NEED OF STUDY

Migraine is a common, debilitating disorder that imposes a large personal burden on sufferers and high economic costs on society (Holmes et al., 2001). It is a chronic disorder characterized by episodic attacks. The acute burden of illness is determined by the intense headache pain and the associated symptoms (e.g. nausea, vomiting) that characterize attacks (Stewart et al., 1994b; Rasmussen, 1995b). The acute effects lead to missed work and impairment of work and non-work activities (Stewart et al., 1994b; Clouse and Osterhaus, 1994; de Lissovoy and Lazarus, 1994; Rasmussen, 1995b; D’Amico et al., 2004; Dueland et al., 2004). Migraine also has chronic effects between attacks. On the long-term basis, the illness may disrupt quality of life, self-assessment of health, and lead to poor school performance, underemployment and unemployment (Miciceli, 1993; Edmeads et al., 1993; Clouse and Osterhaus, 1994; de Lissovoy and Lazarus, 1994; Lipton and Stewart, 1994; Ruiz de Velasco et al., 2003).

The operational diagnostic criteria of the International Headache Society (IHS) (1988) distinguish between migraine with aura and migraine without aura as the major sub forms of migraine. This distinction is based on the clinical presence of aura, i.e. the complex of focal neurological symptoms which initiates or accompanied migraine attacks with aura (Rasmussen, 1995b).

A few studies indicate differences in migraine with aura and migraine without aura. Migraine with aura and migraine without aura have different epidemiologic characteristics. The life time prevalence of migraine with aura is 6% and of migraine without aura 9% (Russell et al., 1995). The sex distribution of migraine with and without aura is
different, indicating the gender-related factors may be of even greater importance in migraine without aura than in migraine with aura. It has been shown that clinical factors related to female hormones (such as menarche, menstruation, pregnancy, use of oral contraceptives, menopause) are more strongly associated with migraine without aura than with migraine with aura (Rasmussen and Olesen, 1992). The age of onset of migraine without aura and migraine with aura also differs and varying risk factors profiles may occur (Stewart et al., 1991; Rasmussen and Olesen, 1992; Rasmussen, 1995b).

According to Russell and Olesen (1995), “the different familial patterns indicate that migraine without aura and migraine with aura have a different etiology. Migraine without aura seems to be caused by a combination of genetic and environmental factors whereas migraine with aura is probably determined largely or exclusively by genetic factors.” A few studies have indicated differences in pathophysiology of the two disorders (Olesen et al., 1981a; Olesen et al. 1981b).

So the differing epidemiologic characteristics, different familial aggregation, and varying pathophysiologic findings strongly support the concept of separate entities (Rasmussen, 1995b). So it can be inferred that migraine with aura and migraine without aura are two different entities, or at least clearly distinct subgroups of migraine. Olesen (1985) emphasizes the marked pathophysiological differences between the two conditions and suggests “despite unquestionable similarities, they should be studied separately to further elucidate where they are similar and where they differ.” Review of literature reveals that there are very few studies comparing the personality characteristics of migraine with aura and migraine without aura sufferers.

Lipton et al. (2000) view migraine as relatively under recognized, under diagnosed, and under-treated. According to Lipton et
al. (2001), “improved migraine diagnoses are required and improved strategies for treating migraine are needed, because many migraine sufferers are dissatisfied with current treatment”.

A study comparing the personality and defense mechanisms of migraine sufferers and controls may prove to be helpful in overall understanding of the psychological factors in migraine, in enhancing the rate of recovery, and in forming certain impressions about case management and outlining the treatment programme. Studies reporting various psychological treatment measures used successfully have been reported by: Howard et al. (1982) using rational stage directed hypnotherapy; Graham (1975) and Ansel (1977) using hypnosis; Gauthier et al. (1994) and Scharff et al. (2002) using thermal biofeedback treatment; Richter et al. (1986) using relaxation training and cognitive coping; Holroyd and Penzien (1994) using relaxation therapy training with optional thermal biofeedback. So the holistic approach towards the treatment of migraine patient would definitely enhance the rate of recovery. Understanding of the personality of migraine sufferers will further help in outlining an effective treatment programme for migraine patients.

Migraine headaches are more prevalent among women. In women, migraine may be caused by reaction to food, stress, or it is directly connected to the fact that they are women. Over two-third of all the people who suffer from migraine are females, and in many cases, the causes (or exacerbating factors) appear to be hormonal. Girls and boys have about the same incidence of migraine headaches, but after puberty, girls speed past boys in the migraine department (Kandel and Sudderth, 1998). According to Rasmussen (1995b), 5% and 11% of women experience migraine with and without aura; respectively, compared with 3% and 2% of men. The discrepancy in incidence between sexes is greatest at the time traditionally associated with child-bearing (15 to 49
years); whereas above or below this age, the evidence in both sexes appeared remarkably similar (Stang et al., 1992). As migraine is more prevalent in females than in males, so a study focusing exclusively on female migraine patients is required to avoid any sex-specific effects.

Like many forms of chronic pain, migraine represents a highly variable condition. Patients display a wide spectrum of headache frequency and intensity and may vary in the way they respond to pain (Lipton et al., 2002; Henry et al., 2002). It is essential therefore to understand the different elements of headache and their impact on various personality variables. Such knowledge could lead to improved therapeutic approaches.

There is growing incidence of migraine patients all over the world as well as in India. Different researchers are working in this area in the west, but there is relative lack of studies concerning migraine in India, particularly regarding migraine with aura and migraine without aura. Such a study may prove to be helpful in overall understanding of the psychological factors in migraine and in enhancing rate of recovery and outlining effective treatment programmes. So keeping in view scarcity of research and contradictory findings, present study is being undertaken to compare female migraine patients with and without aura and controls on personality factors like Depression, Anxiety, Rigidity, Orderliness, Ambition, and Defense Mechanisms. It also intends to discover cluster of variables that can help in distinguishing migraine with aura, migraine without aura from controls.