DEBATE: BEHAVIORAL THERAPY AND MEDICATION ARE BOTH NECESSARY FOR THE COMPLETE TREATMENT OF MIGRAINE: YES

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Ninan Mathew (1981) decades ago provided evidence suggestive of the enhanced value of adding behavior therapy (in this case biofeedback) in the treatment of migraine and migraine combined with tension-type headache. I say *suggestive* because our experimental designs back then typically did not possess the level of rigor that has become the standard today. Approximately a decade and ½ ago the US Headache Consortium visited this topic and determined the combination of medication and behavioral treatments warranted the distinction of Grade B level of evidence. More recently major large scale efficacy trials for both *chronic* migraine and tension-type headache, published within leading medical journals, have provided clear evidence that a combined approach exceeds the outcome achieved by either treatment alone. Finally, an effectiveness trial showed the combination of treatment to be superior to medication alone when treating chronic migraine combined with medication overuse headache at a three-year followup. Perhaps of most interest was the finding of significantly lower relapse to MOH for the group receiving combined treatment. So, as regards the *capsule* statement, which focuses on chronic forms of headache, the answer seems a clear "yes."

Returning to the debate title (behavioral therapy and medication are both *necessary* for the complete treatment of migraine), the answer may merit a more *qualified* yes. Why a *qualified* yes? As a clinical psychologist and someone who has seen headache patients for nearly 4 decades, I have worked with a number of cases where education alone (typically instructing about the proper use of medication), medication alone, or medication withdrawal has been sufficient for reducing headaches to a more manageable level. These cases are increasingly rare, but one can always find an exception. As a general rule and as we have become to realize that headache is a complex mix of biological, psychological, and social factors, interventions involving more than medication are increasingly being found as necessary. The US Headache Consortium was perhaps the first group to point out when nonpharmacological approaches were the preferred approach for certain headache conditions. Bigal and Lipton identified a number of risk factors for headache, many of which would be best addressed by behavioral procedures. Also, as we delve more deeply into headache, we find it is often accompanied by major psychological comorbidities, all of which respond to psychological approaches and some of which may be uniquely suited for such approaches.

One final point is worth consideration. Headache is present in young children, and its prevalence increases over time. Some have argued that headache prevalence may actually be increasing over time, due to increased stress, family dynamics, etc. Should medications, many of which are untested with children and whose effects upon development are unknown, be the first line of treatment? A wealth of evidence suggests behavioral approaches are effective and no less effective than medications. In such cases I would argue that *both* are not necessary. In fact, I would argue that more often than not that behavioral approaches might be all that is necessary.