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Identifying and Explaining the Components, Themes, and Dimensions of Perceptions and Lived Experiences among Patients with Migraine: A Qualitative Phenomenological Study

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ABSTRACT

This study aimed to identify and explain the components, themes, and dimensions of the perceptions and lived experiences of patients with migraine. This qualitative study was conducted using a phenomenological approach. Participants were patients with migraine who referred to Mehraram Clinic in Tehran, Iran. They were selected through purposive sampling with maximum variation. Data were collected through individual semi-structured interviews and continued until data saturation was achieved. The interviews focused on patients' experiences of migraine attacks, bodily perceptions, sensory triggers, emotional reactions, cognitive difficulties, daily functioning, social and family consequences, and coping strategies. The interviews were transcribed verbatim and analyzed using thematic analysis with a phenomenological orientation. Trustworthiness was ensured through credibility, transferability, dependability, confirmability, member checking, repeated review of transcripts, and documentation of analytic decisions. Analysis of the interviews led to the extraction of 312 initial codes. After repeated review and merging of similar codes, 84 final codes were organized into 19 subthemes and 6 main themes. The main themes were: painful and unpredictable body, sensory sensitivity and vulnerability to stimuli, psychological disturbance and emotional exhaustion, impaired cognitive functioning and daily performance, family, social, and occupational consequences of the disease, and coping strategies, adaptation, and reconstruction of the relationship with illness. The findings showed that migraine was experienced as a multidimensional condition that disrupts bodily trust, emotional stability, cognitive clarity, social participation, role functioning, and everyday planning. Migraine is not experienced merely as recurrent headache, but as a complex lived condition that affects the patient's body, emotions, cognition, relationships, responsibilities, and identity. A patient-centered understanding of migraine can help clinicians move beyond symptom counting and design more sensitive assessment and psychological intervention strategies.

Keywords: migraine; lived experience; perceptions; phenomenology; qualitative study; thematic analysis.

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Introduction

Migraine is a complex neurological disorder characterized by recurrent attacks of moderate-to-severe headache and a range of associated sensory, autonomic, cognitive, and affective symptoms. Although headache pain is its most recognizable manifestation, migraine may also involve nausea, vomiting,

photophobia, phonophobia, osmophobia, fatigue, cognitive slowing, irritability, sleep disturbance, and marked impairment in everyday functioning. The disorder is heterogeneous in its clinical expression, attack frequency, duration, precipitating conditions, accompanying symptoms, and degree of disability. Contemporary accounts increasingly characterize migraine as a dynamic neurobiological condition whose manifestations emerge through interactions among genetic vulnerability, neurodevelopmental processes, sensory-processing abnormalities, hormonal influences, environmental exposures, and psychological responses. This multidimensional understanding is particularly evident in pediatric migraine, in which neurodevelopmental mechanisms interact with age-specific clinical phenotypes and psychosocial conditions, indicating that migraine cannot be reduced to an isolated pain event (1). Similarly, the recognition of high-frequency episodic migraine as a potentially distinctive clinical subtype demonstrates that conventional classifications based only on broad frequency thresholds may not fully capture the variability, burden, and progression of the disorder (2).

The burden of migraine is not confined to the duration of an acute attack. Patients may experience prodromal symptoms before pain begins, functional incapacity during the headache phase, and fatigue, cognitive disturbance, or emotional depletion after the most severe pain has subsided. Between attacks, they may remain preoccupied with the possibility of recurrence, possible triggers, access to medication, unfinished responsibilities, or the risk that migraine will interrupt an important personal, family, educational, or occupational activity. Consequently, the actual burden of migraine often exceeds what is represented by attack frequency or pain intensity. Even individuals classified as having episodic migraine may experience continuing restrictions because the anticipation, management, and aftermath of attacks become incorporated into everyday life. The clinical heterogeneity of migraine also changes across the life course. For example, fluctuations in ovarian hormones during the menopausal transition may alter migraine frequency, severity, phenotype, and treatment needs, while the postmenopausal course may differ substantially among women (3). Such variability highlights the importance of understanding how migraine is experienced by particular patients rather than assuming that diagnostic categories alone adequately represent the illness.

The contemporary conceptualization of migraine has therefore shifted from a narrowly biomedical framework toward an integrated biopsychosocial perspective. Neurobiological mechanisms remain fundamental, but they operate within a broader system that includes sleep, stress, emotional states, behavioral responses, interpersonal relationships, beliefs about pain, coping resources, and environmental conditions. Psychological factors are not merely secondary reactions to pain; they may influence symptom interpretation, perceived trigger sensitivity, treatment engagement, disability, and adjustment to recurrent attacks. Cognitive appraisal, anxiety, depression, pain-related fear, catastrophizing, rumination, avoidance, and reduced perceived control have all been identified as important components of the migraine experience (4). This does not imply that migraine is psychogenic. Rather, it indicates that the meaning assigned to symptoms and the behavioral responses developed around them can intensify or reduce the functional and emotional consequences of a biologically based disorder.

Among the most significant psychological dimensions of migraine is the fear of future attacks. Because attacks may occur unpredictably, patients can become increasingly vigilant toward minor bodily sensations, environmental changes, emotional fluctuations, sleep disruption, or other experiences interpreted as

warning signs. Fear of attack may continue during pain-free periods and alter decisions about work, travel, social participation, exercise, and family responsibilities. Research on episodic migraine indicates that fear of attacks is associated with multiple clinical and psychological factors and should be regarded as an important dimension of disease burden rather than a marginal concern (5). More broadly, recurrent and progressive health conditions can generate existential concerns involving uncertainty, vulnerability, loss of control, identity, and the future. In migraine, fear of recurrence or progression may become connected to worries about whether attacks will become more frequent, more disabling, or increasingly incompatible with valued life activities (6). These concerns demonstrate that migraine affects not only present bodily comfort but also the patient's relationship with future possibilities.

The fear-avoidance model provides a useful framework for understanding how cognitive and affective responses can contribute to disability. When pain or premonitory sensations are interpreted as threatening, patients may develop fear, heightened bodily monitoring, anticipatory anxiety, and avoidance of activities believed to precipitate or worsen an attack. Although avoidance may provide short-term protection or reassurance, persistent avoidance can reduce activity, undermine confidence, restrict social participation, and reinforce perceptions of bodily fragility. Cognitive-affective mechanisms may consequently interact with headache symptoms and contribute to disability even when attack characteristics alone do not fully explain the patient's functional limitations (7). Fear of pain may also shape how patients identify and interpret headache triggers. Individuals who strongly fear pain may attribute attacks to a wide range of foods, activities, emotional experiences, or environmental conditions, thereby increasing trigger vigilance and restricting everyday behavior (8). Thus, the patient's perception of triggers may become as consequential as the triggers themselves because it influences planning, exposure, avoidance, and perceived control.

Catastrophizing is another important cognitive-affective process in migraine. Patients who interpret migraine as uncontrollable, overwhelming, or inevitably disabling may experience greater distress and difficulty responding flexibly to symptoms. Catastrophic thinking can include persistent rumination about pain, magnification of its expected consequences, and feelings of helplessness. Evidence indicates that migraine is closely associated with psychosocial factors such as catastrophizing, anxiety, and stress, which may contribute to greater perceived burden and impaired adaptation (9). The relationship between migraine and anxiety has received increasing scholarly attention, reflecting recognition that emotional distress and recurrent headache frequently coexist and may influence one another (10). Anxiety can heighten sensitivity to bodily sensations and uncertainty, whereas repeated migraine attacks may generate anticipatory fear, reduced confidence, and concerns about future functioning. The interaction between migraine and psychological distress is therefore likely to be reciprocal rather than unidirectional.

Pain severity is also associated with mental health outcomes. More intense or persistent pain may increase emotional distress, interfere with restorative activities, and reduce patients' perceived capacity to fulfill expected roles. Conversely, anxiety, depressive symptoms, and diminished psychological resources may alter pain appraisal and reduce tolerance for migraine-related disruption (11). Migraine and depression are particularly important as comorbid conditions because their co-occurrence can produce overlapping patterns of withdrawal, fatigue, reduced motivation, cognitive difficulty, sleep disturbance, and diminished quality of life. Integrative frameworks such as the Hybrid Digital-4E Model emphasize that migraine–depression comorbidity should be understood through embodied, embedded, enactive, and extended

processes rather than through isolated symptom categories (12). From this perspective, the patient's experiences emerge through interactions among the nervous system, body, environment, daily activities, social relationships, and technological or healthcare contexts.

Sleep constitutes another major dimension of the migraine experience. Patients frequently identify insufficient or irregular sleep as a precipitating or aggravating factor, yet the relationship between sleep and migraine is complex and bidirectional. Experimental evidence concerning sleep restriction and nociceptive processing suggests that inadequate sleep may modify pain-related neurophysiological responses in people with migraine (13). At the experiential level, uncertainty about sleep can become part of a broader pattern of vigilance in which patients monitor bedtime, awakening, sleep quality, fatigue, and anticipated daily demands. Rumination may further interfere with sleep, particularly among individuals who already experience anxiety or panic-related symptoms. Evidence from women with panic attacks indicates that migraine and rumination can contribute to the prediction of sleep quality, illustrating the interdependence of headache, repetitive negative thinking, and restorative functioning (14). Sleep difficulties may subsequently reduce pain tolerance, impair concentration, increase irritability, and make adaptation to future attacks more difficult.

Migraine also affects cognitive functioning and subjective mental clarity. During and around attacks, patients may experience difficulty concentrating, remembering information, making decisions, processing language, or sustaining goal-directed activity. These cognitive experiences can be especially distressing because they challenge the patient's sense of competence and reliability. A multidimensional approach to migraine assessment has shown that cognitive reserve and well-being are relevant to understanding how patients function despite recurrent symptoms (15). Cognitive difficulties may be experienced not merely as testable deficits but as disruptions of ordinary agency: the individual may know what must be done but feel unable to organize, initiate, or complete the task. Such experiences can affect employment, education, parenting, communication, and self-confidence. They may also persist into the postdromal period, delaying the patient's return to ordinary routines even after acute pain has diminished.

The influence of migraine on quality of life is consequently broad. Patients may alter their work patterns, reduce social engagement, cancel plans, avoid travel, limit physical activity, or withdraw from environments characterized by bright light, noise, strong odors, crowding, or prolonged screen exposure. Quality of life encompasses not only symptom severity but also emotional well-being, social participation, autonomy, meaningful activity, and the ability to fulfill valued roles. Spiritual well-being may also be relevant because chronic and recurrent illness can affect patients' sense of meaning, hope, connectedness, endurance, and inner stability. Research examining spiritual well-being and quality of life among patients with migraine indicates that spiritual dimensions may form part of the broader experience of living with the disorder (16). Spiritual resources may help some patients tolerate uncertainty and reconstruct meaning, whereas spiritual distress may intensify helplessness or existential concern.

The potential clinical value of spiritually informed intervention has also been examined more directly. A spiritual therapy package developed for patients with migraine was evaluated in relation to pain intensity, pain catastrophizing, distress tolerance, and resilience, suggesting that therapeutic attention to meaning, spiritual resources, and existential adaptation may influence both emotional and pain-related outcomes (17). Such work is important because standard treatment may focus primarily on medication, trigger

identification, and attack reduction while paying less attention to how patients interpret suffering, maintain hope, or reconstruct identity in the presence of an unpredictable condition. Nevertheless, spiritual approaches should not replace neurological treatment; they may function as complementary components within integrated, patient-centered care.

Self-management is another central feature of living with migraine. Patients commonly use medication, sleep regulation, dietary modification, hydration, stress management, sensory control, activity pacing, trigger avoidance, relaxation, information seeking, and social support. These strategies may enhance agency, but they can also become burdensome when the patient feels responsible for preventing every attack. Research on community-dwelling individuals with migraine has identified a meaningful relationship between self-management and emotional well-being (18). Effective self-management may increase confidence and perceived control, whereas unsuccessful attempts can produce guilt, frustration, and self-blame. Patients may conclude that an attack occurred because they failed to sleep correctly, manage stress, avoid a food, or recognize a warning sign. Therefore, the lived meaning of self-management includes both empowerment and responsibility.

Patient-reported outcomes are particularly important for capturing these multidimensional effects. Traditional clinical measures such as headache frequency, attack duration, analgesic use, and pain intensity remain essential, but they may not adequately represent anticipatory anxiety, sensory vulnerability, cognitive disruption, relationship strain, loss of spontaneity, reduced participation, or adaptation. Patient-reported outcome measures can provide direct information about how migraine affects functioning and well-being from the patient's perspective (19). However, standardized questionnaires inevitably structure experience according to predetermined domains. They may overlook culturally specific meanings, unexpected forms of suffering, or coping processes that have not yet been incorporated into existing instruments. Qualitative inquiry is therefore necessary to identify dimensions that are meaningful to patients before these dimensions can be measured comprehensively.

Even treatment itself can introduce experiences that require patient-centered investigation. Modern migraine therapeutics, including calcitonin gene-related peptide inhibitors, have expanded preventive options, yet treatment outcomes cannot be evaluated solely through changes in headache frequency. Case reports concerning possible sexual dysfunction among women receiving CGRP inhibition illustrate that adverse effects may involve intimate and quality-of-life domains that patients or clinicians may hesitate to discuss (20). Such observations reinforce the need to listen carefully to patient narratives and to recognize that clinically significant experiences may remain invisible when assessment is restricted to predefined neurological outcomes.

Behavioral and psychological interventions can reduce migraine burden and complement pharmacological care. A systematic review and meta-analysis of behavioral interventions for migraine prevention supports the clinical relevance of approaches targeting stress, cognition, behavior, physiological regulation, and coping (21). Nevertheless, the availability and integration of these interventions remain inconsistent. Important gaps persist in referral pathways, provider training, patient access, insurance coverage, interdisciplinary collaboration, and the routine incorporation of psychological treatment into headache care (22). These gaps may partly reflect an incomplete understanding of what patients need from behavioral care. Interventions developed primarily around generalized assumptions about pain may fail to

address the specific experiences of bodily distrust, sensory vigilance, anticipatory fear, social invalidation, disrupted roles, cognitive slowing, or identity reconstruction that characterize migraine.

Despite substantial progress in migraine research, much of the literature remains dominated by diagnostic, epidemiological, neurobiological, pharmacological, and quantitative psychosocial approaches. These studies are indispensable, but they do not fully explain how patients make sense of migraine in the context of their own bodies, relationships, environments, responsibilities, and cultural expectations. Numerical indicators can demonstrate that a patient has frequent attacks, high disability, poor sleep, anxiety, or reduced quality of life, yet they cannot independently reveal what it feels like to distrust one's body, fear the interruption of an important event, withdraw from stimulating environments, feel disbelieved by others, or repeatedly renegotiate family and occupational roles. Phenomenological inquiry addresses this gap by examining illness as it is experienced and interpreted in everyday life.

A phenomenological perspective is especially appropriate because migraine alters the patient's experience of embodiment, temporality, environment, and interpersonal life. The body may cease to function as a reliable and unnoticed basis for action and instead become an unpredictable source of pain and warning signals. Time may become organized around anticipation, attack, recovery, and compensation for postponed responsibilities. Ordinary environments may be experienced as threatening because of light, sound, smell, heat, crowding, or lack of access to rest. Relationships may be altered by dependence, guilt, misunderstanding, disbelief, or reduced participation. At the same time, patients may gradually develop knowledge, flexibility, acceptance, and more compassionate ways of relating to their illness. Investigating these processes can provide a richer basis for assessment, treatment planning, family education, psychological intervention, and patient-centered care.

Accordingly, the present study aimed to identify and explain the components, themes, and dimensions of the perceptions and lived experiences of patients with migraine through a qualitative phenomenological approach.

Methods and Materials

Study Design and Participants

This study was conducted using a qualitative phenomenological design. The purpose of the study was to identify and explain the components, themes, and dimensions of the perceptions and lived experiences of patients with migraine. Since the main aim was to understand the meaning of migraine from the perspective of patients themselves, a phenomenological approach was considered appropriate.

Although the original dissertation was designed as a sequential exploratory mixed-methods study, the present article reports only the first qualitative phase. Therefore, this article does not include the instrument-development phase or the intervention phase. The focus of the present article is limited to the qualitative exploration of patients' lived experiences, perceptions, meanings, emotions, bodily experiences, social challenges, and coping responses related to migraine.

The phenomenological approach allowed the researcher to move beyond clinical descriptions of migraine and explore how patients experience the disease in everyday life. This approach was selected because migraine is not only a neurological disorder but also a lived condition that affects the patient's body, emotions, cognition, family roles, social relationships, occupational functioning, and sense of control.

The research population consisted of patients with migraine who referred to Mehraram Clinic in Tehran, Iran. Participants were individuals who had a history of migraine based on a neurologist's diagnosis or documentation in their medical records.

Participants were selected from patients who had direct experience of living with migraine and were able to describe their perceptions, emotions, bodily experiences, and coping strategies. The clinical setting was selected because it provided access to patients with varied experiences of migraine, including differences in duration of illness, frequency of attacks, pain intensity, functional limitations, and psychological responses to the disease.

Participants were selected using purposive sampling. This sampling method was used because the purpose of the qualitative phase was not statistical generalization, but rather the selection of information-rich participants who could provide deep and detailed descriptions of living with migraine.

Maximum variation was considered during sampling in order to capture different dimensions of the migraine experience. Therefore, participants were selected with attention to diversity in age, duration of migraine, severity of symptoms, frequency of attacks, and the extent to which migraine had affected their personal, family, social, and occupational life.

Sampling continued until data saturation was achieved. Data saturation was considered to have occurred when new interviews no longer produced substantially new codes, meanings, or themes, and the main categories of the lived experience of migraine had become sufficiently stable and conceptually rich.

The inclusion criteria were as follows:

1. Diagnosis of migraine by a neurologist or documentation of migraine diagnosis in the medical record;
2. History of migraine for at least one year;
3. Age between 18 and 50 years;
4. Having at least middle-school education or sufficient ability to understand and respond to interview questions;
5. Ability to express personal experiences, feelings, perceptions, and meanings related to migraine;
6. Absence of severe psychiatric disorder or acute psychological crisis based on self-report or clinical records;
7. Willingness to participate in the study;
8. Providing written informed consent for participation in the interview.

Participants were excluded from the qualitative phase if they were unwilling to continue the interview at any stage, were unable to respond meaningfully to interview questions, experienced severe psychological or physical discomfort during the interview, requested that their information be removed from the study, or provided incomplete interview data that could not be meaningfully analyzed.

After obtaining the necessary permissions, eligible patients were identified at the clinic. The purpose of the study was explained to each participant, and written informed consent was obtained before the interview. Participants were informed that participation was voluntary and that they could withdraw from the study at any time. The interviews were conducted in a calm and private setting to allow participants to speak freely about their experiences. With participants' permission, the interviews were audio-recorded. Field notes were also taken during and immediately after the interviews to record nonverbal cues, emotional tone, contextual observations, and the researcher's initial reflections. Each interview was transcribed verbatim. The

transcripts were reviewed several times to ensure accuracy and familiarity with the data. To protect confidentiality, identifying information was removed from the transcripts, and participants were assigned codes.

Data Collection Tools

Data were collected through individual semi-structured interviews. Semi-structured interviews were used because they allowed the researcher to follow a guiding framework while also providing enough flexibility to explore participants' personal narratives in depth.

The interview questions were developed based on the purpose of the study, the theoretical literature on migraine and lived experience, previous qualitative studies, and expert opinions in psychology and qualitative research. Before the main interviews, the questions were reviewed in terms of clarity, relevance, comprehensibility, and consistency with the aims of the study.

Each interview began with general and open-ended questions about the participant's experience of migraine. As the interview progressed, follow-up and probing questions were used to clarify meanings, deepen responses, and explore important aspects of the experience. The interviews focused on how patients perceived migraine, how they experienced their body during attacks, how they responded to pain and sensory triggers, how migraine affected their emotions and thoughts, and how the disease influenced their family, social, and occupational life.

The semi-structured interview guide included questions such as:

1. Can you describe your experience of living with migraine?
2. What does a migraine attack feel like for you?
3. How do you experience your body before, during, and after a migraine attack?
4. What thoughts and emotions usually accompany your migraine attacks?
5. How has migraine affected your daily activities and routines?
6. How has migraine influenced your family, social, occupational, or educational roles?
7. How do others respond to your migraine, and how do you experience their responses?
8. What situations, environments, or stimuli usually trigger or worsen your migraine?
9. What strategies do you use to cope with migraine?
10. How has your understanding of migraine changed over time?

Additional probing questions were used when needed, such as: "Can you explain this more?", "What did that mean to you?", "How did you feel in that situation?", "What changed in your life after that?", and "Can you give an example?"

Data Analysis

Data were analyzed using thematic analysis with a phenomenological orientation. The analysis focused on identifying meaning units, codes, subthemes, main themes, and the overall structure of the lived experience of migraine. The analysis process included the following steps. First, each interview transcript was read several times to gain a general understanding of the participant's narrative. Second, significant statements related to migraine experience were identified. Third, meaning units were extracted from the text. Fourth, initial codes were generated based on participants' own words and the meaning of their statements. Fifth,

similar codes were grouped into subthemes. Sixth, subthemes were compared and integrated into broader main themes. Finally, the relationships among themes were examined to develop a conceptual understanding of the perceptions and lived experiences of patients with migraine. The analysis was iterative and reflexive. The researcher repeatedly moved between the raw data, codes, subthemes, and main themes to ensure that the final thematic structure remained grounded in participants' narratives. The final themes represented the shared yet diverse experiences of patients living with migraine.

To enhance credibility, the researcher established appropriate rapport with participants, conducted interviews carefully, returned repeatedly to the data, and compared the extracted themes with the original interview texts. In some cases, member checking was used by sharing summaries of interpretations or extracted meanings with selected participants to examine whether the findings were consistent with their experiences. To enhance transferability, the study context, participant characteristics, sampling process, data collection method, and analysis procedure were described in detail. This thick description allows readers to judge whether the findings may be applicable to similar clinical or cultural contexts.

To enhance dependability, the research process was documented systematically. Interview procedures, coding decisions, theme development, and analytic steps were recorded so that the process of moving from raw data to final themes would be transparent and traceable. To enhance confirmability, the researcher attempted to keep the findings grounded in participants' narratives rather than personal assumptions. Field notes, repeated transcript review, comparison of codes with original statements, and documentation of analytic decisions were used to reduce interpretive bias. Because qualitative research involves interaction between the researcher and participants, reflexivity was considered throughout the study. The researcher tried to remain aware of personal assumptions about migraine, pain, psychological distress, and coping. During analysis, interpretations were repeatedly checked against the interview transcripts to ensure that the themes reflected the participants' meanings rather than the researcher's expectations.

Findings and Results

In total, 312 initial codes were extracted from the interview transcripts. After repeated review, comparison, and merging of similar codes, 84 final codes remained. These final codes were organized into 19 subthemes and 6 main themes. The six main themes were: painful and unpredictable body, sensory sensitivity and vulnerability to stimuli, psychological disturbance and emotional exhaustion, impaired cognitive functioning and daily performance, family, social, and occupational consequences of the disease, and coping strategies, adaptation, and reconstruction of the relationship with the illness.

Table 1. Main Themes and Subthemes of the Lived Experience of Patients with Migraine

Main theme	Subthemes
Painful and unpredictable body	Severe and disabling pain; distrust of the body; fear of attack onset
Sensory sensitivity and vulnerability to stimuli	Sensitivity to light, sound, and smell; constant monitoring of the environment; avoidance of triggers
Psychological disturbance and emotional exhaustion	Anticipatory anxiety; irritability and mood changes; helplessness and reduced sense of control; reduced self-confidence and guilt
Impaired cognitive functioning and daily performance	Reduced concentration and mental slowing; memory and decision-making problems; suspension of daily activities

Family, social, and occupational consequences of the disease	Being misunderstood and invalidation of pain; disruption of family roles; reduced social participation; damage to occupational and educational functioning
Coping strategies, adaptation, and reconstruction of the relationship with illness	Medication and rest-based coping; lifestyle modification; seeking support and information; gradual acceptance and redefinition of the illness

The findings indicated that the core of the migraine experience was the perception of living in a painful and unpredictable body. Around this core, other experiential layers were formed, including sensory vulnerability, psychological and cognitive consequences, role disruption, social invalidation, and coping efforts. In this way, migraine was experienced not as an isolated neurological event but as a condition that reorganized patients' daily life and their relationship with themselves and others.

Theme 1: Painful and Unpredictable Body

The first main theme was the experience of a painful and unpredictable body. Participants described migraine pain as severe, overwhelming, disabling, and different from ordinary headache. The pain was often described as intense pressure, explosion, pulsation, or an unbearable force inside the head. Patients emphasized that during migraine attacks, the body becomes difficult to control and ordinary movements, speaking, light exposure, or even opening the eyes may become intolerable.

Severe and Disabling Pain

Participants experienced migraine pain as a type of pain that interrupts the body's normal functioning. It was not described simply as "headache," but as a state in which the whole body becomes involved. Some patients explained that during attacks they could not move, work, study, communicate normally, or continue daily responsibilities. The intensity of pain created a sense of physical helplessness and forced withdrawal from activity. This subtheme shows that pain in migraine is not only sensory but also functional. Pain removes the patient from the flow of ordinary life. It stops action, interrupts time, and creates a temporary state of bodily collapse.

Distrust of the Body

Another important aspect of this theme was distrust of the body. Participants reported that repeated migraine attacks had weakened their confidence in their own body. They felt that their body could suddenly betray them, even when they had tried to avoid known triggers. This distrust created a continuous state of caution and monitoring. Patients often described their body as unpredictable. They could not fully rely on their physical state when planning work, family responsibilities, travel, study, or social events. As a result, the body was experienced not as a stable and reliable base for living, but as a source of uncertainty.

Fear of Attack Onset

Fear of the beginning of a migraine attack was another central subtheme. Participants stated that even minor bodily sensations could be interpreted as warning signs. A slight pressure in the head, sensitivity to light, fatigue, nausea, or mood change could trigger anxiety about the onset of a new attack. This anticipatory fear showed that migraine affects patients even before the actual pain begins. The time between attacks is not necessarily free of suffering; rather, it may be filled with worry, bodily monitoring, and fear of recurrence.

Theme 2: Sensory Sensitivity and Vulnerability to Stimuli

The second main theme was sensory sensitivity and vulnerability to environmental stimuli. Participants described themselves as highly sensitive to light, sound, smell, crowding, screen exposure, changes in sleep, stress, and environmental conditions. This sensitivity played an important role in shaping their everyday behavior.

Sensitivity to Light, Sound, and Smell

Participants repeatedly mentioned that bright light, loud sounds, strong smells, perfumes, food odors, traffic noise, and crowded spaces could intensify or trigger migraine attacks. This sensory sensitivity made everyday environments threatening and difficult to tolerate. Patients explained that ordinary environments, such as workplaces, classrooms, family gatherings, shopping centers, or public transportation, could become overwhelming. Therefore, migraine was experienced as a condition that changed the meaning of the environment. Places that were normal for others could become risky or painful for the patient.

Constant Monitoring of the Environment

Many participants described a constant need to monitor their surroundings. They tried to identify possible triggers before entering a situation. They checked lighting, noise, smells, temperature, crowding, and opportunities for rest. This permanent environmental monitoring created mental fatigue and reduced spontaneity in daily life. This subtheme indicates that patients with migraine often live in a state of preventive vigilance. They do not simply respond to pain after it occurs; they continuously scan the environment to prevent the possibility of pain.

Avoidance of Triggers

Avoidance of triggers was another major feature of sensory vulnerability. Participants avoided bright places, loud environments, long screen time, certain foods, perfumes, crowded gatherings, travel, or stressful events. Although avoidance sometimes helped reduce attacks, it also limited social life, work performance, leisure activities, and emotional freedom. The findings showed that avoidance has a double effect. It can protect the patient from immediate pain, but it can also reduce life participation and increase the sense of restriction.

Theme 3: Psychological Disturbance and Emotional Exhaustion

The third theme was psychological disturbance and emotional exhaustion. Participants reported that migraine was accompanied by anxiety, irritability, mood changes, helplessness, reduced sense of control, guilt, and reduced self-confidence. These emotional experiences were not secondary or marginal; they were part of the lived experience of migraine.

Anticipatory Anxiety

Patients often experienced anxiety about the next attack. This anxiety was related to the unpredictable nature of migraine. Participants worried that an attack might occur during work, examination, family responsibilities, social events, travel, or important appointments. Anticipatory anxiety changed the meaning of future time. Future plans were not experienced as fully open possibilities; they were experienced as uncertain situations that could be interrupted by migraine.

Irritability and Mood Changes

Participants reported irritability, mood changes, emotional sensitivity, and reduced tolerance before or during migraine attacks. Some patients stated that they sometimes became angry or emotionally reactive without immediately realizing that migraine was beginning. This subtheme suggests that emotional changes may be integrated into the migraine process. Patients experienced migraine not only as pain but also as a disruption in emotional balance.

Helplessness and Reduced Sense of Control

Many participants described feelings of helplessness when attacks occurred despite taking medication, resting, or avoiding triggers. The repeated failure to fully control attacks created frustration and despair. Patients felt that migraine could take control of the day, the body, and the schedule. This loss of control extended beyond pain. It included loss of control over time, productivity, family responsibilities, social participation, and personal plans.

Reduced Self-Confidence and Guilt

Some participants reported reduced self-confidence and guilt because they could not fulfill family, social, occupational, or educational responsibilities as expected. They sometimes saw themselves as weak, unreliable, or burdensome, even though they knew that migraine was not under their voluntary control. This finding shows that migraine can affect self-evaluation. Patients may internalize the consequences of illness as personal inadequacy, especially when others do not understand the severity of their condition.

Theme 4: Impaired Cognitive Functioning and Daily Performance

The fourth theme was impaired cognitive functioning and daily performance. Participants did not describe migraine only as physical pain; they also described it as an interruption in thinking, concentration, memory, decision-making, and daily activity.

Reduced Concentration and Mental Slowing

Participants reported difficulty concentrating during migraine attacks and sometimes even after pain had decreased. They described mental slowing, confusion, inability to read, difficulty understanding information, and reduced productivity. Some referred to a state similar to “brain fog.” This subtheme indicates that the effects of migraine continue beyond the moment of acute pain. Cognitive fatigue and mental slowing may remain after the attack and interfere with return to normal functioning.

Memory and Decision-Making Problems

Some patients reported forgetfulness, mistakes in daily tasks, and difficulty making decisions during migraine episodes. They explained that when symptoms begin, they may become unable to decide whether to rest, take medication, continue working, contact someone, or stop an activity. These experiences show that migraine can weaken executive functioning in practical situations. The patient may need to make decisions about managing the attack exactly at the time when cognitive capacity is reduced.

Suspension of Daily Activities

One of the most frequent experiences was the suspension of daily activities. Participants stated that migraine attacks caused cancellation of plans, delay in responsibilities, unfinished tasks, and disruption of daily order. They felt that a migraine day was almost removed from life and had to be compensated for later. This subtheme shows that migraine disrupts lived time. Patients do not only lose hours of activity; they also experience accumulated pressure after the attack because postponed responsibilities remain.

Theme 5: Family, Social, and Occupational Consequences of the Disease

The fifth theme was family, social, and occupational consequences. Participants explained that migraine affected their relationships, family roles, social participation, work, and education. A central issue in this theme was the invisibility of migraine and the feeling of being misunderstood.

Being Misunderstood and Invalidation of Pain

Participants reported that others often underestimated their pain or interpreted migraine as an ordinary headache. Some felt that family members, colleagues, or acquaintances did not fully believe or understand the severity of their condition. This invalidation increased emotional distress and made patients feel isolated. The findings suggest that the social meaning of migraine is shaped not only by symptoms but also by how others respond to those symptoms. When pain is invisible or minimized, the patient experiences a second layer of suffering.

Disruption of Family Roles

Migraine disrupted family responsibilities such as cooking, parenting, household management, emotional availability, and participation in family events. Some participants felt guilty because other family members had to adjust their behavior, reduce noise, take over tasks, or avoid activities because of the patient's migraine. This subtheme shows that migraine is not only an individual experience. It reorganizes family interactions and can create tension, guilt, dependence, or role imbalance.

Reduced Social Participation

Many participants reported avoiding social events because of fear of light, sound, crowding, or sudden attack. Over time, repeated cancellations reduced invitations and social contact. Patients gradually felt isolated or separated from friends and social groups. This finding indicates that migraine can shrink the social world of the patient. Avoidance begins as a protective strategy but may eventually lead to loneliness and reduced social support.

Damage to Occupational and Educational Functioning

Participants who were employed or students described reduced productivity, absenteeism, delayed tasks, difficulty concentrating, concern about being judged, and fear of losing opportunities. Some patients stated that colleagues or managers did not understand migraine and considered it an excuse. Migraine therefore affected not only health but also identity and future prospects. Work and education are domains in which patients are expected to perform consistently, but migraine introduces unpredictability and repeated interruption.

Theme 6: Coping Strategies, Adaptation, and Reconstruction of the Relationship with Illness

The sixth theme was coping strategies, adaptation, and reconstruction of the relationship with illness. Despite suffering, participants were not passive. They used various strategies to manage migraine, reduce attacks, and rebuild their relationship with the disease.

Medication and Rest-Based Coping

The most common coping strategies were medication use, resting in a dark and quiet place, reducing movement, sleeping, and withdrawing from stimulation. These strategies were often used during attacks and were considered necessary for reducing pain intensity. However, some participants also expressed concern

about dependence on medication or uncertainty about when to use it. This shows that medication-based coping was experienced as both helpful and sometimes stressful.

Lifestyle Modification

Participants described lifestyle changes such as regulating sleep, avoiding certain foods, reducing screen time, managing stress, drinking enough water, planning rest periods, and avoiding known triggers. These strategies reflected an effort to regain some control over the illness. Lifestyle modification was not simply a medical recommendation; it became part of the patient's everyday identity. Patients learned to organize life around migraine prevention.

Seeking Support and Information

Some participants actively sought information about migraine, treatment options, triggers, and coping strategies. Others sought support from family members, physicians, psychologists, or people with similar experiences. Information and support helped patients feel less alone and more capable of managing the disease. This subtheme shows that understanding the illness can reduce uncertainty. When patients receive valid information and emotional support, they may experience greater control and less fear.

Gradual Acceptance and Redefinition of the Illness

A key finding was gradual acceptance. Some participants stated that over time they had learned to stop blaming themselves and to relate to their body with more patience. Acceptance did not mean surrendering to the disease; rather, it meant recognizing migraine as part of life while still trying to manage it. This subtheme represented a more adaptive relationship with migraine. Patients who reached this stage described greater self-compassion, more realistic planning, and a better ability to distinguish between necessary rest and personal failure.

Based on the extracted themes, the lived experience of migraine can be conceptualized as a layered structure. At the center of the model is the painful and unpredictable body. Around this core, sensory and environmental sensitivity forms the first layer. Psychological and cognitive consequences form the second layer. Family, social, and occupational disruptions form the third layer. Finally, coping strategies and adaptation form the outer layer through which patients try to reconstruct their relationship with illness. This model indicates that migraine is experienced through the interaction of body, mind, environment, relationships, roles, and coping processes. The disease begins with bodily pain, but its consequences expand into emotional, cognitive, social, and existential dimensions. Therefore, the lived experience of migraine is not reducible to headache severity or attack frequency.

Table 2. Conceptual Structure of the Lived Experience of Migraine

Level of model	Main dimension	Description
Central core	Painful and unpredictable body	Severe pain, disability, distrust of the body, and fear of attack onset
First layer	Sensory and environmental sensitivity	Sensitivity to light, sound, smell, stress, sleep disruption, and continuous trigger monitoring
Second layer	Psychological and cognitive consequences	Anxiety, helplessness, irritability, reduced concentration, mental slowing, and impaired decision-making
Third layer	Social and role consequences	Being misunderstood, family role disruption, reduced social participation, and occupational or educational damage
Fourth layer	Coping and adaptation	Medication, rest, lifestyle modification, support seeking, information seeking, acceptance, and redefinition of the illness

The findings showed that patients with migraine experience the disease as a continuous disruption of bodily trust, emotional stability, cognitive functioning, and social participation. Pain was the central experience, but it was not the only one. Patients also lived with fear of recurrence, vigilance toward triggers, social misunderstanding, guilt, reduced confidence, and the need to constantly adjust life to the possibility of an attack.

The first research question asked what the components, themes, and dimensions of the perceptions and lived experiences of patients with migraine are. The findings answered this question by identifying six main themes and nineteen subthemes. These themes show that migraine is a multidimensional lived experience involving bodily pain, sensory vulnerability, psychological distress, cognitive impairment, social and role disruption, and coping reconstruction.

The second qualitative question asked how patients experience and perceive migraine. The findings showed that patients perceive migraine as an unpredictable, intrusive, and life-limiting condition. They experience their body as unreliable, their environment as potentially threatening, their emotions as unstable, their cognition as vulnerable, and their social world as often invalidating or misunderstood. At the same time, patients gradually develop coping strategies and attempt to rebuild a more adaptive relationship with their illness.

Overall, the qualitative findings suggest that migraine should be understood as a biopsychosocial and phenomenological experience. It is not only a neurological disorder with recurrent pain attacks, but also a lived condition that affects how patients experience their body, time, space, relationships, responsibilities, and identity. These findings provide a patient-centered foundation for future assessment, instrument development, and psychological interventions for individuals living with migraine.

Discussion and Conclusion

The present study aimed to identify and explain the components, themes, and dimensions of the perceptions and lived experiences of patients with migraine. Analysis of the participants' narratives produced six main themes: a painful and unpredictable body; sensory sensitivity and vulnerability to stimuli; psychological disturbance and emotional exhaustion; impaired cognitive functioning and daily performance; family, social, and occupational consequences of the disease; and coping strategies, adaptation, and reconstruction of the relationship with illness. Taken together, these findings show that migraine is experienced not merely as recurrent headache, but as a multidimensional condition that affects bodily trust, emotional stability, cognitive clarity, social participation, role performance, and the patient's sense of control over everyday life. The findings support a biopsychosocial and phenomenological understanding of migraine in which neurological symptoms interact with psychological interpretation, environmental sensitivity, interpersonal responses, and coping processes.

The first theme was the experience of a painful and unpredictable body. Participants described migraine pain as severe, disabling, intrusive, and capable of suspending ordinary bodily functioning. They also reported that repeated attacks reduced their confidence in their own bodies. Even when they attempted to avoid triggers or follow preventive routines, attacks could still occur, leading to the perception that the body was unreliable and potentially disruptive. This finding is consistent with contemporary views of migraine as

a heterogeneous neurological disorder whose clinical course varies across individuals and stages of life. Neurodevelopmental mechanisms, sensory-processing differences, biological vulnerability, and changing clinical phenotypes can contribute to the unpredictability of migraine symptoms (1). The diversity of migraine presentations is also reflected in discussions of high-frequency episodic migraine, which may impose a burden approaching that of chronic migraine despite being classified separately (2). Such variability helps explain why patients may experience their bodies as unstable and difficult to trust.

The participants' fear of attack onset further demonstrated that migraine-related suffering extends beyond periods of active pain. Minor bodily sensations, fatigue, nausea, changes in mood, or sensory discomfort were often interpreted as possible warning signs. This anticipatory state placed patients in a continuous position of bodily surveillance. The finding aligns with research showing that fear of migraine attacks is an important contributor to the burden of episodic migraine and may be associated with attack characteristics, disability, emotional distress, and perceived lack of control (5). It is also consistent with evidence that people with migraine may experience fear of recurrence or progression together with broader existential concerns about bodily vulnerability, future functioning, and the possibility that the illness will increasingly restrict their lives (6). Therefore, the experience of migraine includes not only present pain but also the anticipated possibility of future pain.

The second theme concerned sensory sensitivity and vulnerability to stimuli. Participants reported heightened sensitivity to light, sound, smell, crowding, screen exposure, sleep disruption, stress, and environmental changes. These sensitivities transformed ordinary settings into potentially threatening environments. Workplaces, classrooms, family gatherings, shopping centers, and public transportation could become difficult to tolerate because patients could not fully control exposure to sensory stimulation. This finding is compatible with current neurological accounts of migraine, which emphasize altered sensory processing and increased responsiveness to external and internal stimuli. It also reinforces the view that the environmental context is central to the lived experience of the disorder rather than merely an external background.

Participants responded to sensory vulnerability by continuously monitoring their surroundings and avoiding potential triggers. Although these strategies sometimes reduced immediate discomfort, they also restricted spontaneity, social participation, and daily freedom. This pattern can be interpreted through the fear-avoidance model. When bodily sensations or environmental cues are perceived as threatening, patients may become increasingly vigilant, fearful, and avoidant. Over time, these reactions can reinforce disability and reduce confidence in the ability to function despite symptoms (7). Fear of pain may also shape patients' beliefs about triggers, leading them to identify a broad range of activities, foods, emotional states, or environmental exposures as dangerous (8). The present findings therefore suggest that trigger avoidance has a dual function: it can be temporarily protective while simultaneously narrowing the patient's life and reinforcing perceived vulnerability.

The third theme was psychological disturbance and emotional exhaustion. Participants described anticipatory anxiety, irritability, mood changes, helplessness, diminished control, guilt, and reduced self-confidence. These experiences were not viewed as secondary to pain but as integral components of living with migraine. The finding is consistent with evidence that psychological factors such as anxiety, stress, catastrophizing, fear, and maladaptive cognitive appraisal are closely related to migraine severity and

disability (4). Research has also shown that catastrophizing, anxiety, and stress are common psychosocial correlates of migraine and can intensify the perceived burden of attacks (9). The growing scientific focus on the relationship between migraine and anxiety further reflects the importance of emotional processes in the onset, interpretation, and consequences of migraine symptoms (10).

Participants' helplessness was particularly evident when attacks occurred despite medication use, rest, or efforts to avoid known triggers. Repeated failure to control symptoms appeared to weaken their sense of agency and increase emotional exhaustion. Pain catastrophizing may contribute to this process through rumination, magnification of symptoms, and perceived inability to cope. More severe pain is also associated with poorer mental health outcomes, suggesting that pain intensity and psychological distress may reinforce one another (11). When migraine co-occurs with depressive symptoms, the patient may experience overlapping difficulties such as fatigue, withdrawal, sleep disturbance, reduced motivation, and diminished participation. The Hybrid Digital-4E Model conceptualizes migraine and depression as interacting through embodied, environmental, behavioral, and relational processes rather than as isolated clinical conditions (12). The present findings support such an integrated interpretation by showing that emotional distress develops within the patient's relationship with the body, environment, responsibilities, and future plans.

The fourth theme involved impaired cognitive functioning and daily performance. Participants reported reduced concentration, mental slowing, confusion, forgetfulness, decision-making difficulties, and inability to complete ordinary activities. These experiences were sometimes described as continuing after the most intense pain had subsided. The finding indicates that the burden of migraine cannot be adequately assessed by pain intensity alone. Cognitive difficulties may delay recovery, reduce productivity, and undermine the patient's confidence in performing academic, occupational, or family responsibilities. The relevance of cognitive resources to migraine functioning has been emphasized in multidimensional studies of cognitive reserve and well-being, which suggest that cognitive capacity and psychological resources may influence how patients tolerate and compensate for recurrent symptoms (15).

Sleep disturbance may further intensify cognitive and emotional impairment. Participants frequently identified poor or insufficient sleep as a factor associated with migraine attacks and reduced daily functioning. Experimental research indicates that sleep restriction may alter nociceptive processing in individuals with migraine, supporting a physiological connection between inadequate sleep and increased pain vulnerability (13). Rumination may also contribute to poorer sleep quality, particularly among individuals with anxiety-related symptoms. The relationship among migraine, repetitive negative thinking, and sleep difficulties has been demonstrated in women with panic attacks (14). These findings suggest that cognitive slowing, fatigue, emotional irritability, and reduced performance may emerge from the combined effects of pain, poor sleep, anticipatory anxiety, and ongoing mental preoccupation.

The fifth theme concerned family, social, occupational, and educational consequences. Participants reported that others often minimized migraine or interpreted it as an ordinary headache. This invalidation intensified distress because patients felt required to justify symptoms that were severe but largely invisible. The social response to migraine therefore created an additional layer of suffering beyond physical pain. Participants also experienced difficulty fulfilling family responsibilities, attending social events, maintaining productivity, and meeting occupational or educational expectations. Such disruptions often resulted in guilt, reduced self-confidence, and concern about being perceived as unreliable.

These findings are consistent with the broader emphasis on patient-reported outcomes in migraine. Conventional indicators such as attack frequency and pain intensity do not fully capture social withdrawal, impaired role functioning, emotional burden, or loss of autonomy. Patient-reported outcomes are therefore necessary for assessing the real-life impact of migraine from the patient's perspective (19). The participants' accounts also showed that quality of life involved more than functional capacity. Some described changes in hope, meaning, emotional balance, and the ability to maintain a positive relationship with life. Research examining spiritual well-being and quality of life in migraine similarly suggests that meaning, inner stability, and spiritual resources may be relevant to adjustment (16). Because migraine can affect identity and future expectations, its consequences should be understood in emotional, relational, existential, and social terms.

The findings regarding women's experiences are also noteworthy because migraine presentation and burden may change across reproductive and hormonal stages. Migraine patterns can shift during the menopausal transition and beyond, indicating that women's experiences of symptoms, treatment needs, and quality of life may vary across the life course (3). In addition, treatment-related experiences may affect domains not routinely assessed in neurological care. Reports of possible sexual dysfunction associated with CGRP inhibition illustrate that patients may experience adverse effects in intimate and relational areas that are not captured through standard headache indicators (20). This supports the need for comprehensive and sensitive assessment of the personal and interpersonal consequences of both migraine and its treatment.

The sixth theme concerned coping strategies, adaptation, and reconstruction of the relationship with illness. Participants used medication, rest, dark and quiet environments, sleep, trigger avoidance, lifestyle regulation, stress reduction, information seeking, and social support. These strategies demonstrated active attempts to regain control. However, coping was not uniformly adaptive. Excessive avoidance could reduce social participation, while unsuccessful self-management could increase guilt and self-blame. Research has similarly shown that migraine self-management is related to emotional well-being, with effective strategies potentially increasing confidence and maladaptive patterns contributing to distress (18).

Gradual acceptance appeared to represent a more adaptive form of adjustment. Some participants learned to recognize bodily limitations, reduce self-blame, plan more realistically, and develop greater patience toward themselves. Spiritual and meaning-oriented interventions may support this process by strengthening resilience, distress tolerance, and the ability to reinterpret suffering. The effectiveness of a spiritual therapy package for reducing pain intensity and catastrophizing and improving resilience and distress tolerance among migraine patients supports the potential value of such approaches (17). Acceptance in this context does not mean passive surrender; rather, it involves a more flexible relationship with the illness and a reduction in the struggle to maintain total control over an unpredictable condition.

The findings also support the importance of psychological and behavioral interventions in migraine care. Behavioral approaches can address stress, pain appraisal, avoidance, emotional regulation, sleep, relaxation, and coping. A systematic review and meta-analysis has demonstrated the value of behavioral interventions for migraine prevention, although the strength of evidence and accessibility of specific interventions may vary (21). Despite their potential, psychological and behavioral services remain underused in headache treatment because of limited referral systems, insufficient provider training, access barriers, and inadequate integration with medical care (22). The present findings indicate that these interventions should be grounded

in the realities described by patients, including sensory vigilance, fear of recurrence, cognitive impairment, invalidation, guilt, role disruption, and efforts to reconstruct a sense of agency.

Overall, the findings suggest that the lived experience of migraine is organized around a continuing tension between unpredictability and control. Patients experience the body as uncertain, the environment as potentially triggering, future plans as vulnerable to interruption, and social responses as sometimes invalidating. In response, they attempt to restore control through monitoring, avoidance, medication, environmental modification, information seeking, and lifestyle regulation. However, excessive control efforts may themselves become burdensome. A more sustainable adaptation may involve balancing symptom management with acceptance, self-compassion, flexible planning, and continued participation in meaningful activities. This interpretation reinforces the need to move beyond symptom counting and to understand migraine as an embodied, psychological, social, and existential experience.

The present study had several limitations. Because it used a qualitative phenomenological design, its purpose was to achieve depth of understanding rather than statistical generalization. The findings were based on the narratives of patients recruited from one clinical setting and may not represent the experiences of all individuals with migraine, particularly those from different regions, cultures, socioeconomic backgrounds, age groups, or healthcare contexts. The study also relied on retrospective self-reports, which may have been influenced by memory, current emotional state, recent attack severity, and participants' ability to express complex experiences verbally. Patients who were willing to participate in interviews may have differed from those who declined, and the interpretation of qualitative data inevitably involved some degree of researcher subjectivity despite efforts to maintain reflexivity and analytic rigor.

Future studies should examine the lived experience of migraine among more diverse populations, including adolescents, older adults, men, women at different reproductive stages, patients with episodic and chronic migraine, and individuals from different cultural and socioeconomic contexts. Longitudinal qualitative research is recommended to explore how fear, bodily trust, coping strategies, identity, and adaptation change over the course of the illness. Comparative studies could also examine differences between patients with high and low attack frequency, different levels of disability, or different treatment histories. Future research may include family members, caregivers, employers, and healthcare providers to provide a broader understanding of the relational and social consequences of migraine. The extracted themes may also be used to develop and validate a patient-centered instrument for assessing the lived experience of migraine.

Healthcare professionals should assess migraine beyond pain intensity, attack frequency, and medication use. Clinical interviews should include questions about fear of recurrence, sensory sensitivity, cognitive difficulties, sleep, emotional exhaustion, family responsibilities, occupational functioning, social invalidation, coping patterns, and the patient's sense of control. Treatment planning should combine neurological management with psychological support, behavioral interventions, sleep regulation, stress management, psychoeducation, and family education. Clinicians should validate the patient's symptoms and avoid minimizing migraine as an ordinary headache. Interventions should help patients reduce maladaptive avoidance, strengthen flexible coping, improve communication with family and employers, and develop a more compassionate and realistic relationship with their bodies and illness.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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