

THE PSYCHIATRIST'S TOOLBOX

A Hypno-Behavioral Approach to Migraine

For thousands of years, medical scientists and clinicians have studied and tried to treat the painful and often debilitating headache that is migraine. In my experience of treating patients with chronic pain, headache—particularly migraine—has been the most common problem.

Hippocrates used the word “hemicrania” to describe the unilateral headache that often marks the beginning of the headache phase of what we call migraine. It is more accurate, though, to describe migraine as a vascular headache.

Traditionally, two main types of migraine/vascular headache have been described: classic and common. The classic type involves neurologic symptoms such as flashing lights (scotomata), hemioptic visual loss, multiple paresthesias around the mouth and hands, and even aphasia. In the common type of migraine/vascular headache, the neurologic symptoms are absent but the unilateral, severe recurrent headache remains, coupled with the associated problems of nausea/vomiting, malaise, and light sensitivity that are seen in both types.

The exact chemistry leading to the dilation of one or more branches of the carotid artery—gene-related peptides, serotonin substances, or histamines acting together or alone—is still unclear. Theories about what may trigger these headaches in different people abound. Some deal with diet, others with genetics, environment, and emotions. One thing, however, is clear from my experience: There is no migraine-specific personality, as traditional psychotherapists claim.

Complaints of headache are surely among the top 10 reasons people visit doctors' offices. Prescribed and over-the-counter headache remedies are big sellers, and many medications afford tremendous relief to vascular headache sufferers. Certain groups of people, though, do not get relief from medications; others want to try a different approach.

For those two sets of patients, I have developed a treatment strategy using my learning, philosophizing, and action (LPA) technique. For psychiatrists or psychotherapists treating pain, including

headache, it is critical that a primary care or other specialist has referred the patient with their evaluation. If the patient comes to us without a referral, we must refer the patient for an evaluation of the pain pattern before beginning any psychotherapeutic treatment.

Distinguishing a benign headache pattern from more serious illnesses that cause headache is key. We do not want to “shrink” someone who has a brain tumor or needs new glasses.

In the LPA technique, the learning and action phases are usually most operable. For example, if bright or flashing lights precipitate the headache or if certain medication, foods, or environmental factors can be isolated, we should advise the patient to avoid those situations if at all possible.

If emotional stressors leading into the headache pattern are the culprit, elimination of those stressors is critical. If that is not possible, we need to move into the cognitive-behavioral model of learning to get a new perspective on a recurrent set of problems or on poor adjustments to those problems that lead to the headache.

Let me tell you about a person with whom I worked to beat this problem.

The patient, a prominent attorney, was pregnant with her third child. Much of her work centered around the pressure of trying cases and hammering out settlements during actual trials.

After talking with her, I helped her pinpoint the stressors that began the sequences that led to her migraines. Medication usually had been helpful in the past, but the pregnancy had put this pharmacotherapy approach on hold.

With her history on hand, I explained the action phase of the LPA technique. First, the patient was instructed into a hypnotic/relaxation state. This allowed her to quickly shift gears when she was stressed and go to a place where guided imagery would be effective in aborting the migraine. The imagery used most often is a favorite set of scenes or pastimes that allow the patient, with practice, to rapidly move away mentally from the building stressors that might trigger the headache.

My favorite movie screen technique usually accomplishes this. The patient uses the hypnotic relaxation technique to imagine a large movie screen and see herself in a scene that relaxes her. This attorney particularly enjoyed making a lot of money, which, in turn, allowed her to visualize herself paying college tuition for her three children.

The need to practice this is extremely important in light of the tendency of these headaches to overtake the patient if not addressed promptly.

In this case, the preventive strategy was developed over two separate visits that were 2 weeks apart. At the end of the second visit, the attorney had mastered the technique of relaxation and the relaxing imagery. Whatever add-ons or changes she opted to make were fine with me, because the goal was successful prevention of the headache.

Step two of the action phase focused on the control and possible elimination of the migraine once it started. For this, I used guided imagery that followed natural physiology in dealing with the throbbing headache and systemic symptoms such as nausea and gastrointestinal discomfort.

During the headache phase, many migraine sufferers report that their hands and fingers get very cold and numb. For those patients, I have incorporated a guided imagery model aimed at helping to get their hands and fingers to feel warm.

Once the patient has learned how to relax, it becomes fairly straightforward to launch into the actual headache treatment to relieve some or all of the pain and discomfort. While the attorney was in a relaxed state, I got her to imagine an ice cold motorcycle or football helmet on her head. She then was able to feel the ice cooling and numbing part of her head—or her entire scalp. As her head cooled, she could feel the numbness setting in, which *took the hurt out of the pain*—a novel configuration.

As the pain left, it was also possible to get the patient to imagine breathing in cool air and sending cooling sensations into the mouth, esophagus, and down into the stomach. The cooling, in turn, removed the sensations of nausea. To ensure that she learned how this worked, I had her practice this at least 10 times in two separate visits.

If the ice cold helmet strategy does not work, I try the glove anesthesia method of imaging. This works by getting the patient to imagine that she is holding ice cubes in her hands so that they feel frozen and numb. I then have the patient touch her head with this iced hand to transfer the cold and numbness to the headache pain. This might not be the approach to use if her hands and fingers are already cold during the headache or if she needs her hand for a handshake.

Combating pain after it starts is very difficult, so knowing exactly what to do almost reflexively is very important. This patient had experienced the cold, almost numb hands during the migraine episode, so as we progressed in the action phase of the LPA technique I introduced a new idea. While she was using the guided imagery, I told her to imagine the cold on her head and to then begin to see warm water running over both of her hands.

I learned this concept from a colleague who used biofeedback to treat migraine: integrated hand warming was part of the mechanical hook-up he used.

To a large degree, the attorney was successful in preventing and controlling the headaches. The migraines were not eliminated during the pregnancy but very much alleviated. After the birth, she continued to use these techniques and eventually was able to decrease her use of medications by 70%.

Training in techniques directed at symptom removal through cognitive or other behavioral methods is part of graduate medical education, but most trainees just get an overview. Sadly, instead of focusing on genuine treatment options, too much talk psychotherapy seems wedded to age-old concepts of conflict resolution when symptom removal is what we need to do.

I am hopeful that we can move away from these outdated notions and that our teaching programs will begin to offer more training in symptom removal when it comes to pain and suffering.

Let me know your experiences in treating headache, and I'll try to pass them to my readers. ■

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BY ROBERT T. LONDON, M.D.

Study: 44% of Patients Had Visual Auras With Migraine Attacks

LOS ANGELES — Visual disturbances may be far more common among patients with migraines than previously believed, according to a study presented at the annual scientific meeting of the American Headache Society.

Dr. Abouch V. Krymchantowski and Dr. Marcus V. Adriano of the Headache Center of Rio de Janeiro prospectively queried 100 consecutive patients (90 women and 10 men) with

migraine headaches about their visual symptoms, whether or not they believed their symptoms constituted an aura. The patients ranged in age from 17 to 73 (mean age, 36).

Migraine without aura was the most common diagnosis, seen in 74 patients. Another 10 had migraine with aura, while 16 had both types of headache.

Of the 100 patients in the study, 44 reported some visual al-

teration that occurred before or during migraine attacks, far higher than the roughly 10% of migraine patients considered to have visual auras. Symptoms included blurred vision in 31 patients, bright spots in 15, zigzag lines in 7, dark spots in 5, diplopia in 4, transient blindness in 3, and hemianopsia in 2. Some patients reported more than one visual symptom, and 19 said their visual symptoms occurred in

conjunction with every migraine.

Although 17 patients said they had sought consultations with ophthalmologists concerning their vision problems, only two ophthalmologists correctly linked the symptoms to migraines, Dr. Krymchantowski reported.

Blurred vision, the most common visual disturbance experienced by patients in the study, may be often overlooked. “We are in doubt that patients would

report it if not asked,” he said.

An audience member noted that some of his patients report blurred vision that lasts days or even weeks in conjunction with migraine headaches.

Dr. Krymchantowski called for more research into visual alterations related to migraines and suggested that visual auras may be too narrowly defined in current headache guidelines.

—Betsy Bates