

CGRP–Dissociation in Chronic Migraine: Why Pain Relief Still Leaves the Migraine Brain Behind

A peer insight report on the gap between nociceptive suppression and true life restoration in chronic migraine, drawn from neurologists, headache specialists, and neurophysiology-focused clinicians.

Survey ID 8876061 | 76.6% completion rate | 64 total responses

64	49	6	49
total responses	complete responses	reported countries	core analytic base

WHY THIS REPORT

The clinical win of fewer headache days is revealing a second layer of migraine burden.

CGRP-targeted therapies have transformed chronic migraine care. But this survey shows that neurologists increasingly judge therapeutic restoration through function, predictability, cognition, and patient control. In other words, a patient can look better on a headache chart and still not feel neurologically restored.

Methodology note: This report is based on a filtered MDForLives neurology survey export. Questions 1, 2, 14, 16, and 17 were administrative, store-text, or honeypot fields and are excluded from clinical interpretation. Question-level bases vary according to survey completion.

EXECUTIVE SUMMARY

Six peer signals define the CGRP–dissociation phenotype.

01 Function is the new success metric.

71.4% chose functional scale achievement or patient-defined efficacy, rather than a pure headache-day or abortive-use endpoint.

02 Cognitive impairment leads residual burden.

34.7% identified executive cognitive deficits as the most responsible non-cephalic symptom for ongoing impairment.

03 Intercital dread is clinically visible.

79.6% proactively screen for or reactively address cephalalgiaphobia, though only 36.7% do so in nearly every consultation.

04 Access friction remains a clinical problem.

57.1% selected prior authorization or step therapy as the leading barrier to comprehensive care.

1 CONTEXT | DATA | INSIGHT | IMPACT

What does therapeutic restoration mean when headache-day reduction is not enough?

71.4%

prioritize functional or patient-defined restoration over pure pain-day or abortive optimization metrics.

WHAT THE DATA SHOWS

Functional scale achievement leads at 40.8%, followed by subjective patient efficacy at 30.6%. Absolute interictal reset accounts for 16.3%, and abortive optimization for 12.2%.

THE INSIGHT

Neurologists are not rejecting headache-day reduction. They are indicating that it is incomplete unless it translates into predictable days, less disability, lower medication risk, and restored identity.

WHY IT MATTERS

If trials and payers define success narrowly, the care system can mark patients as improved while leaving core interictal disability and occupational impairment unresolved.

Real-world therapeutic restoration metrics



2 RESIDUAL BURDEN

The non-cephalic symptoms tell us where pain suppression stops.

34.7%

rank executive cognitive deficits as the leading persistent impairment after pain suppression.

WHAT THE DATA SHOWS

Executive cognitive deficits lead at 34.7%. Central sensitization follows at 28.6%, migraine drain at 24.5%, and vestibular or autonomic dysregulation at 12.2%.

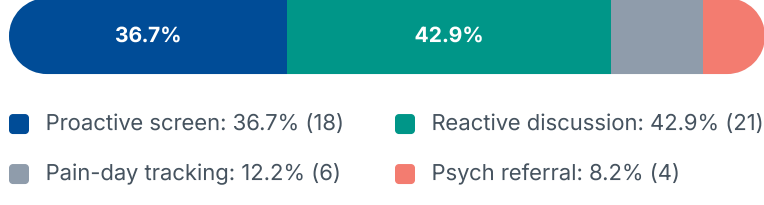
THE PATTERN

The residual burden is distributed across cognition, sensory sensitivity, exhaustion, and autonomic disruption. This makes chronic migraine harder to evaluate with a single headache diary.

IMPACT

Patients may have fewer severe attacks but still struggle with concentration, sensory tolerance, travel, nutrition, and daily routine reliability. The disease remains functionally active.

Persistent non-cephalic impairment after CGRP–targeted relief



Short labels are used for readability.

3 INTERICTAL SHADOW

Cephalalgiaphobia is visible in clinic, but proactive screening is not yet universal.

79.6%

either proactively integrate screening or reactively address cephalalgiaphobia when it becomes visible.

WHAT THE DATA SHOWS

36.7% screen in nearly every consultation, 42.9% discuss it only when anxiety or avoidance is obvious, 12.2% mainly track pain days, and 8.2% refer externally.

THE TENSION

Clinicians recognize the fear of the next attack, but systems still reward shorter, medication-focused encounters. Intercital dread can therefore remain under-treated even when it is clinically acknowledged.

WHY IT MATTERS

The fear of recurrence can narrow behavior, reduce social and occupational confidence, and keep the patient in a defensive posture between attacks.

Cephalalgiaphobia management pattern



4 PSYCHOSOCIAL EROSION

The migraine burden extends into isolation, identity, and credibility.

46.9%

say isolative depressive regression is the hardest non-anxiety factor to reverse.

WHAT THE DATA SHOWS

Social withdrawal leads the long-term psychological burden at 46.9%, followed by self-efficacy erosion at 32.7%. For stigma, the professional space leads at 55.1%.

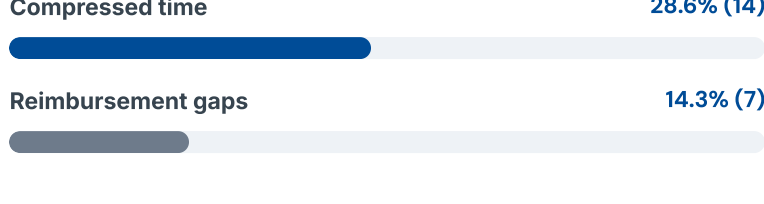
THE INSIGHT

The disease burden is not only biological and psychological. It is social. Migraine can reshape how patients are perceived by employers, families, insurers, and sometimes acute care teams.

IMPACT

For healthcare professionals, this argues for documentation that translates symptoms into functional consequence, especially around cognitive load, predictability, and work reliability.

Hardest non-anxiety psychological factor



Most damaging skepticism site



5 ADMINISTRATIVE TRAUMA

Step therapy is not just a process barrier. It becomes part of the disease story.

57.1%

identify prior authorization or step therapy as the most severe barrier to comprehensive migraine care.

WHAT THE DATA SHOWS

Prior authorization or step therapy leads at 57.1%. Compressed consultation time follows at 28.6%, while reimbursement deficits for multidisciplinary care account for 14.3%.

THE TENSION

The same neurologists who see residual cognitive and interictal burden also report that access pathways force attention back to legacy sequence rules and medication justification.

WHY IT MATTERS

When access is delayed or visits are compressed, the patient may spend longer in an avoidable burden state. Administrative friction becomes clinically meaningful.

Leading systemic barriers



6 CARE MODEL

The strongest support ask is not another drug pathway. It is embedded psychological expertise.

53.1%

would add a specialized health psychologist trained in migraine-specific CBT, biofeedback, and cephalalgiaphobia management.

WHAT THE DATA SHOWS

Health psychology leads the clinic support priority at 53.1%. Nurse navigation follows at 20.4%, lifestyle consultation at 14.3%, and physical therapy at 12.2%.

THE INSIGHT

Neurologists are signaling that the next care frontier is multidisciplinary by design. Pain suppression helps, but interictal fear, avoidance, function, and administrative work need specialized infrastructure.

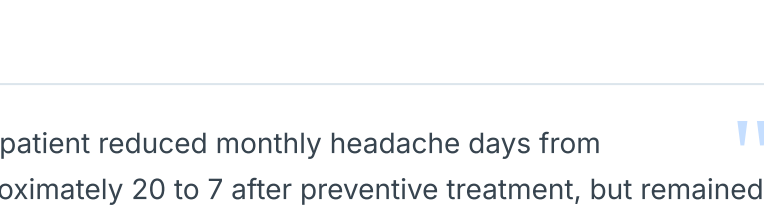
IMPACT

High-value headache clinics may need to pair targeted pharmacology with health psychology, navigation, documentation support, and workplace accommodation pathways.

Most valuable added clinic role



Priority shift for the next decade



7 OPEN-TEXT REALITY CHECK

Several clinicians described patients who looked successful on paper but still did not have their lives back.

The most useful open responses did not reject CGRP-era progress. They exposed its limits.

Clinicians repeatedly described a patient who moved from more than 20 headache days to 5 or 7, yet remained impaired by brain fog, fatigue, sensory hypersensitivity, anticipatory anxiety, insomnia, or social withdrawal.

A patient with chronic migraine had more than 20 headache days per month. After preventive treatment, she dropped to 5 headache days per month. The insurer saw a 70% reduction and the employer saw fewer sick days, but she still felt cognitively impaired, anxious about the next episode, and unable to plan ahead. Her words were: I still don't have my life back.

OPEN-TEXT THEME, PARAPHRASED FROM SURVEY RESPONSES

One patient reduced monthly headache days from approximately 20 to 7 after preventive treatment, but remained disabled by brain fog, sensory hypersensitivity, fatigue, difficulty concentrating, and impaired executive function. The clinician's takeaway was that migraine is a complex neurologic brain disorder, not simply a collection of headache days.

OPEN-TEXT THEME, PARAPHRASED FROM SURVEY RESPONSES

A 28 year old mother of two showed strong improvement in mental health after advanced therapies, but reported that headache, sex drive, and energy levels had not recovered after years of migraine.

OPEN-TEXT THEME, PARAPHRASED FROM SURVEY RESPONSES

An Italian clinician described a patient on preventive gepant therapy whose very painful attacks were almost eliminated, but who still had mild pain days linked to fatigue and confusion. The point: migraine is not exhausted by the painful attack.

OPEN-TEXT THEME, PARAPHRASED FROM SURVEY RESPONSES

Interpretation: The strongest qualitative message is that chronic migraine should be communicated to primary care, employers, and insurance boards as a complex neurologic brain disorder with interictal consequences, not merely a count of painful days.

AUDIENCE LENS

What this means for neurology and headache medicine

The data points toward a practical reframing of chronic migraine care across specialists, primary care partners, payers, and employers.

For neurologists

Clinical measurement

Headache days remain necessary, but insufficient. Functional scales, cognitive burden, interictal fear, and patient control may need consistent documentation.

For headache clinics

Care design

Embedded health psychology is a peer priority. The strongest clinic support ask aligns directly with cephalalgiaphobia, avoidance, and self-efficacy erosion.

For payers

Access policy

Step therapy is seen as a clinical barrier. The data suggests that delay can keep patients in a burden state beyond what pain-day metrics capture.

For employers

Functional credibility

Reduced absence does not always mean restored capacity. Cognitive slowing, fatigue, and unpredictability can persist after attack frequency improves.

FROM INSIGHT TO IMPACT

The next migraine endpoint is not only fewer attacks. It is the return of reliable life.

This MDForLives report shows a clinically responsible middle ground. CGRP-targeted therapies are transformative, but the neurologist view suggests that chronic migraine care must evolve beyond simple nociceptive suppression. The next standard of success should include interictal function, cognitive clarity, psychological safety, workplace credibility, and earlier access to effective therapy.

1 Measure function and interictal pain.

Use disability scales and interictal burden prompts to capture what headache-day counts miss.

2 Screen for cephalalgiaphobia.

Treat anticipatory dread as part of migraine management, not a peripheral concern.

3 Document workplace impairment.

Translate invisible symptoms into functionally relevant language for employers and insurers.

4 Redesign access and clinic support.

Address step therapy friction while embedding behavioral and administrative support inside headache care.

CLINICAL CONTEXT REFERENCES

1. **International Classification of Headache Disorders, ICHD-3, chronic migraine criteria.** Headache on 15 or more days per month for more than 3 months, with migraine features on at least 8 days per month.

2. **American Headache Society 2024 CGRP-targeting therapies position statement.** CGRP-targeting therapies are positioned as a first-line option for migraine prevention.

3. **National Institute of Neurological Disorders and Stroke, Migraine information page.** Migraine is more than a bad headache and can include fatigue, mood change, sensory sensitivity, nausea, and symptoms between attacks.

4. **Cephalalgiaphobia pilot study in high-frequency migraine.** Fear of headache during pain-free periods can influence medication use and is clinically relevant to migraine burden.

5. **Migraine-related stigma and disability research.** Migraine-related stigma is associated with greater disability, interictal burden, and lower quality of life across headache-day categories.

6. **Recent interictal burden reviews.** Interictal symptoms affect cognitive, functional, psychological, interpersonal, and socioeconomic domains.