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Editorial

Transcultural headache medicine: expanding the boundaries of headache research

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Introduction

Headache disorders, particularly migraine, have accompanied humanity throughout recorded history. Long before modern neuroscience, randomized clinical trials, neuroimaging, and molecular biology, people with recurrent headaches sought explanations and treatments within the cultural frameworks available to them. Across continents and centuries, headache has been interpreted through religious, spiritual, symbolic, environmental, familial, and humoral perspectives. Remedies have included medicinal plants, dietary practices, manual procedures, rituals, prayers, blessings, amulets, sacred objects, dreams, and knowledge transmitted across generations (1–4).

Modern headache medicine is grounded in evidence-based principles. This framework has transformed diagnosis, prevention, acute treatment, and patient outcomes. It must remain the foundation of clinical care. However, one important dimension of patient experience remains underrepresented in the scientific literature: many people with headache disorders continue to seek, use, combine, or believe in culturally embedded forms of care (2–6).

Headache Medicine is therefore pleased to introduce a new section entitled Transcultural Headache Medicine. The aim of this section is not to promote unproven therapies or to replace scientific investigation with anecdote or belief. Rather, the aim is to document, classify, analyze, and understand the diverse cultural practices, traditions, languages, and narratives that influence how headache disorders are perceived, explained, and managed around the world.

From documentation to a research agenda

Transcultural Headache Medicine should not be understood as a catalogue of curiosities. It is a structured field of inquiry connecting the lived experience of patients with clinical practice, epidemiology, anthropology, linguistics, ethnopharmacology, psychology, history, implementation science, and global health. Cultural observations can generate scientific questions when they are carefully described, contextualized, and evaluated.

This new section operationalizes the Transcultural Headache Medicine framework previously proposed as a call to action from the International Headache Society (2). It invites contributions that address at least one of the following domains: language and symptom expression; explanatory models of headache; culturally embedded therapeutic practices; medicinal plants and ethnopharmacology; religious, spiritual, and ritual dimensions of care; placebo, expectation, and meaning-related mechanisms; health-seeking behavior and adherence; access to evidence-based treatment; safety, ethics, and regulation; and the development of global maps, databases, and observatories of transcultural headache care.

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In clinical practice, physicians frequently encounter patients who combine conventional and traditional approaches. A patient may consult a neurologist, use a CGRP monoclonal antibody or another evidence-based treatment, drink an herbal preparation recommended by a family member, follow dietary advice rooted in local tradition, and participate in a religious or community ritual seeking relief. These practices do not necessarily compete with biomedical care; often, they coexist with it. Understanding this coexistence is clinically relevant because it may influence diagnosis, disclosure, adherence, expectations, treatment response, and unmet needs.

Why culture matters in headache care

Migraine is a neurological disorder, but it is also a subjective and culturally mediated experience. Pain is shaped by biology, but also by language, memory, expectation, emotion, family narratives, social roles, spiritual beliefs, and access to care. The way patients name their symptoms, attribute causality, and interpret attacks may determine whether they seek medical care, self-medicate, use traditional treatments, delay consultation, or abandon prescribed therapy (1–3,6).

This is especially important in settings where access to headache specialists, diagnostic tools, triptans, preventive medications, botulinum toxin, or newer migraine-specific therapies is limited. Cultural beliefs may either create barriers to care or provide pathways for engagement. A transcultural approach can help clinicians ask better questions, communicate more effectively, identify hidden treatment use, recognize safety risks, and design interventions that are more acceptable to patients and communities.

Language is one of the most important gateways to this field. Local terms for headache, migraine, dizziness, pressure, heat, wind, nerves, heaviness, spiritual burden, or imbalance may not map neatly onto biomedical terminology. Misalignment between patient language and diagnostic categories can contribute to misunderstanding, misclassification, stigma, and undertreatment. For this reason, reports on local terminology, metaphors, symptom narratives, and translations of headache concepts are highly relevant to the new section.

Explanatory models and therapeutic practices

Across cultures, headache may be explained through multiple models: ancestry and inherited vulnerability; environmental or exposure-related causes; mental, emotional, or spiritual factors; and systems of imbalance, excess, deficiency, obstruction, stagnation, or disharmony. These models influence how patients understand attacks and which solutions they consider legitimate.

Similarly, culturally embedded therapeutic practices may include herbal preparations, physical techniques, dietary interventions, prayer, blessings, healing rituals, meditation, community-based practices, indigenous healing systems, and family remedies. Some may have no direct biological effect. Others may operate through expectation, stress reduction, social support, ritual meaning, behavioral change, or placebo-related mechanisms. A smaller subset may contain pharmacologically active compounds or reveal mechanisms worthy of future study (4,7–10).

Publication in this section should not be interpreted as endorsement of efficacy. Instead, publication indicates that the observation is culturally relevant, sufficiently contextualized, and potentially useful for hypothesis generation. Practices with possible toxicity, drug interactions, exploitation, coercion, or regulatory concerns should be discussed explicitly, with appropriate caution and ethical sensitivity.

Scope of the new section

We invite submissions that document culturally relevant observations, historical accounts, ethnographic experiences, traditional headache remedies, regional practices, linguistic patterns, explanatory models, and reflections on the interaction between culture and headache disorders. Authors may describe observations from clinical settings, communities, indigenous populations, family traditions, archives, historical records, or interdisciplinary fieldwork.

Whenever possible, reports should specify the cultural context, population, source of knowledge, local terminology, type of headache being addressed, perceived mechanism, pattern of use, coexistence with conventional care, safety concerns, and the scientific question generated by the observation. This structure will help transform individual observations into comparable data that can inform future qualitative studies, epidemiological surveys, pharmacological research, clinical trials, and implementation strategies.

The section will also welcome methodological and conceptual contributions, including taxonomies of explanatory models, cross-cultural validation of headache terminology, ethnopharmacological reviews, safety reports, implementation studies, and analyses of how cultural beliefs influence health-seeking behavior, adherence, access to care, and unmet needs. In this way, the section may contribute to a global transcultural map of headache care, connecting local observations to a broader scientific agenda.

A bridge between patients, science, and global health

Headache medicine has always benefited from interdisciplinary perspectives. Neurologists, neuroscientists, psychologists, psychiatrists, pain specialists, epidemiologists,

anthropologists, historians, sociologists, linguists, pharmacologists, and public health researchers all bring essential tools to the study of headache. Transcultural Headache Medicine creates a space where these perspectives can interact.

In an increasingly globalized world, cultural diversity is not peripheral to medicine. It is part of the clinical reality. Migraine affects individuals from every continent, language, religion, and socioeconomic background, yet the narratives surrounding headache remain diverse. By studying these narratives, we may improve communication, identify barriers to care, understand unmet needs, recognize potential safety issues, and generate new scientific hypotheses.

Medicine is not practiced in laboratories alone. It is practiced in homes, communities, temples, churches, villages, cities, clinics, and families. Patients do not arrive as biological organisms only; they arrive carrying memories, expectations, beliefs, fears, traditions, and hopes. A scientifically responsible medicine should be able to listen to these dimensions without abandoning rigor.

Conclusion

Transcultural Headache Medicine represents an important evolution in headache science and care. It does not ask us to replace evidence with belief. It asks us to recognize that beliefs, language, cultural practices, social context, and access to care shape the way headache disorders are experienced, interpreted, and treated.

By creating this new section, Headache Medicine establishes a forum for preserving observations, structuring cultural knowledge, generating hypotheses, and encouraging interdisciplinary research. The scientific study of headache should not be limited to what is already known; it should also be open to carefully documented observations that reveal questions not yet asked. Somewhere between patient experience, cultural tradition, and scientific method may lie discoveries that can improve headache care across the world.

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