**COGNITIVE BEHAVIORAL THERAPY IS A GOOD TREATMENT FOR MIGRAINE**

**Frank Andrasik.**
*Department of Psychology, University of Memphis, Memphis, Tennessee, USA*

It is clear that various abortive and prophylactic medications are indeed helpful for many patients with migraine. My distinguished colleague, Dr. Lampl, will certainly provide an excellent summary of these investigations. However, several things need consideration when evaluating the role of medication. Among these are the following. 1.Not all patients are helped to a significant degree, thus other treatments are often needed. 2. Adherence to medication can be poor: less than 60% of migraineurs have been found to properly adhere with medication[1], 20-25% do not comply with prophylactic medications[2-7], and 10-20% of prescriptions are never filled[2,8,9]. 3. Overreliance on certain medications can actually worsen headache, leading to a condition known as medication overuse headache (MOH). Ergotamine preparations, triptans, analgesics, and opioids are among the leading candidates for promoting MOH. 4. Medication options with certain patients are limited. 5. Cognitive and behavioral factors can greatly influence the course of headache[10,11].

Cognitive behavioral therapy (CBT) places more demands on patients, but this heightened involvement has several distinct advantages. It can increase confidence in the patient to prevent, manage, and cope with pain, which in turn can leads to reductions in pain-related disability[12]. Further, patients who attribute improvement to their own efforts (versus a medication) reveal better long-term maintenance[13]. CBT has an extensive base of evidence, including support from reviews completed by many expert panels (most notably the US Headache Consortium, which consisted of representatives from 7 professional medical societies-American Academy of Family Physicians, American Academy of Neurology, American Headache Society, American College of Emergency Physicians, American College of Physicians, American Osteopathic Association, and National Headache Foundation)[14] and numerous meta-analytic reviews[15-27]. The US Headache Consortium gave the following treatments their highest level of support-Grade A evidence, meaning the procedures were considered as treatment *options* for prevention of migraine: relaxation, thermal biofeedback combined with relaxation, electromyographic biofeedback, and cognitive behavior therapy (or stress coping training). The US Headache Consortium noted instances where CBT warranted special consideration: when patients prefer a nondrug approach (which is increasingly becoming the case); drug treatment cannot be tolerated or is medically contraindicated; response to drug treatment is absent or minimal; the patient is pregnant, has plans to become pregnant, or is nursing; there is a history of frequent or excessive use of analgesic or other acute medications; and there is significant life stress or the patient has deficient stress-coping skills.

These evidence-based reviews and meta-analyses have shown that CBT can rival the effects for certain medications, that CBT can enhance the effectiveness of medication alone (the US Headache Consortium rated the combination as Grade B level but more recent published studies suggest the higher Grade A level may now be warranted[28]), and that CBT effects are “real” and can impact pain pathways deep within the brain (as judged from laboratory studies when effects of components of CBT have been examined by fMRI)[29-31].

CBT begins with a great deal of education, which can be of high value alone when dispensing medication. It is the patient who decides which attacks to treat, when to treat, how to treat, and what, if any, behavioral or lifestyle changes will be attempted. A study comparing routine administration of abortive medications to a treatment that incorporated very specific education (like that typically included in CBT) found both a greater level of compliance and effectiveness for the medication[32].

MOH overuse is being increasingly recognized as a problem among headache sufferers. Even when effectively treated with medication, relapse rates are high. For example, a study with 4 years of follow-up showed the following rates of relapse for specific medications: 71% for analgesics, 27% for ergotamine preparations, and 21% for triptans[33]. Our research has shown that adding components of CBT when treating patients with chronic migraine combined with MOH (mainly overuse of analgesics) improved long term outcome overall at 3 years and significantly reduced rates of relapse[34].

In summarizing the value of CBT, perhaps Dr. Lake[35] said it best: ““Patients learn to restructure their cognitive approach to pain, in essence learning how to tolerate discomfort, reduce pain-related emotional distress, stop the overly frequent pharmacological preemptive treatment of an impending headache, and reduce limbic escalation of the pain experience. If reinforced and maintained over time, these learned behaviors can help reduce the likelihood of overusing pain medication and MOH relapse.”

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