Proposition: Behavioral therapy is necessary for the complete treatment of chronic migraine.
Capsule: Medication and psychological intervention are often used in primary headache disorders. Are both necessary?
Position: No
Frank Andrasik, Ph.D., Distinguished Professor and Chair, Department of Psychology, University of Memphis, Memphis, TN, USA

All treatments for headache serve 1 or more of 3 functions. One is to abort an existing attack, another is to relieve pain when headache is present, and the other is to prevent occurrence of future headache attacks. This presentation reviews the evidence base for medication and psychological interventions for achieving each of these aims, paying special attention to the qualifiers “necessary” and “complete”. Numerous well-designed clinical trials support the utility of various medications, primarily triptans, for aborting migraine attacks. Only one psychophysiologically-based approach—blood volume biofeedback for constricting blood flow in the temporal artery—purports to serve abortive functions. Although developed and designed with this intent in mind, not a single investigation has attempted to examine if it indeed serves this purpose (or what is its exact mechanism of action). Evidence is similarly lacking to support the notion that psychological approaches alone have palliative effects for existing headaches, while evidence does support medication as lessening intensity of extant headaches. The major thrust of psychologically-based treatments for headache can thus be considered as focusing on prevention of future attacks. In this regard, both treatment approaches (medication and psychological) have been shown to be of value to chronic migraineurs. Again, numerous well controlled trials and qualitative and quantitative reviews (meta-analyses) support the efficacy of varied prophylactic pharmacological agents (anti-epileptics, beta-blockers, botulinum toxin, etc.) for reducing key headache parameters. With very few exceptions, the clinical trials examining psychological prophylaxis have been confounded by allowing patients to continue on their current medication regimes. Meta-analyses comparing medication and these “confounded” psychological treatments generally find similar outcomes, raising questions about the unique contributions of the psychological interventions. Only a few large-scale clinical trials have compared “unconfounded” psychological treatments to medication alone, with both forms of treatment being found to produce similar effects. The combination of the 2 different treatments in these limited trials has shown some additive effects. Having presented this brief review of the evidence, it is time to return to the central aspects of this debate—are both treatments *necessary* for *complete* treatment? The conclusion has to be a definitive *no*, for two main reasons. 1. Psychological treatments have yet to show any clinical utility for aborting or palliating existing headaches. For many patients, medications are not only sufficient, but they are the only approach with supportive evidence for these purposes. For many patients, medication alone provides the level of relief they are seeking (and thus may be considered complete). 2. As a substantial number of migraine patients respond well to prophylactic medications, one must ask what is the incremental utility of additionally pursing psychologically-based treatments, given they require special training that few providers have, are often effort-intensive, sometimes require specialized devices (in the case of biofeedback), are not widely

available, have yet to be routinely imported into primary care and specialty settings where treatment is typically administered, and often are not covered by third party payers. It may turn out to be the case that a small percentage of migraineurs will find it *necessary* to pursue both treatment options (perhaps others as well), but the research existing at present provides very few insights into deciding which patients might in fact *need* or even *want* a combination of treatments, nor is there a solid basis for deciding what in fact constitutes *complete* treatment.