Behavioral Assessment in Headache Medicine

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Disclosures

- Advisory Boards: Alder, Allergan, Amgen Novartis, Biohaven, Percept, Teva, Xoc
- Speaker's Bureau: Amgen Novartis, Biohaven
- Editorial Boards: Associate Editor, Headache

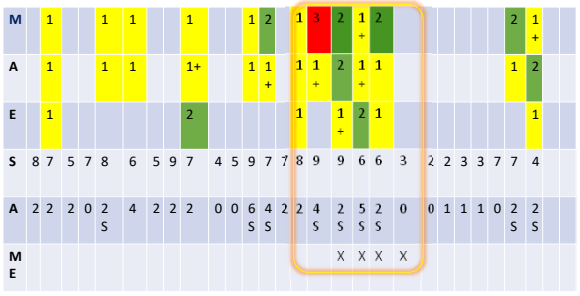
Objectives

- Utilize the ABC's of behavior.
- Perform a multiaxial behavioral assessment.
- Assess adherence to pharmacological and behavioral therapy regimens.
- Evaluate stress-related factors and coping styles.
- Diagnose psychiatric comorbidities.
- Outline how anxiety sensitivity may be the driver of distress in migraine.

Case-Arielle

- 21 yo female university student 5 migraines/mo and many interictal less intense HA's. Historically 1-2 migraines/mo responsive to OTC's. Her PCP gave her sumatriptan 50 mg. Takes suma after non-response to asa, apap, caffeine tablets. "It doesn't work." HA frequency, intensity, disability increasing.
- Hx of depression, sleep disorder, "stressed-out," Increasing OTC's to 3-4 days/week.

One-month headache diary



Risk Factors for CM progression

Comorbidities
- Depression
- Anxiety
- Other pain disorders
- Obesity
- Asthma
- Snoring and sleep disorders

Exogenous Factors
- Stressful life events, childhood maltreatment
- Head/Neck injury
- Caffeine

Treatment-related
- Poor treatment efficacy
- Medication overuse

Headache Features
- Attack frequency (headache days)
- Persistent, frequent nausea with migraine
- Allodynia

AMPP; FRHE. Scher, et al 1998, 2003,2004; Bigal & Lipton, 2006; Katsarava, et al, 2004; Tietjen GE, et al. *Neurology*. 2007;69(10):959-968; Tietjen, GE, et al. *Headache*. 2017 Jan;57(1):45-59

ABC's of Behavior

- **Antecedents**: Events or triggers that precede migraine or periods of increased headache.
- **Behavior:** Actions taken during prodrome, headache or escalation of pain. May experience cephalalgia phobia (pre-emptive meds), or may delay taking meds, may increase or decrease activities, pain behaviors.
- **Consequents:** The impact and effect on the environment. Changes in pain or anxiety levels effects previous behaviors. Avoidance learning.

Adapted from Lake AE. *Medical Clinics of North America* 2001;85:1055-1074

Antecedents: "I feel like I never have enough time." **Very fearful of any sensation that "may lead to a migraine."** "Never a good sleeper." Stopped exercising because "I need the extra time and I get a little panicky."

Increased use of caffeine "because I'm always tired" and alcohol because "I can't relax."

Behavior: Beginning to reach "limits" on abortive medications without effectiveness. She treats fear of HA or low-grade pain with pre-emptive OTC's and sometimes delays triptan.

She "accelerates" behavior after taking medication to get everything done before the migraine is full-blown. "I avoid many social events….I feel overwhelmed."

Consequents: Much discord with boyfriend. Increasing probability of CM and MOH. Missing classes. Grades "slipping".

Increasing alcohol when anxious and increasing caffeine when fatigued.

Multiaxial Assessment

I. Headache diagnosis; frequency, intensity, duration and level of disability
II. Assessment of adherence to therapy regimens including medication use, overuse, and misuse
III. Factors that chronify and stress-related issues
IV. Comorbid psychiatric disorders

Modification of Lake, 2001

Arielle

- 5-6 headaches/mo that meet criteria for migraine without aura
- Takes asa, asap, caffeine then suma 50, ineffective
- Escalating use of OTC's
- High stress, "can't cope."
- Less exercise
- Chronic insomnia
- ? Mood/anxiety disorder. Past history of depression/panic disorder in first year of college. Left for a semester, took sertraline, with benefit and saw psychologist.

Multiaxial Assessment

I. Headache diagnosis; frequency, intensity, duration and level of disability

Migraine; 13 days of headache last month with 5 days of migraine; ? MOH; Midas score=12 (moderate disability)

Modification of Lake, 2001

Treatment Adherence
Assessment Basics

- Is patient motivated for Rx? Sequence of intervention may be required.
- Does patient understand therapy rationale?
- Did patient receive adequate drug or behavioral Rx?
- Has patient adhered to past therapy regimens?
- Did medication overuse problems or emotional distress affect outcome?
- At what point does patient medicate?
- Ask open-ended questions. "How do you decide when to take your medication?"

Cheng MKS. *Psychiatr Clin N Am.* 2007;30:157-166

Do clinical features influence adherence?

- No significant association between adherence and sex, age, or educational level.
- Neither attack frequency, duration of attacks, degree of recovery between attacks nor cardinal symptoms during attacks were significantly associated with adherence.
- Even a problem with severe migraine

Linde M, et al. *Acta Neurol Scand.* 2008;118:367-372; Hedenrud T et al. *Ann Pharnacother.* 2008;43:39-45; Evans R, Linde M, *Headache* 2009;49:1054-1058

Stress-Related Factors

- High levels of daily stress may transform to chronic
- "Let-down" post-stress may be migraine precipitant.
- The effect of stress greater in migraine patients with co-morbid depression.
- In victims childhood maltreatment, more disabling HA's and more likely to "transform" from episodic to chronic
- Many patients do not have the coping skills necessary to manage stress or recurrent headache.

DeBenedittis, et al, 1990; Chabriat, et al, 1999; Holm, et al, 1997; Scher, et al, 2003; Bigal & Lipton, 2006; Scher, et al, 2008; Drummond & Passchier, 2006; Hung, et al, 2008; Lipton RB, Buse DC, et al, 2014; Tietjen and Peterlin, *Headache* 2011;51(6)869-979; Peterlin BL et al, *Headache* 2011;51(6)860-869.

Self-Efficacy

- Patients belief in the ability to control the headache
- Belief in the ability to manage emotional reactivity to pain and to other distresses
- Believe that they can achieve functionality in the presence of a significant headache disorder
- Headache Management Self Efficacy Scale

Locus of control

- Internal= perception that life events and circumstances (headache) are the results of one's own actions, a sense of control
- External= perception that life events and circumstances are beyond one's own control. Reliance on fate, chance, other people.
- Headache Specific Locus of Control Scale

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Psychiatric Comorbidity

- May complicate differential diagnosis
- Non-adherence with treatment regimens 3 X more likely if suffer from a mood or anxiety disorder
- Poorer drug tolerability
- Reduced response to pharm and behavioral Rx's
- May increase risk of relapse
- Is a risk factor for migraine chronification

Baskin SM. and Smitherman TA. *Neurol Sci*. 2009;30:S61-S65; Blanchard et al., 1985; Guidetti et al., 1998; Holroyd et al., 1988; Radat et al., *Cephalalgia*. 2005;25:519-522
Lanteri-Minet et al., 2005; Bigal ME, Lipton RB 2006; Micieli et al., 1985; Mongini et al., 2003
Waldie & Poulton, 2002; Scher, et al 2008

Screening Tools

- Beck Depression Inventory-II (BDI-II)
- Quick Inventory of Depressive Symptomatology (QUIDS-SR)
- PRIME-MD
- PHQ-9, PHQ-2
- MMPI (self report with validity scales)
- GAD-7
- PTSD Checklist-Civilian Version (PCL-C)

Maizels M, Et. Al. A review of screening tools for psychiatric comorbidity in headache patients. *Headache* 2006;46(S3):S98-S109.

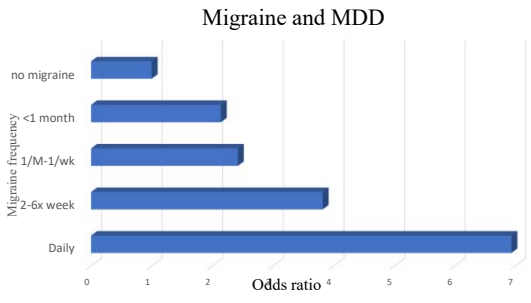
Comorbid Psychiatric Disorders

Prognosis for Refractory Headache
8-year follow-up of adolescents & young adults
N=100

Multiple disorders	57% same or worse	29% improved	14% HA-free
Single disorder	15% same or worse	46% improved	39% HA-free
No psych disorder	7% same or worse	53% improved	40% HA-free

Guidetti V, Galli F et al: *Cephalalgia* 1998;18:455-462

Brazilian Adult Health Study



Goulart A, Santos, I, et al. *Headache* 2014;54:1310-1319

Bipolar Depression

There is about a 2.5 to three-fold higher relationship between migraine and bipolar spectrum disorders

Spectrum theory of BPD ranging from full-blown mania (Bipolar I) to "sub-syndromal" conditions.

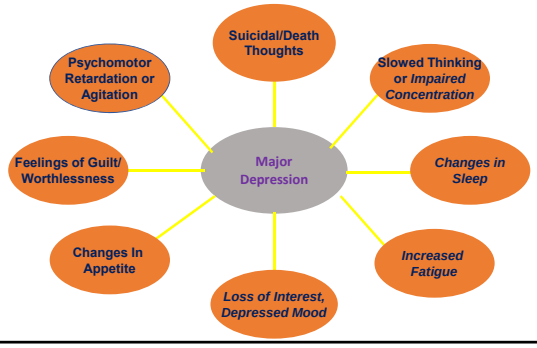
Bipolar spectrum misdiagnosed as unipolar in around 30-40% of patients

Many patients once considered to have MDD now viewed as being in bipolar spectrum. Mixed features likely suggest bipolarity

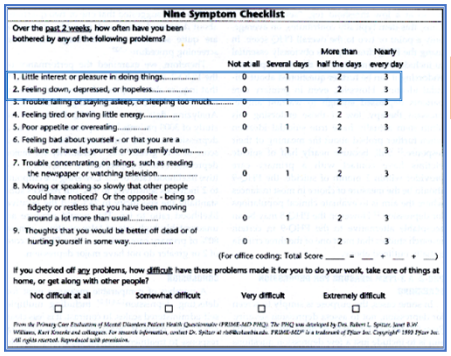
Minen, MT, et al. *J Neurol Neurosurg Psychiatry* 2016;87:741-749.
Jette N et al. *Headache* 2008;48:501-516; Ratcliffe et al. *Gen Hospit Psychiatry* 2009;31:14-19
Benazzi F, *Lancet* 2007;369:935-945; Frye MA. *N Engl J Med* 2011;364:51-59

Depressed Patients Will Present With a Constellation of Symptoms

A major depressive episode includes the persistence of *at least 5* of the following:



PHQ-*2 Screener*



Nine Symptom Checklist

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: Total Score ____ = ___ + ___ + ___ + ___)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rlsmd@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1995 Pfizer Inc. All rights reserved. Reproduced with permission.

Cut Score of 3 = Sensitivity of 83%/ Specificity of 90% re: Major Depression

Kroenke K, Spitzer. The PHQ-9: A New Diagnostic and Severity Measure.

Psychological Assessment for Depression

Behavioral assessment to evaluate the behavioral deficits and excesses associated with depression (e.g., low activity level, frequent complaints, poor social skills, etc)

Interpersonal issues that may be contributory (e.g.,loss of relationships, frequent discord, low assertiveness)

Cognitive assessment evaluates distorted depressive automatic thinking, maladaptive assumptions, and negative schemas that are intervention targets

Predictors of Bipolarity in Depressed Patients

- Psychotic symptoms
- Family history of bipolar disorder
- Early age of onset (before 25 years of age) and high frequency of depressive episodes; post-partum episode
- High frequency of suicidal thoughts
- A quicker onset or improvement of symptoms
- Pharmacologic-induced mania or hypomania; poor response to antidepressants
- "Rapid cyclers" migraine prone
- Hypersomnia, psychomotor retardation, profound fatigue, "leaden paralysis." overeating found in some studies.
- **Distractibility, irritability, agitation; depression with mixed features (co-occurring mania) worse prognosis**

Frye MA. *N Engl J Med* 2011;364:51-59; Dervik, et al. *Eur Psychiatry* 2015;30:106-13.
Minen, MT, et al. *J Neurol Neurosurg Psychiatry* 2016;87:741-749.

How we miss the diagnosis of bipolar disorder?

Clinician factors
- Not asking about manic/hypomanic symptoms; longitudinal; low index of suspicion
- Not including a family member in evaluation

Illness factors
- Depressive episodes last longer than hypomanic episodes. Bipolar II 39:1

Patient factors
- Lack of insight about mania and hypomania. Hypomania represents a period of "wellness" after an episode of depression.

Goodwin, F., Jamison, K. & Ghaemi, S. (2007). Manic-depressive illness : bipolar disorders and recurrent depression. Oxford University Press.

Association Between Migraine and Anxiety: Community Studies

Odds Ratio

Reference	Panic	GAD	OCD	Phobia
Breslau (1998)				
migraine with aura	10.4	4.1	5.0	2.9
migraine w/o aura	3.0	5.5	4.8	1.8
Swartz et al (2000)	3.4	--	1.3	1.4
Breslau et al (2001)	3.7			
Merikangas et al (1993)	3.3	5.3		
McWilliams (2004)	3.6			
Saunders et al (2008)	3.6			
Wang et al (2007)	6.6 (chronic migraine)			

Modified from Smitherman, TA et al. *Headache* 2013;53:23-45

Anxiety Disorders

Symptoms common to most all anxiety disorders:
- Anxiety-related and danger-related cognitions (fear or worry)
- Physical symptoms
- Avoidance behaviors (some are very subtle).
- Overestimate the probability of danger (migraine) and perceive it as more unmanageable and threatening than objective reality. Very sensitive to medication side effects and somatic sensations.

Smitherman TA, et al. *Headache* 2013;53:23-45

Anxiety Disorders

- Onset of anxiety generally precedes the onset of episodic migraine, whereas the onset of major depression follows the onset of migraine. Anxiety may appear in childhood, followed by migraine then depression then by CM.
- The lifetime prevalence of anxiety disorders in migraineurs (ranging from 51-58%) is almost twice that of major depression.
- Anxiety disorders may complicate migraine more than depression with greater long-term persistence, greater headache-related disability, and reduced satisfaction with acute therapies. Anxiety is the driver of distress across most emotional disorders.

Merikangas, et al, 1990; Mercante, Peres, et al, 2011; Breslau et al, 1991; Breslau et al, 1998; Lipchik, 2005; Swartz et al, 2000; Baskin, Lipchik, Smitherman, 2006; Smitherman, Penzien, Maizels, 2008; Lanteri-Minet et al, 2005; Smitherman, et al, 2013

Generalized Anxiety Disorder

A. Excessive anxiety and worry occurring more days than not for at least 6 months.

B. The individual finds it difficult to control the worry.

C. Anxiety and worry are associated with three or more of the following:

- Restlessness or feeling keyed up on or edge.
- Easily fatigued
- Difficulty concentrating or mind going blank.
- Irritability
- Muscle tension
- Sleep disturbance

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T___ = ___ + ___ + ___ + ___)

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(For office coding: Total Score T___ = ___ + ___ + ___)

Cut score of 3 for first two items similar to full GAD-7

Panic Disorder DSM-5
Diagnostic Criteria

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) symptoms from a list of 13 physical and cognitive symptoms.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.)

Panic Disorder DSM-5
4 or more of a list of 13 symptoms

11 Somatic Symptoms
- Pounding heart
- Sweating
- Shaking/trembling
- Sensations of SOB
- Feelings of choking
- Chest discomfort
- Nausea/abdominal distress
- Feeling dizzy, unsteady
- Paresthesias
- Chills or heat sensations
- Derealization or depersonalization

2 Cognitive Symptoms
- Fear of dying
- Fear of losing control or "going crazy"

Panic Disorder DSM-5

B. At least one of the attacks has been followed by one month (or more) of one or both of the following:

1. Persistent worry about additional panic attacks or their consequences (losing control, "going crazy", having a seizure, etc.)
2. A significant maladaptive change in behavior related to the attacks (such as avoidance of exercising or unfamiliar places)

Agoraphobia

- Anxiety about being in situations related to perceived inability to escape or get help if a panic attack occurs
- Situations are avoided or endured with significant distress (zone of comfort gets narrower over time)
- Approximately one-third to one-half of individuals with PD in community meet criteria for agoraphobia. Ratio much higher in those seeking treatment. Female preponderance as agoraphobia worsens.

Thyer, Himle, et al, 1985. *Comprehensive Psychiatry*; 26:208-214;Craske MG & Barlow DH, 1989. *Clin Psy Rev*;8:667-85

Screening questions

- Do you currently have times when you feel a sudden rush of intense fear or discomfort?
- In what kinds of situations do you have these feelings? Do they ever come "from out of the blue," for no apparent reason?
- How long does it usually take for the rush of fear to reach its peak level? How long does it last at this peak level?
- In the last month, how fearful have you been about having another panic attack? (0-8 scale)

Adapted from Anxiety Disorders Interview Schedule-Fourth Edition (ADIS-IV)

Anxiety Sensitivity

- Tendency to notice and fear benign physical sensations due to beliefs that these sensations will have harmful and have possibly catastrophic consequences.
- Positive correlation between anxiety sensitivity and brain activation in anterior cingulate cortex (ACC), medial prefrontal cortex (mPFC) and insula.
- Predicts fear of pain and maladaptive avoidance behaviors in migraine patients.
- Associated with more frequent and disabling headaches as well as greater susceptibility to headache triggers. May be relevant to people with epilepsy, MS, vertigo.

Smitherman TA, et al *Headache* 2013;53:23-45; Norton PJ &Asmundson CJG, *Pain* 2004;111:218-223; Poletti S, et al. *Psychiatry Res.* 2015 Aug 30;233(2):95-101.

Pain Catastrophizing

- Catastrophizing is "an exaggerated negative mental set brought to bear during actual or anticipated painful experience" (Sullivan et al., 1995).
- Helplessness, rumination, magnification.
- Individuals who tend to "catastrophize" experience higher levels of psychological distress, poorer physical functioning, increased disability, greater levels of pain intensity, pain chronification.

When I'm in pain ...

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better.	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore.	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events.	
8	I anxiously want the pain to go away.	
9	I can't seem to keep it out of my mind.	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop.	
12	There's nothing I can do to reduce the intensity of the pain.	
13	I wonder whether something serious may happen.	

Sullivan ML, et al. *Psychol Assess* 1995; 7: 524-532; Holroyd KA, et al. *Cephalalgia*. 2007 Oct;27(10):1156-65. Bond DS, et al. *Headache* 2015; 923-933; Komandur B, et al. *Clin J Pain* 2018 Jul;34(7):638-649; Alvarez-Astorga, A et al. *Neurologia* 2019 Mar 8. pii: S0213-4853(19)30015-5;

Distorted Automatic Thoughts

- **Fortunetelling:** "I'll have an attack, I'll lose control…I'll faint
- **Labeling:** "I am crazy…I am sick"
- **Overestimate of danger:** "There was red wine in that sauce…I'm sure I'll get a migraine"
- **Catastrophizing:** "This will be the big one."
- **Mind reading:** "People know I'm losing it"
- **Underestimate coping skills:** "I can't handle this"

Leahy, et al 2012; Clark DM, *Behavior Research and Therapy* 1986;24:461-70

Maladaptive Assumptions

- " I need to be completely panic free (headache free)"
- "Having panic (migraine) is intolerable."
- "All of these medications have horrible side effects."
- "If I worry about it, I might prevent it. I need to figure out all possibilities"

Dysfunctional Schemas

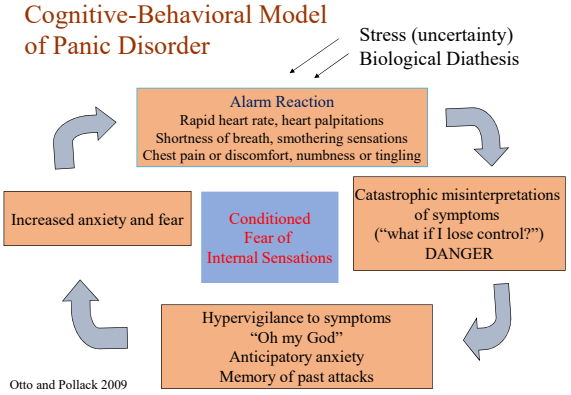
- **Vulnerability to harm**: "I am fragile. I get easily distressed. I am helpless managing panic (these headaches)."
- **Biological integrity**: "I'll become debilitated."
- **Control**: "I need to always be in control. This uncertainty is unbearable."
- **Specialness or humiliation**: "How can someone so competent get so many HA's." "Everyone at work is making fun of me."

Vulnerability factors in panic disorder that may be relevant to migraine

- Genetics and Temperament (neuroticism, harm avoidance)
- Early developmental experiences leading to a diminished sense of control
  - history of medical illness, childhood maltreatment
- Interoreceptive Awareness
  - An individuals sensitivity to bodily signals, e.g. heart rate
- Anxiety Sensitivity
  - Tendency to fear benign physical sensations due to beliefs that these sensations will have harmful and possibly catastrophic consequences. Linked to migraine severity in women.

Craske MG & Barlow DH, 2008; Pollatos O, et al *Journal of Anxiety Disorders* 2007;21:931-943; DeCort DC, et al *Behav Ther. 2012;* 43:203-25; Bouton ME, et al *Psychological Review* 2001;108:4-32. Kossowsky, et al Am J Psychiatry 2013;170:768-781; Farris SG, et al. *Headache* 2019;59:1212-120.

Cognitive-Behavioral Model of Panic Disorder



Otto and Pollack 2009

Psychiatric Disorders in MOH

DSM-IV Dx	Precedes MOH	Follows MOH
First episode of MDD	76%	24%
Panic disorder	79%	21%
GAD	80%	20%
Social phobia	100%	0%
Substance abuse	89%	11%

Radat F et al *Cephalalgia* 2005;25:519-522

PTSD, childhood maltreatment, adult abuse

- Migraine appears to be related to childhood maltreatment, in particular emotional abuse.
- PTSD more prevalent in migraineurs compared to population at large.
- Headache in abused is more disabling and more likely to "transform" from episodic to chronic
- Childhood maltreatment was more common in women with migraine and comorbid major depression than in those with migraine alone
- The presence of PTSD may increase disability substantially.

Tietjen GE, et al. *Headache* 2017 Jan;57(1):45-59;Tietjen GE, Buse DC, Collins SA. *Curr Treat Options Neurol.* 2016 Jul;18(7):31 Tietjen GE et al, *Headache* 2007;47:857-865; Tietjen GE, et al. *Neurology.* 2007;69(10):959-968; Tietjen and Peterlin, *Headache* 2011;51(6)869-979; Peterlin BL et al, *Headache* 2011;51(6)860-869.

Borderline Personality Disorder:

The ultimate in emotional dysregulation

- In primary care, 4X the prevalence than in the general population; BPD are frequent users of general medical care. 10% of all psychiatric outpatients.
- Suicidal gestures, self-injury and unstable relationships most useful for correct diagnosis.
- Suicide risk 20-50 X higher than general population.
- More likely to have more pervasive HA
- PD's affect 26% of inpatients with refractory CM (most BPD).
- More HA-related disability
- Lower probability of responding to standard preventative pharmacological therapy
- More prone to medication overuse

Lake A, et al. *Headache*, 2009; Rothrock, et al. *Headache,* 2007
Leichsenring F, et al. Borderline Personality Disorder. *Lancet* 2011;377:74-84.

Headache and Psychiatric Comorbidity (multi-axial examples)

Axis I Major Depression	Axis I Major Depression Panic Disorder	Axis I Major Depression Panic Disorder
Axis II No disorder	Axis II No disorder	Axis II Borderline personality
Axis III Episodic migraine	Axis III HF Episodic migraine	Axis III Chronic migraine MOH

Increasing Complexity and Difficulty →

Sheftell FD, Atlas SJ. Headache 2002; 42: 934-944

Process of Change

- Identify patients' readiness to change
- Set stage-based treatment goals
- Accept that a sequence of interventions will be required
  - Within a given visit
  - Over a series of visits
  - Motivational Interviewing
  - Continuous behavioral assessment

Prochaska JO, et al. In: *Health behavior and health education.* Jossey Bass; 1997
Prochaska JO, et al. In: *Patient education: A practical approach.* Sage Publications; 2001

Behavioral assessment conclusions for the busy headache specialist

- Evaluate ABC's of behavior, adherence issues, stress-related risk factors, coping skills and psychiatric comorbidities while taking headache history.
- Use a headache diary for self-monitoring and to maximize adherence.
- Diagnose comorbid psychiatric disorders that are prevalent in migraine, most notably in chronic forms.
- Anxiety confers greater negative impact than depression in migraineurs and predicts long-term migraine persistence so needs to be carefully assessed.
- With mood issues, anxiety, somatization, abuse, consider PTSD and personality disorders.
- The possibility of bipolar disorder needs to be evaluated.