putting across own viewpoint.
- **Remind** the group that when they have a headache communication maybe more challenging and the common pitfalls which prevent good communication are:
  - not listening
  - getting angry
  - repeating same problems
  - assuming and 'mind reading'
  - negative thinking
  - not choosing a good time or place to talk

- aggressive body language
- not being honest and open.

➢ **(SLIDE 59)**

➢ Give the group ***Handout 12*** **(*Page 74)*** with a listening exercise which they may want to try at home.

Summary

1. Remind the group that essence of any good relationship is communication.

2. This could be particularly important if looking at making changes such as a reduction in medication, you may need the support of family and friends at that time. Remember they are not mind readers so effective communication will be key.

3. Mention that is can be helpful to plan what to say in advance for important things.

Day 2 – Session 17	
Title: Communicating better with health professionals	**Time: 13:50-14:10**

Aim: To reflect on consulting behaviour and promote effective communication and constructive consultations.
Rational: To promote effective healthcare utilisation.

PART 1 – Consulting patterns

- **Ask** the group the following questions
  - How often do you visit your GP?
  - How many tests/investigations have you had that have made any difference to your headaches?
  - How do you feel after you have visited your GP?

(SLIDE 60)

Examples:

- The final question should promote discussion about their experiences with their GPs or health professionals some of which maybe positive and others negative
- Was not listened to
- Was not taken seriously
- Just wanted to give me more medication
- If they report the outcome as not being satisfactory, ask them why they continue to consult.

PART 2 – Role play

- *Role play 1* - Both facilitators **perform a role play** a 'typical' headache patient in a GP consultation. (Script on page 89) – first
- is very focused on what the doctor can do for the patient.

- **Ask** the group to comment on the role play:
  - What did they notice about the exchange?
  - What could the patient have done differently? (Encourage the group to think about purpose of going to the doctor, being clear about their situation and what is required of the doctor).

Examples:

- Patient could be more specific
- Doctor could have stopped the patient rambling on
- Doctor could have been less dismissive
- It seems the patient just wanted the headaches to go away with is unrealistic
- The doctor can't perform miracles
- Neither seemed to be listening to each other, they both had set agendas that were different
- Doctor could have been more empathic.

- *Role play 2* - Both facilitators then **perform the second role play** employing some of the recommendations the group have suggested – it should help demonstrate a role play that is more focused on what I can do for myself.

- **Ask** the group to comment on the role play:
  - What did they notice about the exchange?

Examples:

- Patient seems to have more purpose, she is more specific and has questions
- Patient asks for specific information and help about taking her drugs
- Patient didn't ramble on about her headaches like the first one she explained it better
- They both listened to each other this time and there was an end result rather than a dismissal
- Patient was more prepared to do stuff herself, to help herself, not expecting the GP to do everything.

➢ Give the group ***Handout 13 (Page 75),*** a checklist for communicating with the GP.

Summary

1. Clarify the purpose of the visit and plan your questions before visiting your GP.

BREAK (14:10-14:20)

Day 2 – Session 18	
Title: Managing setbacks- what to do when things don't go to plan	**Time: 14:20 -14:45**

Aim: To know what to do when experiencing a setback or a flare up.
Rational: Preparation and embedded learning.

PART 1 – Things that disrupt goals

- **Ask** the group to summarise the things that caused them to disrupt their goals and plans (triggers) - remind them that things may not go as planned but it is what you do to move forward that is important.

Examples:

- Mood / feeling low
- Family / other people
- Money
- Life events that disrupt plans
- Overthinking / over worrying
- Excuses for not doing things
- Confidence
- Time / busy life
- Weather
- Unrealistic goals
- Medication.

- **Point out** that having identified the things that caused disruption, it is easier to make action plans and prevent reoccurrences. **Ask** the group to consider whether they are, short term, long term, within their control or not?

- **Remind** the group that during an acute attack it may be unrealistic to expect more than just trying to get over the attack.

PART 2 – How to manage setbacks

- **Ask** the group to come up with positive ideas for managing setbacks they have identified.

- **(SLIDE 61)**

Examples:

- Communication with others, maybe ask for help if needed
- Remind yourself that this phase will pass
- Break the cycle – use tools like challenging unhelpful thoughts
- Planning and prioritising
- Pacing
- Remember back to basics
- Do something to pick you up (elevate your mood)
- Try not to look back, if something hasn't worked look forward to think about how to improve
- Be realistic
- Revisit goals and action plans
- Take time out, relax or do mindfulness
- Think about the things that have gone well
- Have a back-up plan.

- **Remind** the group that it is easy to fall back into old habits e.g. drinking, poor diet, lack of activity, overly stressing etc.

- **Remind** them to be:
  - Mindful of the lifestyle factors
  - Pacing – not over stressing to play catch-up
  - Recognising unhelpful thoughts and challenging them.

PART 3 – Things that have gone well

- **Ask** the group about things that have gone well since starting the programme and to remind them to dwell on the positive things they have achieved.

- If there is time **seek** suggestions for continuing the good work. For example suggest keeping a note book, so that the participants can log their goals, ideas and successes and organise thoughts logically etc.

- Finally: **refer** the group to the list of useful charities **(give *Handout 14 – Page 76)*.**

Summary

1. There will be times when you experience setbacks to your plans and goals, sometimes these setbacks will have a trigger but others will not.

2. Remind yourself of the back to basics and try to challenge any unhelpful thought patterns.

3. Focus your attention on all the positive things you have done.

Day 2 – Session 19	
Title: Summary of the course and arrangement of 121's	**Time: 14:45-15:00**

Aim: To clarify learning from the two days and introduce the structure of the one to one sessions
Rational: Embedding learning.

PART 1 – Summary of Day 2

- **Display SLIDE 62**

PART 2 – Personal aims

- **Refer back** to the group's personal aims from the first day and **ask** each person how far they think they got to achieving them.

PART 3 – Personalised goal setting

- **Remind** them of S.M.A.R.T goal setting and using ***Handout 7 (Page 68)*** to consider one thing they are going to improve or change.

- **Ask** them to consider this and to bring this piece of paper with them to the one to one nurse appointment.

- **Reassure** participants that what they have written on the paper is confidential to them. Remind the group to:

Reflect and read the course notes again, think about application of tools, start planning and start doing.

PART 4 – Thanks and arrangement of one to one consultations

- **Arrange** 121's (if you haven't already done so) and provide a card with details of the appointment. Remind the participants to bring their headache diary to the consultation.

- For your record complete the one to one booking form which will be provided by the research team. A copy of the form should be provided to the study team for record and safety. The booking form will include the participants TNO, initials and telephone number.

- Thank everyone for coming, say something positive about the group (e.g. pleasure working with them, valued contributions, you know it's not been easy and you appreciate the effort that everyone has made).

- Say something motivating (e.g. they have shown the capacity to communicate, think purposefully and have the ability to use their learning).

- **(SLIDE 63)**

HANDOUTS

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Handout 1 – Depressive symptoms list

The symptoms of depression can be complex and vary from one person to another. If you are experiencing some of the following symptoms below every day for more than two weeks you should consult your GP.

Psychological symptoms include:

- continuous low mood or sadness
- feeling hopeless and helpless
- having low self-esteem
- feeling tearful
- feeling guilt-ridden
- feeling irritable and intolerant of others
- having no motivation or interest in things
- finding it difficult to make decisions
- not getting any enjoyment out of life
- feeling anxious or worried
- having suicidal thoughts or thoughts of harming yourself*

Physical symptoms include:

- moving or speaking more slowly than usual
- change in appetite or weight (usually decreased, but sometimes increased)
- constipation
- unexplained aches and pains
- lack of energy or lack of interest in sex (loss of libido)
- changes to your menstrual cycle
- disturbed sleep (for example, finding it hard to fall asleep at night or waking up very early in the morning)

Social symptoms include:

- not doing well at work
- taking part in fewer social activities and avoiding contact with friends
- neglecting your hobbies and interests
- having difficulties in your home and family life

*if you have suicidal feelings then please book an appointment with your GP

http://www.nhs.uk/Conditions/Depression/Pages/Symptoms.aspx

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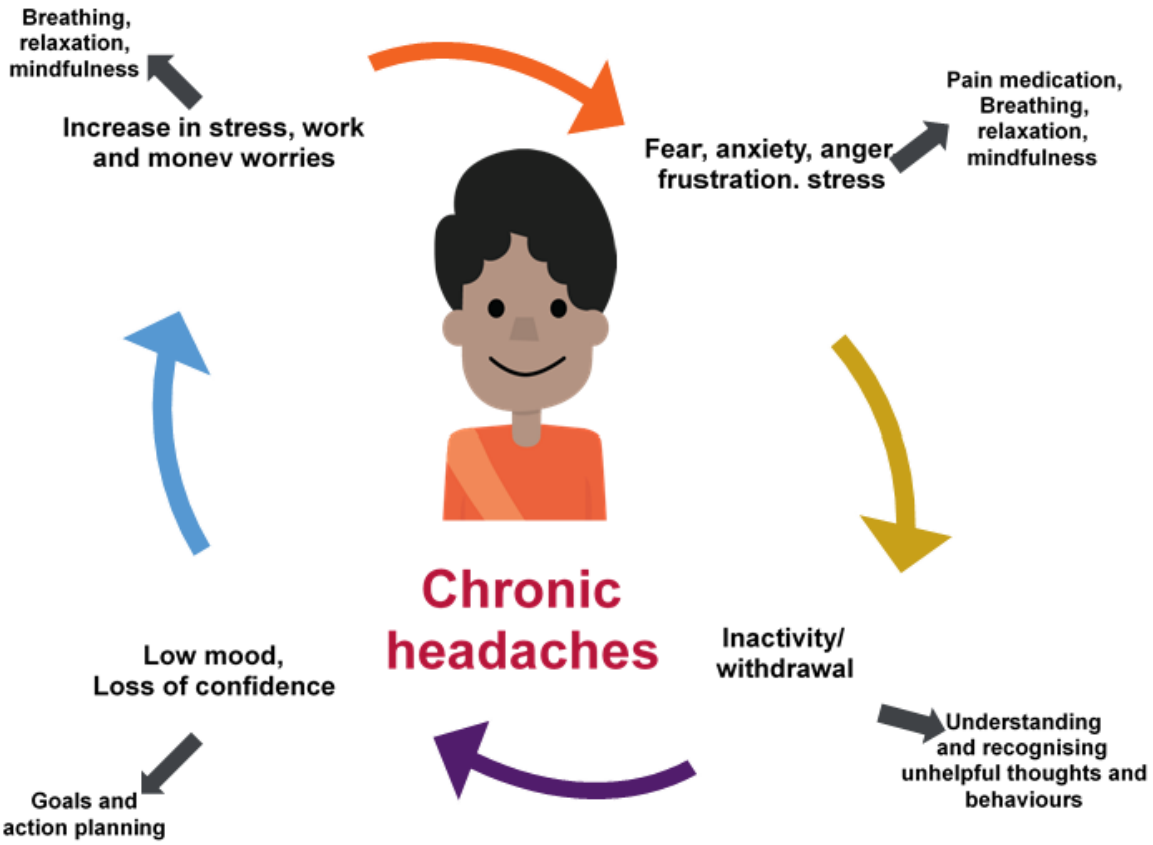
Handout 2 – Breaking the headache pain cycle



Examples of unhelpful coping strategies

- Overly worrying or getting stressed
- Poor diet – not eating regularly
- Not hydrating
- Over doing it – playing catch-up
- Doing little or no physical activity
- Setting unrealistic targets
- Drinking too much alcohol/caffeine
- Getting angry and frustrated
- Irregular sleeping patterns

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Unhelpful Thinking Habits

Over the years, we tend to get into unhelpful thinking habits such as those described below. We might favour some over others, and there might be some that seem far too familiar. Once you can identify your unhelpful thinking styles, you can start to notice them – they very often occur just before and during distressing situations. Once you can notice them, then that can help you to challenge or distance yourself from those thoughts, and see the situation in a different and more helpful way.

Mental Filter
When we notice only what the filter wants or allows us to notice, and we dismiss anything that doesn't 'fit'. Like looking through dark blinkers or 'gloomy specs', or only catching the negative stuff in our 'kitchen strainers' whilst anything more positive or realistic is dismissed

Judgements
Making evaluations or judgements about events, ourselves, others, or the world, rather than describing what we actually see and have evidence for

Mind-Reading
Assuming we know what others are thinking (usually about us)

Emotional Reasoning
I feel bad so it must be bad! I feel anxious, so I must be in danger

Prediction
Believing we know what's going to happen in the future

Mountains and Molehills
Exaggerating the risk of danger, or the negatives. Minimising the odds of how things are most likely to turn out, or minimising positives

Compare and despair
Seeing only the good and positive aspects in others, and comparing ourselves negatively against them

Catastrophising
Imagining and believing that the worst possible thing will happen

Critical self
Putting ourselves down, self-criticism, blaming ourselves for events or situations that are not (totally) our responsibility

Black and white thinking
Believing that something or someone can be only good or bad, right or wrong, rather than anything in-between or 'shades of grey'

Shoulds and musts
Thinking or saying 'I should' (or shouldn't) and 'I must' puts pressure on ourselves, and sets up unrealistic expectations

Memories
Current situations and events can trigger upsetting memories, leading us to believe that the danger is here and now, rather than in the past, causing us distress right now

Finding Alternative Thoughts

Unhelpful Thinking Habit	Alternative more balanced thought
Mental Filter 	*Am I only noticing the bad stuff? Am I filtering out the positives? Am I wearing those 'gloomy specs'? What would be more realistic?*
 Mind-Reading	*Am I assuming I know what others are thinking? What's the evidence? Those are my own thoughts, not theirs. Is there another, more balanced way of looking at it?*
Prediction 	*Am I thinking that I can predict the future? How likely is it that that might really happen?*
 Compare & despair	*Am I doing that 'compare and despair' thing? What would be a more balanced and helpful way of looking at it?*
Critical self 	*There I go, that internal bully's at it again. Would most people who really know me say that about me? Is this something that I am totally responsible for?*
 Shoulds and musts	*Am I putting more pressure on myself, setting up expectations of myself that are almost impossible? What would be more realistic?*
Judgements 	*I'm making an evaluation about the situation or person. It's how I make sense of the world, but that doesn't mean my judgements are always right or helpful. Is there another perspective?*
 Emotional Reasoning	*Just because it feels bad, doesn't necessary mean it is bad. My feelings are just a reaction to my thoughts – and thoughts are just automatic brain reflexes*
Mountains and molehills 	*Am I exaggerating the risk of danger? Or am I exaggerating the negative and minimising the positives? How would someone else see it? What's the bigger picture?*
 Catastrophising	*OK, thinking that the worst possible thing will definitely happen isn't really helpful right now. What's most likely to happen?*
Black and white thinking 	*Things aren't either totally white or totally black – there are shades of grey. Where is this on the spectrum?*
 Memories	*This is just a reminder of the past. That was then, and this is now. Even though this memory makes me <u>feel</u> upset, it's not <u>actually</u> happening again right now.*

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Handout 5 – Checklist for unhelpful thinking

1. What is the evidence?

- What evidence do I have to support my thoughts?
- What evidence do I have against them?

2. What alternative views are there?

- How would someone else view this situation?
- How would I have viewed it before I got stressed/depressed/anxious?
- What evidence do I have to back these alternatives?

3. What is the effect of thinking the way I do?

- Does it help me, or hinder me from getting what I want? How?
- What would be the effect of looking at things less negatively?

4. Is my thinking realistic?

- Am I thinking in all-or-nothing terms?
- Am I condemning myself as a total person on the basis of a single event?
- Am I concentrating on my weaknesses and forgetting my strengths?
- Am I blaming myself for something which is not my fault?
- Am I taking something personally which has little or nothing to do with me?
- Am I expecting myself to be perfect?
- Am I using a double standard - how would I view someone else in this situation?
- Am I paying attention only to the bad side of things?
- Am I overestimating the chances of disaster?
- Am I exaggerating the importance of events?
- Am I fretting about the way things ought to be instead of accepting and dealing with them as they come?
- Am I assuming I can do nothing to change my situation?
- Am I predicting the future instead of experimenting with it?

5. What action can I take?

- What can I do to change my situation?
- Am I overlooking solutions to problems on the assumption they won't work?
- What can I do to test out the alternative views I have arrived at?

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Handout 6 – S.M.A.R.T Goal Setting

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Handout 7 – Personal goal setting sheet

	MY GOAL
SPECIFIC • clearly define your goal (think of the who, what, where, why and how)	
MEASURABLE • make your goal measureable to help you monitor your progress	
ACHIEVABLE • make sure the goal is realistic, sensible and something you can accomplish	
RELEVANT • make sure the goal is something that you want to engage in and of interest to you	
TIMEBOUND • Set a timescale for achieving your goals	

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Handout 8 – Lifestyle factors

Get Regular Sleep 	• Go to bed and wake up at regular times each day, even at weekends • Do not sleep excessively on the weekends and too little on the weekdays • Most adults need approximately 6-8 hours of sleep per night • Try to avoid shift work or stick to the same shift all the time
Eat Regular Meals 	• Low blood sugar can trigger a headache • Eat regular meals three times each day • Ensure you have a balanced diet including protein, fruits, vegetables and carbohydrates.
Get Moderate Amounts of Routine Physical Activity 	• Moderate physical activity (enough to raise your heart rate) three to five times each week will help reduce stress and keep you physically fit • Too much physical activity or inconsistent patterns of activity may trigger headache
Drink Plenty of Water 	• A normal adult should drink plenty of water throughout the day (at least 2-3 litres per day) • Dehydration may cause headaches
Limit Caffeine, Alcohol and other Drugs 	• Caffeine is a stimulant and caffeine withdrawal may cause headaches when blood levels of caffeine fall • Excessive caffeine can lead to a worsening of headache and even cause chronic daily headaches • Alcohol may be a trigger for headaches • Regular painkillers (especially codeine containing drugs) will lead to a gradual worsening of headache and stop anti-migraine drugs from working (medication overuse headache)
Reduce Stress 	• Stress may lead to an increase in headache • Relaxation and stress management may help reduce headaches.

*From University College London Hospitals NHS Foundation Trust – Headache Group

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FACTSHEET 4

Physical activity guidelines for

ADULTS (19–64 YEARS)

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Individual physical and mental capabilities should be considered when interpreting the guidelines.

Examples of physical activity that meet the guidelines

Moderate intensity physical activities will cause adults to get warmer and breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples include:

- Brisk walking
- Cycling

Vigorous intensity physical activities will cause adults to get warmer and breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation. Examples include:

- Running
- Sports such as swimming or football

Physical activities that strengthen muscles involve using body weight or working against a resistance. This should involve using all the major muscle groups. Examples include:

- Exercising with weights
- Carrying or moving heavy loads such as groceries

Minimising sedentary behaviour may include:

- Reducing time spent watching TV, using the computer or playing video games
- Taking regular breaks at work
- Breaking up sedentary time such as swapping a long bus or car journey for walking part of the way

What are the benefits of being active daily?

- Reduces risk of a range of diseases, e.g. coronary heart disease, stroke, type 2 diabetes
- Helps maintain a healthy weight
- Helps maintain ability to perform everyday tasks with ease
- Improves self-esteem
- Reduces symptoms of depression and anxiety

For further information: *Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers* (2011)

DHSSPS Department of Health, Social Services and Public Safety

The Scottish Government

Llywodraeth Cymru Welsh Government

DH Department of Health

FACTSHEET 5

Physical activity guidelines for

OLDER ADULTS (65+ YEARS)

1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
2. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
4. Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
5. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Individual physical and mental capabilities should be considered when interpreting the guidelines.

Examples of physical activity that meet the guidelines

Moderate intensity physical activities will cause older adults to get warmer and breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples include:

- Brisk walking
- Ballroom dancing

Vigorous intensity physical activities will cause older adults to get warmer and breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation. Examples include:

- Climbing stairs
- Running

Physical activities that strengthen muscles involve using body weight or working against a resistance. This should involve using all the major muscle groups. Examples include:

- Carrying or moving heavy loads such as groceries
- Activities that involve stepping and jumping such as dancing
- Chair aerobics

Activities to improve balance and co-ordination may include:

- Tai chi
- Yoga

Minimising sedentary behaviour may include:

- Reducing time spent watching TV
- Taking regular walk breaks around the garden or street
- Breaking up sedentary time such as swapping a long bus or car journey for walking part of the way

What are the benefits of being active daily?

- Helps maintain cognitive function
- Reduces cardiovascular risk
- Helps maintain ability to carry out daily living activities
- Improves mood and can improve self-esteem
- Reduces the risk of falls

For further information: *Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers* (2011)

DHSSPS Department of Health, Social Services and Public Safety

The Scottish Government

Llywodraeth Cymru Welsh Government

DH Department of Health

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Handout 10– Tips on managing stress and anxiety

- Challenging unhelpful thoughts
- Accepting that you can't do or control everything
- Problem solving and time management
- Mindfulness
- Relaxation
- Breathing
- Staying active
- Feeling in control and positive
- Having some time out - 'me time'
- Balanced diet including drinking plenty of water
- Try and get adequate amount of sleep

Do something to pick you up (elevate your mood)

Remind yourself that this phase will pass

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Handout 13 – Communication with your doctor – GP checklist

Questions to consider before vising your GP

1. What is your reason for going to see your GP?

2. What questions do I want to ask?

3. Will my GP be able to do anything different from my last visit?

4. Do I have any ideas to help myself that my GP might be able to offer me support with?

TIPS:

- Describe symptoms clearly
- Write down your questions so you do not forget
- Write down the answers you get from the GP if it helps you to remember
- Take someone with you to the consultation so that they can act as a second pair of ears

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CLINICAL TRIALS UNIT

Handout 14 – Useful contacts

- Migraine Action - http://www.migraine.org.uk/
- The Migraine Trust - https://www.migrainetrust.org/
- National Migraine Centre -http://www.nationalmigrainecentre.org.uk/

This project was funded by the National Institute for Health Research- Programme Grants for Applied Research (project number RP-PG-1212-20018). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR, NHS or the Department of Health. IRAS ID: 215304

Funded by NIHR

CHESS
Chronic Headache Education and Self-management Study

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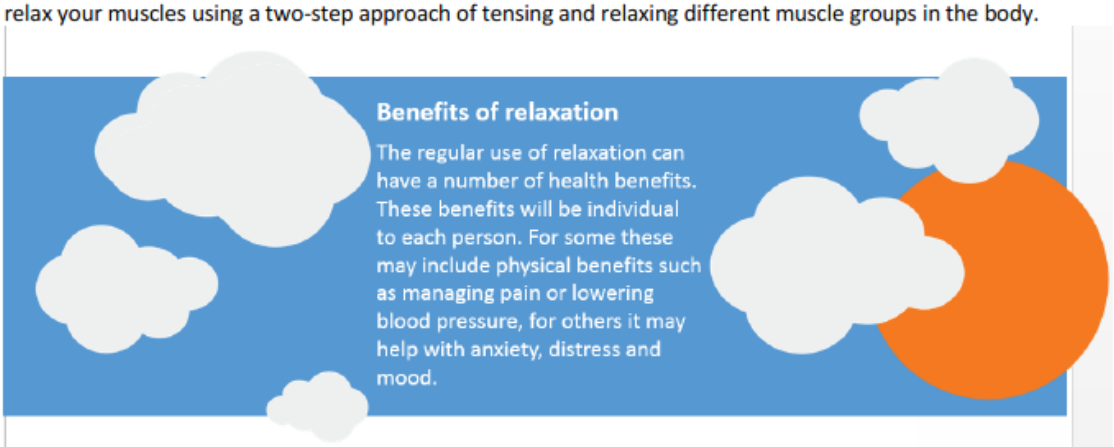
A Guide to Using your Relaxation CD

You will find enclosed a relaxation CD which consists of one track which lasts XX minutes. Alternatively the audio track can be downloaded from the following link: <Insert Link>/password?

This track will take you through a progressive muscle relaxation. This method of relaxation teaches you how to relax your muscles using a two-step approach of tensing and relaxing different muscle groups in the body.



Using your CD:

- We recommend that you use this CD 2-3 times a week or as often as you feel is appropriate.
- We ask that you use the CD for the duration of the study, up until your final follow up questionnaire at 12 months. You are, of course, free to continue using it after this if you want to.
- You can use the CD at any time of day, when you find you have time to take a moment away from your daily activities.
- It is advisable that you use the CD sitting in a relaxed position, fully supported, in a quiet, comfortable space.
- We do **not** recommend that you use the CD whilst driving or operating heavy machinery.
- You do **not** have to stop using other methods of relaxation, this CD can be used in addition to these.

It may take time for you to become comfortable with relaxing and the relaxation technique. Try to keep practicing regularly.

Should you have any questions please call the CHESS Study team on:
Tel: 02476 151 634 or email: CHESS@warwick.ac.uk

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CHESS Relaxation CD Instructions V1.0 13Mar2017. IRAS reference ID: 215304

Mindfulness Practices

It is useful to set aside some time each day to take a formal practice. The start of the day is a good time; perhaps linking your mindfulness practice to something else you do routinely to establish it as a habit. Some people also find it beneficial to practise at the end of the day to let go of a busy day at work. Remember, it is *better to take a regular mindfulness practice*, so you may like to start with a short one you can sustain and once established increase the length of time, rather than saving up for a marathon session.

Mindfulness is not "a quick fix solution" it takes time and with practise you will notice benefits. Often you may feel that "you are not getting anywhere" or that "you must be doing something wrong". There is no right or wrong experience; you are cultivating being with your experience as it is. This refers to both your external and your internal experience (thoughts, bodily sensations and feelings). We can almost develop a distance or "give some space" to our experience so that we *learn to respond rather than react*.

Setting intention by adopting a dignified posture. Each time you take a practice you will be guided to adopt a "dignified" posture. This is typically sitting and is an upright but not rigid posture; it should be comfortable enough so that you can maintain it with ease for the duration of the practice. Ideally, you don't want to be distracted by your posture or add extra tension as this will be detrimental. Experiment, and if you find while practising you are uncomfortable you can choose to adjust your posture but rather than reflexively moving try being mindful how you move.
If taking an informal short practice, this may be standing; you will be invited to make a deliberate change in your posture that signifies coming off "automatic pilot" and being fully present. You may choose to simply stand still, a little more upright, relaxed but not stiff.

Selecting a practice. A number of practices are available on the CD. You may like to start by taking a short informal practice, such as **PAUSE** to become more mindful throughout your day, before moving on to a formal attention training practice such as a **Breath Awareness** practice.

Practices focusing on body sensations such as the **Body Scan** continue to train attention but increase body awareness and get us "out of our heads". Increased body awareness enables us to get in touch with physiological signals from the body, which provides us with important information. Emotions themselves are just physiological signals, if we recognise them as such, then we are better able to be aware of emotions arising and use these as early warning signs rather than amplifying them. This means we can use the body as a barometer for stress, anxiety and low mood and learn to better manage them.

As we progress practices become more exploratory. **Mindfulness of thoughts** encourages practising watching our thoughts without getting caught up in them, becoming aware that "thoughts are just thoughts" and are not facts. Like body sensations they are transient, they come and go. As we observe thoughts we begin to gain insight into "what makes us tick". Overtime we start to dis---identify with those thoughts that exacerbate pain.

There are also practices that can be used to work with both pain and stress. We know that holding tension in the body increases pain and signifies a stress response **identifying and learning to release tension** is beneficial to reducing both. **Exploring pain** can be a useful practice, looking at approaching and accepting difficulties as a means to reducing resistance and the tendency to add extra layers to pain.
Short "first aid" practices can be used to help anchor us back to the present moment when we are feeling overwhelmed **Breath & Body as an Anchor** and the **Breathing Space** can be used to step back, pause and gain perspective.

Mindfulness CD

	Practice	How to use it	Benefits
1.	**PAUSE**	Use throughout the day to increase mindfulness. Set times/reminders to take a short practice and bring yourself back to the present moment.	Step out of "automatic pilot" become more mindful.
2.	**Identifying & releasing tension** **(With simple movements)**	This can be used during the day to raise awareness of tension held in the body and our tendency to "brace" against experiences we don't want such as pain. Actively scanning for tension and exploring how the body feels when tensed compared to relaxed allows us to recognise triggers for stress. Simple movements provide extra focus for an agitated mind and help switch on the relaxation response.	Reduce stress. Help "Turn down the volume" on pain by not bracing against it. Switch on relaxation response.
3.	**Breath Awareness (Short practice)** **10 mins**	This formal practice can be taken on a regular basis to train attention. Focus is on the sensations of breathing; when you notice that your mind is wandering bring it back to focus on the breath.	Gather a "scattered" mind. Brings calm.
4.	**Breath Awareness Extended** **(Cultivating attitudes) 20 mins**	This extended practice can be used to refine training attention by further exploring how we pay attention – looking at the approach we bring.	Develops openness free from prior expectations and assumptions Brings clarity
5.	**Body Scan (Short Practice) 15 mins**	This formal practice continues to train attention using body sensations and explores with a narrow and broad focus of attention. Here we are also tuning in to body sensations, increasing body awareness.	Reconnects mind and body. We learn to notice the difference between sensing a sensation and thinking about a sensation.
6.	**Body Scan Extended. (Cultivating attitudes) 25 mins**	This extended practice is used to further increase awareness of body sensations. As we practise we are aware of accompanying thoughts and emotions arising in relation to body sensations. As they do we can cultivate how we approach them with an equanimity and curiosity.	Learning to tune into the body we are able to develop personal signatures for emotions. Body as a barometer for emotions arising.
7.	**Observing thoughts 10 mins**	This formal practice uses the breath and bodily sensations to steady and calm the mind before opening up to observe thoughts. Here we watch thoughts come and go without getting caught up in them. Aware that "thoughts are not facts."	Gain insight into what goes on in our heads and what pulls our attention away from being fully present.
8.	**Exploring pain – Turning towards**	This formal practice explores approaching pain. Turning towards may be counter----intuitive. Here we are learning to "soften" and be open rather than resisting, which adds extra layers.	How to be with pain in a different way. May turn down the "volume" of pain.
9.	**Breath & Body as an anchor**	This short practice is used as an anchor back to the present moment and gets us "out of our heads."	Grounding.
10.	**Breathing Space**	This short practice allows us to step back and gives "space" for our experience to unfold.	Gain perspective and learn to respond.

Additional Material for Facilitators

Relaxation script *(read slowly with a calm low voice)*:

Welcome to this relaxation practice.

Please make yourself comfortable; ensuring that as much of your body is supported as possible including your arms and your feet. If you are seated rest your arms on the arms of the chair, or on your lap, with your feet flat on the floor. Make sure your legs and arms are not crossed. Don't worry if you need to move during the relaxation; just make sure you are as comfortable as can be. Make sure you are warm, particularly your hands and feet.

First, close your eyes, feeling your body supported and just listen to the noises around you. You may hear some noises outside, focus on these noises……really listen to what you can hear.

Pause (count slowly 1 and 2 and 3 and 4)

Now focus on the noises in the room and around you. What can you hear? Really listen to the sounds around you.

Pause (count slowly 1 and 2 and 3 and 4)

Now become aware of the sound of your own breathing, in and out. Visualise the air as it moves around and through you, your abdomen gently rising and falling as you breathe.

Pause (count slowly 1 and 2 and 3 and 4)

Now slow your breathing down, and take a slightly longer breath in……. and breathe out again. Let the breath out of your body nice and slowly, all the way out.

Remember, slow your breathing down, and take a slightly longer breath in, all the way in……. and breathe out again. Let the breath out of your body nice and slowly, all the way out.

Just nice and slow easy breathing, letting your body relax, feeling heavy and supported.

Pause (count slowly 1 and 2 and 3 and 4)

Now I will ask you to focus your attention on various muscles in your body. I will ask you to tense those muscles. If you feel uncomfortable at any point just relax and breathe normally.

Pause (count slowly 1 and 2 and 3 and 4)

Bring your awareness to your feet and to your toes. As you breathe in, clench your toes and tense the muscles in your feet. Try and hold this feeling, as you breathe out release and relax your feet and toes. Experience the tension float away and notice how relaxed you now feel.

Pause (count slowly 1 and 2 and 3 and 4)

Move your attention up towards your ankles and calves. As you breathe in tense this part of your body. Hold this tense feeling, as you breathe out release and relax your ankles and calves. Experience the tension float away and notice how relaxed you now feel.

Pause (count slowly 1 and 2 and 3 and 4)

Focus your attention on your knees. As you breathe in tense this part of your body. Try and hold this feeling. As you breathe out release and relax your knees. Experience the tension float away and notice how relaxed you now feel.

Pause (count slowly 1 and 2 and 3 and 4)

Now bring your attention to your upper legs. As you breathe in tense this part of your body. Try and hold this feeling. As you breathe out release and relax your upper legs. Experience the tension float away and notice how relaxed you now feel. Breathe in and out and on the outward breath really relax and feel any tension disappear.

Pause (count slowly 1 and 2 and 3 and 4)

Become aware of your buttocks. And as you breathe in tense this part of your body. Try and hold this feeling. As you breathe out release and relax your buttocks. Experience the tension float away and notice how relaxed you now feel. Breathe in and out and on the outward breath really relax, sinking down, nice and heavy, nice and relaxed.

Pause (count slowly 1 and 2 and 3 and 4)

Focus your attention now on your tummy muscles. Feels these muscles move up and down as you breathe slowly and calmly. As you breathe in tense your tummy muscles. Try and hold this feeling. As you breathe out release and relax. Experience the tension float away and notice how relaxed you now feel. Breathe in and out and on the outward breathe really relax, sinking deeper and deeper into a calm and relaxed feeling.

Pause (count slowly 1 and 2 and 3 and 4)

Bring your attention to your back muscles. Breathe in and out, nice and slowly, nice and relaxed. On your next breath, breathe in and arch your back slightly and tighten these muscles. Try and hold this feeling. As you breathe out release and relax your back. Experience the tension float away and notice how relaxed you now feel. Breathe in and out and on the outward breath really relax and feel any tension disappear.

Pause (count slowly 1 and 2 and 3 and 4)

Take your awareness to your shoulders. As you breathe in bring your shoulders to your ears and feel the tension. Try and hold this feeling. As you breathe out release and relax your shoulders, letting them hang and allowing the tension to float away, and feel deeply relaxed.

Pause (count slowly 1 and 2 and 3 and 4)

Focus your attention on your arms and hands. As you breathe in clench your fists and tighten the muscles in your arms. Try and hold this feeling. As you breathe out release and relax your arms, and hands. Feel the tension disappear from your upper arms, your elbows, your forearms, your wrists, your hands and your fingers. Let everything relax, nice and loose.

Pause (count slowly 1 and 2 and 3 and 4)

Take your awareness to your neck, notice any tension you may have. As you breathe in tense this part of your body. Try and hold this feeling. As you breathe out release and relax. Experience the tension float away and notice how relaxed you now feel. Breathe in, and out, and on the outward breath, really relax. Feel the tension disappear, let your neck relax.

Pause (count slowly 1 and 2 and 3 and 4)

Enjoy the feeling of being relaxed.

Take you awareness to your face and head. As you breathe in tense the muscles in your face. Try and hold this feeling. As you breathe out release and relax. Experience the tension float away and notice how relaxed you now feel. Notice your forehead has smoothed out, how your jaw and mouth are now relaxed.

Pause (count slowly 1 and 2 and 3 and 4)

Feel your whole body nice and relaxed. Enjoy this moment and know when you are tense you can always do this on your own and feel the tension disappear.

Pause (count slowly 1 and 2 and 3 and 4)

Bring your awareness to your breath, breathe in and out nice and slowly. Start to become more aware of the sound of your breathing, in, and out.

Now start to notice the sounds around you, gradually becoming more aware of the room, aware of your toes and your fingers.

And when you are ready, slowly open your eyes. Gently wiggle your fingers and toes. Breathe deeply and stretch.

This is the end of the relaxation practice

END

Mindfulness CD to be used. Please select a track based on the time you have for this taster activity. The details of the tracks are provided on the mindfulness handout.

Mindfulness as a Tool: Managing Chronic Headaches

"Mindfulness is the awareness that emerges through paying attention on purpose, in the present moment and non----judgementally to things as they are"

Williams, Teasdale, Segal and Kabat-Zinn [1]

Too often in our busy lives we find ourselves operating on "automatic pilot" being mindless as we go about our daily activities and work. When we are operating like this we are more likely to get hijacked by our emotions and fall into reactive patterns of behaviour. Furthermore, we frequently get caught up in the stories in our heads creating a mental model of how things are and how they will be. If we are in physical pain we can exacerbate this by adding extra layers. [2]

Mindfulness can help by allowing us to come off automatic pilot and see experience as it is rather than as we think it is. We cannot change our experience but we can change how we relate to it.

Mindfulness has been shown to be beneficial in managing pain. While research continues to look at how this works in terms of chronic headaches, it is thought that it might be by changing how we interpret pain or through a therapeutic effect on other factors playing a role in headache, such as improved emotion regulation, less pain catastrophising, and increased pain acceptance. [3]

"Attending mindfully to the experience of pain may detach the cognitive and emotional components of pain from the sensory components"

Dr Jon Kabat-Zinn, 1982 [4]

Mindfulness can simply be considered as training for the brain and practising mindfulness has been shown to change the brain in a positive way. It improves cognitive faculties, emotional regulation and stress resilience. People regularly practising mindfulness report benefits such as improved concentration, wellbeing and better sleep. In clinical studies looking at chronic illness, improved quality of life has been a consistent finding.

Training mindfulness

We can practise mindfulness both formally and informally. Formal practice is through mindfulness meditation and there are a series of practices given on the CD to guide you. Informally, we can increase how mindful we are by deliberately choosing to pay attention to everyday activities such as walking, eating or taking a shower.

How to Practise Mindfulness

There are considered to be three components in training mindfulness: Intention, Attention and Attitude. [5] Setting our intention helps motivate us and when practising becomes difficult it is useful to re-visit this. When we take a formal mindfulness practice we also "set our intention" to practise by adopting a "dignified" posture (see below)

It is worth remembering that mindfulness is simply "exercise" or training for the brain and that by taking just 10 minutes regular practise you can change your brain.

Key to practising mindfulness is training attention. We know that our minds like to wander, in fact nearly half the time our minds are not where we intended them to be, we are on "automatic pilot", and when that is the case we are unhappy. [6] We train attention by selecting a focus for attention such as the breath, sensations of breathing or body sensations. As we practise we notice that the mind wanders and we "gently" bring it back to where we intended it to be. This is "flexing our mindfulness muscle" and is what brings about changes in the brain. Although we are training attention mindfulness is more than just a concentration exercise. We also train how we pay attention, which is the third component of mindfulness.

The attitude or approach that we cultivate when practising mindfulness is curiosity and kindness. We let go of the reactive harsh judgemental attitude that often comes in, such as "*I am useless*" or "*This won't work*" and replace it with an open interest, a curiosity. The ability to distance ourselves from our thoughts, letting go of our assumptions and preconceptions, allows us to shift perspective, which is central to how mindfulness works in changing how we relate to experience. [7]

In mindfulness training a number of attitudes have been suggested. Dr Jon Kabat-Zinn refers to the seven foundational attitudes: Non-judging, Patience, Beginners mind, Trust, Non-striving, Acceptance and Letting go. [8] You may like to explore these in your formal practice or apply them to your daily activities. Conveniently, there are seven so you could try one for each day of the week.

Professor Mark Williams considers the two different modes of mind, the one caught up in "*Overthinking*" on autopilot, and the fully present mindful one, that is just "*Being*" with experience as it is, through sensory perception. [9] This is why when we practise mindfulness the first step is to deliberately come off "automatic pilot "and shift to being fully present and as we do so we often turn our attention to the body, to actual physical sensations, and away from thinking about our experience.

Overtime, as we practise, we are able to look at the content of our thoughts without getting dragged into them. We can begin to see the familiar patterns that come round and those thoughts that drag us away from being fully present. Through this we develop self-awareness and insight, understanding what we do and why? This leads to skillful action, awareness of choice, and the ability to respond rather than react to events, leading to more flexible adaptive behaviour and the reduction of stress and anxiety.

If you wish to explore mindfulness in further detail or follow a structured course we recommend the books highlighted in blue in references 2 and 9. Please note any specific references to pharmacological pain management may not apply to chronic headache, so please discuss with your consultant.

Mindfulness Practices

It is useful to set aside some time each day to take a formal practice. The start of the day is a good time; perhaps linking your mindfulness practice to something else you do routinely to establish it as a habit. Some people also find it beneficial to practise at the end of the day to let go of a busy day at work. Remember, it is *better to take a regular mindfulness practice*, so you may like to start with a short one you can sustain and once established increase the length of time, rather than saving up for a marathon session.

Mindfulness is not "a quick fix solution" it takes time and with practise you will notice benefits. Often you may feel that "you are not getting anywhere" or that "you must be doing something wrong". There is no right or wrong experience; you are cultivating being with your experience as it is. This refers to both your external and your internal experience (thoughts, bodily sensations and feelings). We can almost develop a distance or "give some space" to our experience so that we *learn to respond rather than react*. The Breathing Space, a key practice in Mindfulness based cognitive therapy (MBCT) is useful for this. [10] *This changing perspective leads to more flexible adaptive behaviour and enables us to face difficulties and be with new experiences even challenging ones.*

Setting intention by adopting a dignified posture. Each time you take a practice you will be guided to adopt a "dignified" posture. This is typically sitting and is an upright but not rigid posture; it should be comfortable enough so that you can maintain it with ease for the duration of the practice. Ideally, you don't want to be distracted by your posture or add extra tension as this will be detrimental. Experiment, and if you find while practising you are uncomfortable you can choose to adjust your posture but rather than reflexively moving try being mindful how you move.

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References

[1] Williams JM, Teasdale J, Segal Z and Kabat-Zinn J (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness.* London: Guildford Press

[2] **Burch V. & Penman P. (2013).** ***Mindfulness for Health: A practical guide to relieving pain, reducing stress and restoring wellbeing.*** **London: Piatkus**

[3] Wells *et al*. (2014) Meditation for Migraines: A Pilot Randomised Controlled Trial Headache 54:1484-1495

[4] Kabat-Zinn J. (1982). An outpatient program in behavioural medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. Gen Hosp Psychiatry 4:1 33-47

[5] Shapiro S.L., Carlson L.E., Astin J.A. & Freedman B. (2006). Mechanisms of mindfulness. J Clin Psychology. 62: 373-386

[6] Killingsworth M.A. and Gilbert D.T. (2010). A Wandering Mind is an Unhappy Mind Science Vol. 330 no. 6006 p. 932 DOI: 10.1126/science.1192439 BREVIA

[7] Shapiro S.L. et al. (2006) As above.

[8] Kabat-Zinn J. (1990). *Full catastrophe living: How to cope with stress, pain and illness using mindfulness meditation.* NY: Delta Publishing.

[9] **Williams M. and Penman D. (2011).** *Mindfulness a practical guide to finding peace in a frantic world.* **London:Piatkus**

10 Segal Z. V., Williams M. G., & Teasdale J. D. (2013). *Mindfulness based cognitive behaviour therapy for depression.* (Second Edition) New York: Guildford.

	Practice	How to use it	Benefits
1.	**PAUSE**	Use throughout the day to increase mindfulness. Set times/reminders to take a short practice and bring yourself back to the present moment.	Step out of "automatic pilot" become more mindful.
2.	**Identifying & releasing tension** **(With simple movements)**	This can be used during the day to raise awareness of tension held in the body and our tendency to "brace" against experiences we don't want such as pain. Actively scanning for tension and exploring how the body feels when tensed compared to relaxed allows us to recognise triggers for stress. Simple movements provide extra focus for an agitated mind and help switch on the relaxation response.	Reduce stress. Help "Turn down the volume" on pain by not bracing against it. Switch on relaxation response.
3.	**Breath Awareness (Short practice)** **10 mins**	This formal practice can be taken on a regular basis to train attention. Focus is on the sensations of breathing; when you notice that your mind is wandering bring it back to focus on the breath.	Gather a "scattered" mind. Brings calm.
4.	**Breath Awareness Extended** **(Cultivating attitudes) 20 mins**	This extended practice can be used to refine training attention by further exploring how we pay attention – looking at the approach we bring.	Develops openness free from prior expectations and assumptions Brings clarity
5.	**Body Scan (Short Practice) 15 mins**	This formal practice continues to train attention using body sensations and explores with a narrow and broad focus of attention. Here we are also tuning in to body sensations, increasing body awareness.	Reconnects mind and body. We learn to notice the difference between sensing a sensation and thinking about a sensation.
6.	**Body Scan Extended. (Cultivating attitudes) 25 mins**	This extended practice is used to further increase awareness of body sensations. As we practise we are aware of accompanying thoughts and emotions arising in relation to body sensations. As they do we can cultivate how we approach them with an equanimity and curiosity.	Learning to tune into the body we are able to develop personal signatures for emotions. Body as a barometer for emotions arising.
7.	**Observing thoughts 10 mins**	This formal practice uses the breath and bodily sensations to steady and calm the mind before opening up to observe thoughts. Here we watch thoughts come and go without getting caught up in them. Aware that "thoughts are not facts."	Gain insight into what goes on in our heads and what pulls our attention away from being fully present.
8.	**Exploring pain – Turning towards**	This formal practice explores approaching pain. Turning towards may be counter----intuitive. Here we are learning to "soften" and be open rather than resisting, which adds extra layers.	How to be with pain in a different way. May turn down the "volume" of pain.
9.	**Breath & Body as an anchor**	This short practice is used as an anchor back to the present moment and gets us "out of our heads."	Grounding.
10.	**Breathing Space**	This short practice allows us to step back and gives "space" for our experience to unfold.	Gain perspective and learn to respond.

Role play – Communicating with GPs (Session 17)

Role Play 1

Dr: Good morning Mrs Smith. What can I do for you today?

Pt: My headache has been really bad this last week, but I haven't done anything different to normal. It's been really awful, it's so bad I didn't get to work on Monday. I was feeling really sick and just wanted to be in a dark room. I'm struggling to keep up with everything at home and at work, I'm really worried, I can't sleep, my medication isn't helping and I'm worried there might be something seriously wrong with me. What can you do? Can you give me different medication and send me for a scan?

Dr: Well let me see what you are taking now, if I remember rightly when I saw you last you were taking (looks up in notes)..... ah yes.....yes.....OK. I am reluctant to increase this dose as we have only just changed it recently..... now let me see.

Pt: But my headaches seem to be worse, what else can you do?

Dr: Well taking too much medication can be problematic therefore I am very reluctant to give you more at this stage.

Pt: But what about another scan? I just want the headaches to go away.

Dr: Well, we have already ruled out any serious problems. Why don't we just keep trying these tablets for a bit longer and see how you go? Is there anything else you would like to discuss?
.....

Role Play 2

Dr: Good morning Mrs Smith. What can I do for you today?

Pt: Good morning Dr. I've come here today because my headaches are worsening and I would like to discuss my medication with you. I need to check that I am taking it correctly and in the most effective way to make it work better for me. My headaches are particularly bad when I have slept badly and when I am stressed it's this that I would like to focus on.

Dr: Yes of course, can you describe the headaches and tell me how and when you take you medication.

Pt: My headaches seems to vary, sometimes I get headaches that start in the morning but then seem to ease off as the day goes on. I can usually get on with things if I take 2 ibroprofen. A few times a month I get really bad headaches that seems to last a couple of days, when I get these I feel really nauseous and don't like the light therefore have to close myself off in to a darkened room. If this has happened when I am at work I have had to wear sunglasses, which then everyone will comment on! When I get these types of headaches even taking a regular dose of ibroprofen and paracetamol does not help.

Dr: That's really useful information, I suggest that we start you on a triptan which is a specific treatment for migraine as it sounds like you are having some episodes of tension headaches and other episodes of migraines which have different features. (Dr goes on to explain how to take the medication and gives lifestyle advice). I would like to review your progress in three months therefore please do book an appointment to come and see me.

Pt: Thanks I'll try that and let you know how I am getting on in a few months. Goodbye Dr.

Facilitators need to highlight in role play one:

- How might the patient feel at the end of this consultation?
- How might the doctor feel after the consultation?
- The different agendas of the patient (more drugs and tests) and the doctor (side effects of the drugs and reluctance to give more unnecessary tests).
- Patient spends a lot of time explaining the impact, but is not very specific or concise about the headache
- The purpose of the visit appears to be 'to make the headaches go away', ask the group if this is reasonable expectation considering a long history of headaches.

Facilitators need to highlight in role play two:

- What do the group notice that's different
- How might the patient feel at the end of this consultation?
- How might the doctor feel after the consultation?
- Clear purpose of visit
- Concise description of headaches with distinction made for different types of headaches

References

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