INTERVIEW TRANSCRIPT

DISCUSSIONS WITH WORLD-LEADING EXPERTS

How Behavioral Therapies Help Prevent & Manage Migraine

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Introduction (00:05): Medication is often the first thing that comes to mind when we think about migraine treatment. But what about the role of psychology or behavioral treatment? Living with pain or a chronic condition comes with so much to manage beyond the physical. Can retraining the way we respond to stress, triggers, and pain actually change our migraine patterns? Today, we're joined by adjunct professor Paul R. Martin, a leading expert on behavioral treatments for migraine and headache, to unpack what the research says and how these approaches can support people living with migraine. Paul, welcome back to the Migraine World Summit.

Dr. Martin (00:35): Thank you.

Kate May (00:36): So you've been working in this field of psychology, behavioral treatments, and migraine research for decades. What first drew you to this area of work and what's kept you inspired to keep exploring it?

Dr. Martin (00:46): Can I start with what's meant to be a bit of a joke, which is that it's always said that researchers do research into their own problems. In Oxford, they argued I added a corollary to that, which is that if you don't do research into your own problems, you develop the problems you do research into. I'd never had a migraine until starting research in this area, and then I started getting migraines. And even at my age, the only time I've ever been hospitalized overnight is for a migraine.

Dr. Martin (01:22): So I have very much had the lived experience, and they were dreadful migraines with every type of migraine symptom imaginable. Having said that, I haven't had a migraine for well over 40 years because it is my area of research and I was able to get on top of them. But I suppose that's one answer to your question. There's a personal interest there as well. Some of the answers to the question, to be honest, are rather boring.

Dr. Martin (01:48): It's pragmatic, which is that trying to get research grants is very, very difficult. In my discipline of psychology, the success rate with the National Health and Medical Research Council [NHMRC] is less than 10%. And everyone knows that. So 90% of researchers don't apply because they know they won't get any money. So it's 1 out of 10 applications amongst the top researchers.

Dr. Martin (02:13): What that means is that if the research community doesn't see you as a leading international expert in that area, you really stand no chance of getting funded. So that tends to also keep you involved because if you want funding for your research, you have to be doing it in an area that you have that international recognition for.

Kate May (02:40): So I'd love to break down this topic a little bit. For those who may not be familiar, behavioral treatment might sound like it's only about thinking differently, but it actually involves changes in the brain and body and how they respond to stress, pain, and triggers. Can you explain what's really happening physiologically when people use these techniques?

Dr. Martin (02:59): There haven't really been studies done combining behavioral approaches with CAT [computed tomography, or CT] scans and so on. In other words, studies that actually look at the biological mechanisms that may be activated by behavioral treatment. It's unfortunate; it would be good to do it. I've thought about doing it at times.

Dr. Martin (03:21): I work, of course, with neurologists, but … again it's so hard getting research funding, and for various reasons, that type of research is hard to get funded. So I'm not sure we really know about the impact. To be honest, we're still very unclear about the biological mechanisms of migraine. We have this small book called *The Headaches*, and in there, there's a section on migraine mechanisms, and there are 12 chapters.

Dr. Martin (03:55): I would argue if we really knew what the mechanism was, there'd be one chapter, but we're still learning. So we know quite a bit, but we're still learning. I would assume that the behavioral treatment is impacting on those biological mechanisms. I think you can analyze any problem, whether it's migraine or what's seen as a more psychological problem like depression, at different levels; there'll always be a biological substrate, biological mechanisms.

Dr. Martin (04:25): Then there'll also be a psychology side, like the experience and so on, as well. And obviously, drug approaches really are going in at the biological level, whereas behavioral [approaches] are going in more at the experiential behavioral level of migraine.

Kate May (04:42): What are some different types of evidence-based behavior treatments that can be helpful for migraine?

Dr. Martin (04:46): The three that have been researched the most would be biofeedback training, relaxation training, and cognitive behavior therapy. So biofeedback training, that's really where it all began and where my original research was. Some of your listeners may not know what biofeedback training is. What happens in biofeedback training is you put electrodes or transducers onto people monitoring some biological process, and you give them feedback about what's happening.

Dr. Martin (05:21): For example, you might put electrodes on top of the muscles on the forehead and then give people feedback as to how tense the muscles are, either visually, like a dial moving on a screen, or in auditory mode, a tone varying in frequency. And the whole idea is that by giving them this feedback to a biological process, they can learn to control the process. In the case of muscles, it helps them learn to relax the muscle. There's others.

Dr. Martin (05:52): With migraine, the most common approach has been what's essentially hand-warming. If you ask, “What's hand-warming got to do with migraine?” The rationale always was that hand-warming means you're increasing blood flow to the hands. And so the argument was, that means you're redirecting blood flow from the head to the hands.

Dr. Martin (06:14): And given the pain mechanism of migraine was always believed to be about extended cranial and extracranial arteries, it was argued that that form of biofeedback — by training people to warm their hands, you were training [them] to bring blood away from the head, which was helping the migraine. So that was biofeedback training. Relaxation training — there's, of course, lots of different ones around.

Dr. Martin (06:39): Progressive relaxation training’s had more research than any other, and a fair bit of research on autogenic training. Cognitive behavior therapy is really more complicated because at its core, it's about identifying and challenging maladaptive thoughts and their underlying beliefs.

Dr. Martin (07:03): To give you a simple example: You had a migraine. If you start having thoughts like, "Oh God, this is going to ruin my day; I'm not going to be able to get any work done; heaven knows when all this is going to end," and so on. In other words, what we would call catastrophizing — although it's understandable why people might think that way, it's only going to make the problem worse. It's going to make them more stressed, which will make the problem worse.

Dr. Martin (07:30): So there's that element of cognitive therapy, but it usually includes other things like educating the patients about their migraines; it includes teaching them various pain management strategies; using imagery, attention diversion training; [it] usually involves some relapse prevention training; and so on. So there's a whole range of different techniques. But then it's also the case that, quite honestly, people often combine them together.

Dr. Martin (08:00): CBT often involves relaxation training, and biofeedback training often involves relaxation as well. Some people put all of them together. So different people use all sorts of different

variations. There have been some new ones in recent times, although I'm not sure how much it's really taking anything forward. There's the so-called third-wave behavior therapies: mindfulness-based cognitive therapy (MBCT), and acceptance and commitment therapy (ACT).

Dr. Martin (08:33): There's evidence out there [that] these can be quite helpful. There isn't really any evidence they're any better than the ones that were developed before, but there are more options. And we have moved in some alternative delivery formats like so-called minimal therapist contact, where we reduce the number of sessions with a therapist, with a psychologist, by giving them manuals so they can do a whole lot of it on their own. And that can work just as well.

Dr. Martin (09:03): Some people have offered treatment in group format rather than individual format, and that can work quite well. People have converted to internet-based interventions. We've struggled a bit with the effectiveness of them because there tends to be a very high dropout rate with internet-based approaches and app approaches. That's not to say they're useless or they're never going to be effective. I think we're still trying to work out how to make sure we don't have adherence problems with them.

Kate May (09:35): Fantastic. Thanks for walking us through that. It sounds like there's lots of different options and lots of different types of behavioral therapies from biofeedback training to mindfulness and CBT, and we'll come back to a couple of these to talk in a bit more detail later on. I'd like to ask, are behavioral therapies standalone treatments or are they often combined with medications or other interventions when it comes to migraine?

Dr. Martin (09:58): There's no reason they can't be standalone treatments. Obviously, when patients refer to psychologists, they're usually on medication. Of course, it would be quite inappropriate for a psychologist to say, "Oh, you can stop taking that now." We can't give advice with respect to medication; that's up to the prescribing medical practitioner. So they're often on both.

Dr. Martin (10:21): Traditionally, when we do research in this area, you find that as well as a reduction in headaches, there's a reduction in taking medication. In other words, it's not us telling them to take less; they just find they need it less. Typically, there'll be like a 70% reduction in medication-taking in association with it.

Dr. Martin (10:41): What we really want in terms of research, I believe, is what is called client-treatment matching research, where you compare pharmacological on its own, behavioral on its own, with a combination of the two; then what you're trying to do is not so much work out which is best, but more which works for who. It's client-treatment matching — but again, that research really hasn't been done. Again, it gets back to the problems of funding. You need very large sample sizes to do that sort of research. It's just very difficult to get enough money to do that type of study. I wish we could.

Kate May (11:22): Yeah, absolutely. It sounds like it would be fascinating and having that matching ability would be incredibly helpful when it comes to practice. You've written about something called a functional model of migraine. Can you explain to us what that means?

Dr. Martin (11:35): My approach to CBT is a little different from other people's in that mine is very much based on a functional model of headache and migraine. What's a functional model? Let me start by going backwards a bit. Medics tend to treat migraine — they approach migraine the same way as they really approach all problems. The starting point for them is a diagnosis. They do that on the basis of asking a whole lot of questions about symptoms and so on. They often do a physical examination.

Dr. Martin (12:09): They often ask for various tests to be done, and after that, they make a diagnosis. Why do they do that? They believe the diagnosis tells the mechanism, which in turn tells them what drug to use. Now, of course I'm not against that approach. It's definitely the best starting point in the

area of migraine because with headache and migraine, what you're always most concerned about is the fundamental diagnostic thing: Is it a primary headache or a secondary headache?

Dr. Martin (12:43): Primary headache, headache is the disorder. Secondary, you've got headaches because of some other problem, which can be anything from a cerebral tumor to an aneurysm, etc. And of course, it's vital to start with that diagnosis.

Dr. Martin (12:59): I would argue once you've decided it's a primary headache, worrying about what type of headache — migraine or tension-type headache, for example — let alone what subtype, let alone what sub-subtype, I'm not convinced it's of huge value because I'm not convinced that they have totally different mechanisms. I instead use this functional model where I ask what I call the "why" questions.

Dr. Martin (13:30): So I'm curious, like, if you got a migraine yesterday morning at 11 o'clock or it got worse yesterday morning at 11 o'clock, why? I want to know why you're suffering from migraines at this time in your life rather than other times in your life. I want to know why did the migraine problem begin when it did. I want to know why you're vulnerable to getting migraine.

Dr. Martin (13:55): The medics, of course, talk about genetics; sure, that's a legitimate thing, but there may be other factors that make you vulnerable to getting migraine, too. So I develop a functional model by asking lots of questions of people. Psychologists work with people very much in a collaborative model. Medics work on an expert model. They're the experts. They ask you questions, do the test, [and] tell you what the problem is and what you need to do. We work more collaboratively.

Dr. Martin (14:25): So I develop a draft model, show it to the patients, and they're welcome to tell me, "You've got this wrong; that shouldn't be there," or, "You should add this," and the idea is we agree [on] a model between us. Then that's the platform for going forward because there are various treatments that make sense to use regardless of the specifics of someone's migraines.

Dr. Martin (14:52): Things like education, helping people understand their migraines, relaxation training, cognitive therapy, trigger management, and pain management strategies all make sense regardless. Then some of the rest will depend on specifics. For example, you're always welcome to ask what your triggers are, and we know the most common trigger for migraine is stress. If you say stress, they'll write that down and then move on to a different question.

Dr. Martin (15:22): For me, that's a starting point, not an end point. I want to know: Where's the stress coming from? Is it problems in your marriage? Is it more problems at work? Is it more problems with your children?

Dr. Martin (15:38): And of course, I want to know the answers to that because it may well be that part of the treatment program might be, if the problem is largely coming from marital discord, that one of the most useful things you can do with the person is help try to resolve marital issues. But there are other things. We know that social support is very protective against stress. If you've got a strong social support system, it really does help you deal with stress.

Dr. Martin (16:08): So if I find someone's got very little support in their life, part of the problem might be trying to help them build the size and the quality of their social support systems. It's the case that sometimes onset factors have no real significance anymore, but sometimes they [do]. So that's really what the functional model is about.

Dr. Martin (16:32): It also looks at the consequences side, like how does the person and significant others react to having a migraine, and also what has been the long-term impact of having a migraine problem? Because again, there are often ways there you might look for changes. I remember one

migraine patient I had; she was a primary school teacher by training, but she stayed at home, looked after the kids, cooked the meals, and so on.

Dr. Martin (16:58): And her husband had the absolute classic old stereotypical attitudes to all of this. You know, what a great life she had — she didn't work. She just cooked — well, everyone knows that's a hobby. Want to play with the kids? Well, that's fun. So she would phone him sometimes, [and] say, "I've got a migraine. You've got to come home, take over, look after the kids, cook the meals."

Dr. Martin (17:22): It would infuriate him because he thought she had this great life, whereas he was doing all the hard work, paying the mortgage and putting food on the table. So what would he do? He'd come home — he knew his wife always liked the house to look perfectly tidy and clean, which is a bit hard when you've got three little kids, but that's what she always wanted.

Dr. Martin (17:44): So he would walk through the front door, take his tie off and throw it in one direction, take his jacket off and throw it in another direction, take his shoes off — one in that direction, one in that direction — because he knew that would infuriate her. That was his way of getting at her for asking him to come home and help. So again, in that situation, you have to try and work with them and show you can understand each other's situation, but it's not working.

Dr. Martin (18:11): You have to have a different approach. Yes, she's likely to need to call him home to help out, but he can't react that way because it's just going to compound the situation — make it all worse. So it's about negotiating with the two of them how maybe there's times she doesn't need to phone him to come home, but he should keep his levels of support up and ideally higher. But it shouldn't be just dependent on her phoning out and saying, "I've got a migraine." It's about working with them to get them to operate in a more functional way. Does that make sense?

Kate May (18:55): Yeah, absolutely. It's fascinating hearing the reflections on that functional model and sitting and understanding how stress may be at play and interrelating with physical symptoms and the migraine presentation. I like listening to your reflection of asking the "whys" and taking that time to look at a situation like that more closely and playing with it for a little while.

Kate May (19:18): It seems like a more in-depth approach compared to the medical model, where it is often a quick diagnosis or a short amount of time when you're talking about something like stress. So thank you for breaking that down and explaining that for us.

Kate May (19:31): We've touched on CBT or cognitive behavioral therapy. Can you explain to us in a bit more detail what CBT is and what the evidence tells us about CBT for migraine?

Dr. Martin (19:42): Well, the evidence is strong for CBT. Behavioral treatment for headache really got going in the 70s, but right back as far as 2000, we had the U.S. Headache Consortium, which was a group of seven medical and headache associations, all the high-status ones: the [American Academy of Neurology], the [American Academy of Family Practice], American Headache Society, and so on. They did all this reviewing to come up with evidence-based guidelines for the treatment of migraine.

Dr. Martin (20:10): And they came to the conclusion that the evidence available for behavioral treatment was what they called Grade A. And Grade A is defined as multiple well-controlled trials that consistently give a very positive outcome for that result. So I think for a long time — never mind psychologists — the headache community, the neurologists and so on, have accepted that behavioral treatments are effective. But since then, I think some people have gotten stronger results.

Dr. Martin (20:43): Following that consortium, the American Headache Society funded a group of psychologists to do all this research. And they concluded that the average improvement with CBT for migraine was 52%. But like in the NHMRC-funded clinical trial that we did in my approach, the

reduction in headaches from pre- to post-treatment was 68%. And at 12-month follow-up, rather than relapsing, that increased to 77%. So that's a pretty high reduction in headaches.

Dr. Martin (21:23): An early study that compared behavioral treatment with pharmacological treatment — the reduction in headaches was 27% — so way below that sort of level. Remember, too, that drug treatments — there are hazards associated with them. I mean, there's side effects.

Dr. Martin (21:41): I think it's an interesting question whether you want a 27% reduction in headaches if it has that effect, or whether you'd rather just stay as you are, whereas the side effects of behavioral treatment are reduced anxiety, reduced depression, reduced anger, and so on. So the side effects are good. Overall, the evidence for CBT is very strong.

Kate May (22:03): Yeah, fascinating. It's really promising to hear that there's some research that shows some of those gains and shows some of those benefits without potentially some of those side effects that can come with other interventions. You've previously published about learning to cope with headache or migraine (LTC) and the EASE approach. Can you walk us through what these are?

Dr. Martin (22:21): I use as an analogy anxiety, because we know so much about anxiety. We know that the more you try to avoid the situations that cause anxiety, the more those situations will cause anxiety. You get a so-called sensitization effect. Avoidance leads to sensitization. And that's why the way we treat anxiety is we reverse that around and we use exposure-based approaches because exposure desensitizes them. And I said to NHMRC, “I think it might be the same with headaches.

Dr. Martin (22:56): “The more you avoid the triggers, the more sensitive you become to the triggers. And that therefore potentially makes you even more vulnerable. And so we should consider whether this is the right approach and you should consider exposure to some triggers to try to desensitize people to the triggers.” And the response of the NHMRC was they said, "Good Lord, what an interesting idea. We'd never thought of that," and then proceeded not to fund me on the grounds they thought it was speculative.

Dr. Martin (23:25): So interestingly, I've got some funding to do some research on this theory funded by a drug company. And the results we got perfectly fitted my theory. The fit was so perfect, if someone else had gotten it, I'd think they were making it up. They perfectly fitted the theory. So the next year I went back to NHMRC and was able to present these results and they've funded the program ever since.

Dr. Martin (23:51): And we've had some success with it because the research program's taken all sorts of twists and turns. I've published a number of reviews in this area, which have been very highly cited. And now it's been taken on board by neurologists, by the headache community. For example, the European clinical practice guidelines have been changed. It always used to say part of management is to tell people, “avoid triggers.”

Dr. Martin (24:21): It now says, “No, learn to cope with triggers,” and references my work and this approach as an alternative. So it's taken a bit of time to get the changes in the system. And of course, lots of people wouldn't be aware of this, but in the official guidelines and in the research literature, lots of neurologists now, when they talk about trigger management, refer to our studies and recommend the learning-to-cope approach.

Kate May (24:49): Yeah, fantastic. And I'd like to dig down into triggers a little bit more because many people learn to cope with migraine by avoiding triggers, such as certain foods, bright lights, and disrupted sleep. What are some of the problems with an avoidance approach to triggers?

Dr. Martin (25:04): Well, just that it can make you overly sensitive to those things. If you start with our laboratory studies, flicker, glare, and eye strain can trigger migraine. Now, I make the crack that I

think after all these years, I'm quite good at treating migraine. I have to say after all these years, I'm even better at giving people migraines. Because in our research, of course, we need to try to set off mechanisms so we can study them, and flicker, glare, and eye strain is brilliant.

Dr. Martin (25:33): I've got this — actually, it's in the background of the office somewhere — I have this thing where I have a stroboscopic light going off at people, flashing away, and they have to read rather small print off the screen. So there's the flashing light and there's eye strain because they're trying to read these words that are not very easy to read, and so it's bringing on and giving people headaches.

Dr. Martin (25:59): We've also been able to show that if we expose people to this absolutely minimally, they get more sensitive to it. If we expose it more maximally, they desensitize; they habituate to it; they build tolerance for it. So with my approach, it has various steps. The first step is really trying to work out with people what the triggers of their migraines are. Now I say that because of course a lot of migraine people say, "Well, I know what my triggers are."

Dr. Martin (26:35): Yes, but it's complicated and their beliefs are not necessarily correct. If you look at some of the complications, a lot of people will say eating chocolate can trigger a migraine. OK. We did a study where the big chocolate makers — Cadbury, Fry's — were behind us. They created all this chocolate for us.

Dr. Martin (27:00): Placebo chocolate looked like chocolate, tasted like chocolate, smelled like chocolate, with no chocolate ingredients in [it], and we had a whole lot of migraine sufferers who believed their headaches were triggered by chocolate. Take chocolate for a prolonged period, placebo chocolate for a prolonged period, or neither. Not a hint of a difference in the number of migraines in any of the three groups. So we work with people to try and experiment a bit.

Dr. Martin (27:26): So if they believe a particular food is a trigger, try the food and see if it does cause a headache. What a lot of people do is once they've decided, they stop eating the food, so they never test the hypothesis. It's complicated. There are lots of different triggers. I believe that triggers often aggregate together. You don't get a headache because of one trigger; you get a headache because there's more than one present.

Dr. Martin (27:54): So that can make it hard to see because you believe your headaches are A, B, C, and D. And you think, "Well, none of those were really much present before that migraine attack." But if you look closely, you realize three of them were there a bit. And then the three have aggregated together, and that's what's giving you your migraine. So we work with people, get them to experiment a bit and look at these different hypotheses. That's step one, to try to be more clear what the triggers actually are.

Dr. Martin (28:28): The next step is then developing plans. Do we go for avoidance or do we go for exposure? For example, we don't use exposure for everything. If you get headaches as a result of dehydration, I'm hardly going to say, "Well, go for ages without drinking." That's incredibly unhelpful. It's incredibly unhealthy. People need regular hydration.

Dr. Martin (28:50): Similarly, if they think they get headaches as a result of going too long without eating food, I'm not saying, "Well, starve yourself for ages because that's very unhealthy." So with those, we'd more work on an avoidance model: Regularly drink water, regularly eat food. But then some of the others like the flicker, glare, and eye strain or noise, we might work on more of a desensitization model, trying to desensitize them to those triggers.

Dr. Martin (29:18): Because the last thing we want is numerous different triggers, because if they're then having to try to avoid them all, it obviously hugely impacts on their whole way of life, their whole lifestyle.

Dr. Martin (29:31): So if we can knock off some, it works well in its own right so that your lifestyle is not restricted. But also given the aggregation effects, it may be some of the triggers we're left with are not such a big deal because they're not aggregating together with the triggers that we're desensitizing. Does that make sense?

Kate May (29:55): Yeah, absolutely. There's a lot to learn and reflect on there in triggers. And when you take that lens of examining them over time and looking at the other factors going on, I think there's a lot we can learn about our own triggers. I'd love to touch on a concept: hypervigilance. This is something that some people might be navigating or struggling to understand.

Kate May (30:14): I know when I first personally learned about it in relation to my own migraines, it took me a while to get my head around it and how it can relate and how challenging it can be for people living with migraine. Can you explain what hypervigilance is and how it might impact migraine and headache?

Dr. Martin (30:32): Well, I think probably different people use the term differently.

Dr. Martin (30:34): So it's not easy to give a simple answer to your question, but certainly, for example, given the relationship to stress and migraine, hypervigilance implies that you're tense, that you're looking for triggers and looking for things that could bring on a migraine or make your migraines worse or whatever. And obviously that's a bad thing because that puts you in a biological state where it's more likely that a migraine will come on.

Dr. Martin (31:06): So for example, I do talk to people who suffer from migraine and say to them, "Look, you can maybe think of every migraine you have as a learning experience, where you try to work out why it happened and what maybe you could have done differently for it to have not happened or to minimize its duration or intensity," and so on.

Dr. Martin (31:34): But I would encourage, like if someone gets a migraine attack, yeah, spend a little bit of time trying to analyze it and work out why it happened, but don't spend too long on it because the last thing you want to do is agonize about it indefinitely, because that'll just make the whole experience worse. And that's what we don't want.

Dr. Martin (31:54): I do believe that the key mechanism of migraine is a vicious cycle model. The more migraines you get, the more migraines you're likely to get. So in a treatment approach, you try to create a positive cycle instead of a negative cycle. The goal is always that next week, try to get less migraine than the previous week, recognizing progress is not going to be smooth. If improvement is like that [in a straight line] — you're never going to get a straight line like that.

Dr. Martin (32:33): You're going to get a line that's going to go like that [in a zigzagging pattern]. The hope is the overall is down. It's partly the way people react to migraine. One of the words I use sometimes for quite a common reaction to migraine is what I call "spring cleaning."

Dr. Martin (32:47): You get people — we know migraine is more common in females, and we know that females do more work around the home than males — and quite often what they'll do is if a migraine comes on, or even if they think a migraine is going to come on, they'll immediately do all the things they feel they won't be able to do when a migraine does come on, like they'll cook the next three lots of meals; they'll clean the house and so on.

Dr. Martin (33:13): And that to me is not the right reaction because that type of reaction, all it does is it guarantees a migraine will come on and it'll probably be of longer duration and more intense. For me, as soon as one comes on, or you think one's coming on, it makes sense much more to get into that mode of, “What can I do to maybe prevent it coming on?” Or, “What can I do to minimize the duration and intensity of the migraine?” That should be the priority.

Kate May (33:45): Interesting. I'm sure a lot of people listening along will definitely relate to getting stuck in a cycle of migraine and experiencing [that] once you've had one migraine, it can feel like more and more keep coming on and it's very hard to break that cycle. I'd love to pivot into summarizing some of the practical takeaways and what people can do.

Kate May (34:04): It sounds like there's lots of good evidence and possibilities for CBT and other behavioral approaches in migraine, but how do people access these sorts of approaches? Luanne from our community asks, "How can you find CBT clinicians that have experience specifically with migraine, not just for mental health?"

Dr. Martin (34:20): The main journal for headache and migraine, *Cephalalgia*, run by the International Headache Society — they invited me to write an editorial for them, which I have written and sent off to them. And it's all about how we can move towards more people with migraine getting behavioral treatment. Because at the moment, all the evidence suggests hardly anyone does.

Dr. Martin (34:41): One of the problems is that the majority of psychologists have not had specific training in assessing and treating migraine, but that doesn't mean none have. This may amaze you, but I've run postgraduate clinical program training my entire career. And strangely enough, I always have a whole lot of training in there about how to assess and treat migraine. So my graduates will have experience in this area. I do training workshops or conferences and so on.

Dr. Martin (35:09): So there are some people around, but even if people haven't had specific training in working with people with migraine, a lot of the techniques are things that psychologists use all the time. So if you look at some of the standard things we use, like relaxation training and cognitive therapy, every clinical psychologist has had training in that area.

Dr. Martin (35:35): So there's no reason that any clinical psychologist couldn’t potentially help someone with migraine. Even if they haven't had specific training in that domain and haven't had experience doing it, they still should be able to help.

Kate May (35:51): I know that some people from within the pain community may have tried psychological treatment and it maybe hasn't helped them. Some people may feel that their migraine wasn't taken seriously or they weren't understood. What would you say to someone that's had that experience and was thinking about whether they should consider it again?

Dr. Martin (36:07): Look, I think traditionally, people with migraine have had all sorts of bad experiences. I can only say, I think it's getting better. Remember that tension-type headache used to appear in the classification of psychiatric disorders in section five on personality disorders. It was viewed as a type of personality disorder. Well, obviously that's ridiculous and that's not how it is today.

Dr. Martin (36:34): Much more common amongst women. I think a lot of females in particular have had bad experiences where they've gone to their GP [general practitioner] and the GP has trivialized the problem and said, "Ah, it's women, you know, they can't really cope with stress. They're a bit sensitive," and things like this. And so that would be a terrible experience for someone who has migraine and so inappropriate. I must admit, my advice to patients I see who've had that sort of experience is, “Go and look for a GP who's suffered from migraine themselves and you'll get a different response.” But the problems are much wider than that. We have the global burden of disease study, which looks at how much disability is caused by different disorders.

Dr. Martin (37:28): When they first did the global burden of disease study in 1990, migraine wasn't considered because, was it disability? It wasn't in there. It wasn't until 2000 that it came in, but having come in, it's now ranked as the second-highest cause of disability worldwide. So I guess what I'm trying to say is, I do feel huge sympathy for people who've had these bad experiences. I think it's

improving. I think the world is more and more coming to recognize it's a very significant, serious problem that is going to be taken very seriously with every sort of option explored to help people.

Kate May (38:12): I think that's a great message for those who experience that and are living with migraine. I'd love to wind up this interview with a message of hope. Barb from our community asks, "Do you have any advice on staying positive when you're living with daily headache and facing isolation?"

Dr. Martin (38:26): Well, absolutely. I think it's always hard to know exactly how to put this because if you ever talk to people about how there are ways of getting on top of your migraine, there's a danger that they think you're trivializing it. The neurologists often talk about migraine as a neurological disorder and they talk about it being a genetic disorder and there being no cure for it, and so on.

Dr. Martin (38:57): And the trouble is that makes people with migraine feel there's no hope. Now, I don't believe that. I think there is hope. There are ways forward, but I know some people with migraine then get upset because they feel then I'm blaming them for having the problem in the first place, which I most certainly am not. But there is hope. Look at our study: the 68% reduction, 77% by 12 months.

Dr. Martin (39:26): There are ways forward. It's just that they're difficult. They're time-consuming, and people need professional help to get there. It'll be a collaborative model. No one's telling them what to do, but they need that knowledge, that assistance, and that support to actually go forward.

Kate May (39:44): Fantastic. And look, I think there's been lots of positive messages in our discussion today and seeing how the field of research and care has changed over your career as well, and where it might be going in the future. It'll be really interesting to watch this space and see where this continues to go. Thank you so much for your time and breaking that down for us and telling us a bit more about CBT and other behavioral approaches.

Kate May (40:05): Where can we learn more about your work or follow along and learn a bit more? I know you've mentioned you have a book. Is there any way we can point viewers who might like to learn more about CBT or behavioral approaches?

Dr. Martin (40:16): I have to admit, I've been threatening to write a self-help book on migraine for about 40 years, but I think I'm probably getting closer. I might actually write a self-help book so people could directly use that because that would be the best way of doing it.

Dr. Martin (40:30): I wrote a chapter — there's a prestigious series of 12 volumes called *Comprehensive Clinical Psychology* that's supposed to tell clinical psychologists everything they need to know — and I always get asked to write the chapter on headache and migraine. The last one was written in 2022. So there is a chapter where I've written about all the sorts of things we've talked about today and a whole lot more. That might be a helpful thing for people to look at.

Kate May (41:04): Brilliant. I'll make sure that we can link that to our viewers and they can continue to learn if they would like to. Thank you again for your time. It's been great to listen today and learn more about this topic.

Dr. Martin (41:15): All good. Thanks, Kate.