Migraine: Symptom Or Disease

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An estimated 5% of the adult population suffer from migraine headaches (Hilgard 1975). Migraine has been recorded as far back as 400 BC by Hippocrates, who referred to it as Dolores Hemicraniae. Gradually the word Hemicraniae became our present word migraine (Friedman 1968). The organic basis is distention or dilatation of intra- and extracranial arteries. We contend that some conscious emotional conflicts can lead to this dilatation of cranial arteries and that these repressed emotions can be identified with hypnoanalysis and treated, resulting in cures in many cases. A number of case histories are outlined to illustrate various psychodynamics and treatment approaches.

SYMPTOMS AND SIGNS

The outstanding feature is a periodic headache usually unilateral in onset, at times becoming generalized. Symptoms in an individual case usually follow a pattern, however a patient with right sided attacks may, sometimes, have a left sided one or visa versa. The attacks vary in duration and severity lasting from a few hours to several days. The headaches are frequently associated with irritability, photophobia, nausea and vomiting. The arteries on the surface of the head may be prominent and pulsations increased. Preceding the headache the patient may experience vertigo, scintillating scotomas or visual field defects, such as homonymus hemianopsia. As the prodromes recede, sometimes after a symptom free interval, the throbbing aching headache begins. The pain is characteristically modified by vasoconstrictor drugs like egotamine tartrate.

ETIOLOGY

The cause of migraine is unknown, but most clinicians assume it to be due to a functional disturbance of cranial circulation. The prodromal symptoms (e.g. flashes of light, hemianopsia and paresthesias) are probably due to intra-cerebral cranial arteries e.g. those of the dura and scalp. As the dilatation persists the walls of the cranial arteries and the adjacent tissues become edematous. Stress, resentment, fatigue or prolonged tension frequently bring on an attack. Migraine is 3 times more common

"The cause of migraine is unknown."

in females than in males. At one time or another, various investigators have attempted to ascribe migraine to allergy, heredity, epilepsy, electrolyte disturbance, serotonin disregulation, histamine sensitivity, ocular malfunctions, hormonal imbalance or other conditions, but the evidence has been un-

convincing. As a hypnoanalyst I postulate that subconscious conflicts can lead to vascular spasm of a cranial artery, causing the prodomes and as the vasospasm subsides the compensatory dilatation with the edema leads to the throbbing migranous headache. We will not concern ourselves here with conversion headaches, but limit our discussion to a bona-fide vascular migranous headaches. Migraine patients are frequently described as tense, perfectionistic and order loving, fearful of making mistakes and overly sensitive to criticism by others. We feel that many patients have become rigid and order loving as a consequence of the disease, trying to avoid emotional upheaval that may bring on an attack.

DIAGNOSIS

Recently a patient came to our office with the complaint of excessive perspiration. He told me that his disease had been diagnosed by a dermatologist as "Hyperhidrosis." I told him that hyperhidrosis is the latin translation of excessive perspiration. This is analogous to the manner in which migraines are sometimes diagnosed.

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The diagnosis of migraine is based on a history of recurrent headaches associated with nausea or vomiting in a patient showing no evidence of intracranial pathological changes. The diagnosis is more probable if there is a positive family history or if the headaches are preceded by visual prodromata. Again if we rule out intracranial pathology (e.g. intracranial vascular malformations, tumors, subarachnoid hemmorrhage etc.) and we make the diagnosis migraine, are we not saying to that patient in latin that he has a "sick headache."

TREATMENT

There are two parts to the treatment, one preventing the attack from occurring and the other, treating the attack after it has started.

A. Surgical

Since the most direct method for eliminating arterial dilatation is interruption of the vessel, a number of arteries in the head and neck have been ligated for this disease. These neurosurgical procedures, including interruption of the trigeminal nerve, when the headache is confined to frontal area, all have been rarely permanently successful (Finneson 1969).

B. Drugs

Ergotamine and its derivatives head the list of effective medication in the treatment of the migraine attack. Ergotamine tartrate is most effective intramuscularly, if administered as close as possible to the onset of the attack. Dihydroergotamine (D. H. E. 45) intramuscularly is better tolerated, but less effective. Ergotamine orally is less effective than intramuscularly, but often helpful. Oral ergotamine is usually combined with caffeine. Ergotamine is a vasoconstrictor and is contraindicated in severe arteriosclerosis, coronary artery disease, Raynaud's syndrome, Buerger's disease, infectious states and in pregnancy. When vomiting is a prominent feature the combination of ergotamine tartrate and caffeine can be administered rectally in suppository form. Sometimes antiemetics, such as prochlorperazine, are needed. For the patient who does not respond to ergotamine sopoforics such as barbiturates and diazepam have been used to help foster sleep. The main stay in migraine prophylaxis is the serotomin antagonist methysergide (Sansert). Retroperitoneal fibrosis with utereral obstruction is a well known, but rare, complication of prolonged usage. Other drugs included in the list of migraine prophylaxis include propranalol, thranylcypromine, and amitriptyline.

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No discussion of drug therapy is complete without Beecher's observation (1955) in evaluating drugs and placebos in migraine,

that the placebo not only relieved the symptoms in nearly 50% of cases, but caused 9-25% subjective and up to 47% objective side-effects.

C. Autogenic training and biofeedback

Some patients, after several months of practice of autogenic training, lessen the frequency and intensity of the headaches and some have learned to interrupt the onset of an attack by starting autogenic exercises as soon as the prodromal symptoms appeared (Schwartz 1971).

Many physicians have turned to biofeedback. Biofeedback is a psychophysiological method in that it depends on amplification of physiological responses for the purpose of gaining control over these responses by becoming aware of them. Unfortunately biofeedback has been so exploited, either commercially or by uncritical enthusiasts, that at present it is difficult to gauge its therapeutic successes (Hilgard 1975). We have come to realize that a great deal depends on the influence of suggestion, expectation, motivation and relaxation in combination with the instrumentation.

Combining autogenic training and biofeedback called autogenic feedback training (Sargent 1973) holds promise in that the suggested relaxation affords relief after the onset of the migraine prodromes.

D. Hypnoanalysis and hypnotherapy

Hypnosis is often an excellent method of exploring the unconscious mind and allowing forgotten or repressed memories to flow back into consciousness. A re-education can take place and during the hypnotic state a new appraisal becomes possible. As far back as 1937 Eisenbud recommended that migraine headaches be treated by hypnoanalysis, especially those cases that seem resistant to other forms of treatment. Harding (1967) in reporting on hypnotherapy of ninety patients with migraine (26 males and 64 females) demonstrated in a six month to eight year follow-up, 38% complete relief, 32% moderate relief and 30% had either no relief or were lost in follow-up. Much can be accomplished by an all embracing approach which assesses not only the somatic part of the migraine, but also the underlying psychological factors adversely affecting the individual.

PERSONAL EXPERIENCE

Our therapeutic series consists of 12 consecutive migraine patients, diagnosed by one or more competent neurologists. 9 were females, 3 were males. All but one were analysed under hypnosis. By the time a patient reaches a hypnoanalyst for migraine she (or he) has seen an average of 5 doctors. The duration of migraines prior to hypnotherapy varied from 7 years to 36 years (median 21 years). The one patient that was not analysed was a male, who felt the questions asked were too personal. He was treated with direct suggestions under hypnosis and the frequency and severity of his attacks decreased substantially. He still needs oral ergotamine tartrate off and on.

"By the time a patient reaches a hypnoanalyst for migraine, she (or he) has seen an average of 5 doctors."

In follow-up, from 8 months to 5 years after completion of hypnoanalytic therapy, of the remaining 11 patients, 7 are cured (no headaches, not on medication), 2 are improved (frequency of headaches less than 50% of pretreatment and less severe) one is lost in follow-up and one is considered a treatment failure. All migraine patients were treated for 12 to 14 one hour sessions at weekly intervals with the exception of the male who was not analyzed; he was treated 8 times. The first 6-7 sessions are devoted to diagnosis, history, teaching hypnosis, word association tests under hypnosis, dream interpretation and age regressions. Usually by the 6th or 7th session the psychodynamics are clear to the patient both in hypnosis and in the waking state. Frequently by this time most patients feel markedly improved and some even completely well. We insist on continued therapy. The remaining 6 to 8 sessions are devoted to desensitization, to get the patient to the point where he or she can say, "Yes all this happened to me, but it does

not bother me emotionally anymore." At the same time re-education and ego strengthening procedures are used.

CASE HISTORIES

Jane M., a 28 year old female, came to us complaining of severe migraine headaches. The headaches started when Jane was 16 years old and became progressively worse during the last two years. She was rapidly becoming addicted to narcotics. The headaches would last 4 to 7 days and were totally absent during her pregnancy 4 years before. Under hypnosis she was age regressed to an episode at the age of 5, when she was molested by several older boys. She had no conscious memory of this, but after she had relived this episode under hypnosis she not only completely lost her headaches, but also for the first time in her life she became orgasmic. A three year follow-up reveals no recurrence of headaches.

"Her subconscious mind set up a mechanism that I call neurotic bookkeeping . . ."

Francis P., a 40 year old single female, came to us complaining of frequent recurrent headaches, mostly on the right side. She stated, "Every time I go on a vacation or there is something I look forward to, I have a headache." She also mentioned that she had headaches in one form or another a "*good part* of her life." Under hypnosis she relived at the age of 6 going under ether-anaesthesia for a tonsillectomy. She felt she could not breathe and he thought she was dying. Before she went in she was told, if she would be a good girl in the hospital, she would get a bicycle. At the age of 15, three days after her first sexual relations, her father died of a massive heart attack. Her subconscious mind set up a mechanism that I call neurotic bookkeeping: i.e. for anything good to come along there has to be some bad. After three months of hypnotherapy she has markedly improved. The improvement has been sustained over 2½ years follow-up, although she still gets an occasional mild headache that responds to aspirin.

Tracy G., a 42 year old female came to our office with a 22 year history of left sided headaches associated with vomiting and requiring bedrest for two to three days. The headaches used to come about once a month, but in the past four years had increased in severity and frequency, occuring three to four times a month. Tracy's father was killed in an automobile accident, when she was 10 years old. Her mother, her sister and she slept in one room while on vacation and when the children were assumed to be asleep, mother brought in her boyfriend and had sexual relations with him, while Tracy pretended to be asleep. Her emotions were disgust and anger. She stated: "It is awful and makes me sick." When she at the age of twenty, started having sexual relations herself, she enjoyed it, but the subconscious reliving of her mother's indiscretion created the tension that made her sick. By draining out the voltage of the repressed emotion at the age of 10 and accepting her own sexuality as wholesome and healthy she has been free of headaches for the past 3½ years.

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Susan J., is a 54 year old woman who complained of throbbing headaches, over the right eye with nausea and vomiting. She stated they started "when I was 26 years old, I had headaches now and then, but in the last 10 years they have been worse and more often, almost weekly." She said, "I usually wake in the morning *with them.*" When Susan was 15 years old, her sister had to get married, and under hypnosis she recalled her mother's saying: "No wonder I have headaches raising two girls like you." Susan didn't get married until she was 25 years old, and then it was to a man who was divorced, and that dissappointed her strict Catholic parents. Ten years ago, her daughter married a man her husband did not approve of, which reinforced her own guilt feelings. Under hypnosis Susan was able to let go of her guilt

feelings and the disapproval from her parents (so she would no longer wake up with them). She still gets an occasional headache, that she now controls with self hypnosis and has not missed a day's work since her therapy was concluded one year ago.

CONCLUSION

Migraine is a relatively common symptom complex manifesting itself in vasoconstriction followed by vasodilatation of cranial arteries, frequently caused by subconscious conflicts. The mainstay of therapy during the attack is ergotamine tartrate. The value of simple reassurance should never be underestimated. Many patients with migraine, and for that matter any patient with chronic or recurrent headaches, frequently have unspoken fears (fear of brain tumor, fear of stroke and fear of going insane). Many a patient concludes that when the physician reports that all tests are negative: "I must be crazy." After careful neurologic examination and proper testing (assuming that all tests are negative) the patient needs to be told, whether directly asked for or not, that there is no evidence of brain tumor, that the headaches do not mean that she (or he) is going to have a stroke and that the headaches do not indicate mental illness. A simple explanation of vasospasm and vasodilatation leading to the periodic headache is necessary. The fact that emotions can lead to vasoconstriction and vasodilatation can be explained to the patient using the analogy of blushing on embarassment and turning pale on fear. A cure is possible in selected cases with the hypnoanalytical procedure. I believe that, because of its relatively rapid conclusion and absence of side effects, hypnoanalysis should be considered earlier in the more severe cases of migraine and in patients who fail to respond to medical management.

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