

Chapter 137

Headaches in Patients with Coexisting Psychiatric Disease

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INTRODUCTION

Although most individuals with headache in the general population do not have comorbid psychiatric disorders, many patients presenting to specialty clinics do—especially those with chronic daily headache (24) and those with medication-overuse headache (35). Recent epidemiologic studies have identified a strong association between migraine and psychiatric disorders (11–13). For example, more than 30% of migraineurs compared with 10% of nonmigraineurs have a lifetime prevalence of major depression; similarly, 11% of migraineurs compared with 2% of nonmigraineurs have a lifetime prevalence of panic disorder (9). Migraine with comorbid depression is often complicated by the presence of an anxiety disorder, with the onset of the anxiety disorder typically preceding the onset of migraine and possibly present as early as childhood (33,51).

The exact nature of the relationship between migraine and mood disorders remains unclear. It is unlikely that depression results simply as a consequence of the burden of living with a recurrent painful condition. Several epidemiologic studies suggest the relationship is bidirectional, with the presence of major depression or anxiety increasing the likelihood of subsequently developing migraine (10–12). It is generally believed that the occurrence of comorbidity most likely arises from shared pathophysiology of migraine and mood disorders; this is discussed in detail by Drs. Merikangas Low, and Rasmussen in Chapter 26 of this volume.

Although one might expect psychiatric comorbidity to predispose headache patients to a poorer headache prognosis, this notion only rarely has been investigated. However, one recent longitudinal study revealed that the presence of psychiatric disorders (especially multiple disorders) foretold a poor headache treatment outcome (19). This 8-year prospective study of 100 young headache

sufferers by Guidetti and colleagues (19) revealed that 86% of headache sufferers diagnosed with two or more comorbid psychiatric disorders in childhood or adolescence reported either no improvement or a deterioration in their migraine or tension-type headache (TTH) over time. In 62% of patients diagnosed with one comorbid psychiatric disorder, their headaches remained unchanged or worsened. Alternatively, the absence of psychiatric disorders was associated with remission of headaches after 8 years. Moreover, there is emerging evidence that a number of behavioral/psychologic risk factors are associated with progression of headache from episodic to chronic and daily (29,43) and that psychologic distress may play an even greater role in the transformation and chronification of headache than does analgesic overuse/abuse (47). Thus, the identification and treatment of psychiatric disorders in headache patients is essential beginning at an early age.

In this chapter we discuss the role of psychiatric illness in headache disorders. We briefly discuss the assessment of psychiatric illness in a nonpsychiatric medical setting. We also enumerate a number of opportunities as well as obstacles for the management of comorbid headache and psychiatric illness, and we close with an overview of a new diagnostic classification for headache symptoms attributable to a psychiatric disorder.

ASSESSMENT OF COMORBID PSYCHIATRIC DISORDERS

Given the frequent co-occurrence of recurrent headache and psychiatric disorders, depression and anxiety at a minimum merit a brief investigation during the clinical evaluation of migraine or TTH. This is particularly pertinent for patients presenting to specialty centers. There are a variety of well-validated and efficient screening tools designed to facilitate psychologic symptom assessment. The

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presence and severity of depressive illness can be evaluated rapidly by the Beck Depression Inventory (BDI) (5,7) or the Hamilton Depression Inventory (HDI) (39). Likewise, the presence and severity of anxiety can be evaluated by the Beck Anxiety Inventory (6) or the Trait Anxiety Inventory (48).

The PRIME-MD (Primary Care Evaluation of Mental Disorders) (49) is yet another diagnostic tool designed for use in medical settings to assess the presence of a variety of comorbid psychiatric disorders. It is a 26-item self-administered symptom checklist designed to screen for common psychiatric disorders based on diagnostic criteria from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (2). The list of disorders screened by the PRIME-MD includes mood disorders (depression, bipolar), anxiety disorders (panic disorder, generalized anxiety disorder), eating disorders, alcohol abuse or dependence, and somatization disorders. The PRIME-MD has been well utilized in a large number of published studies, including an increasing number addressing recurrent headache. Schriger and colleagues (44), for example, administered the PRIME-MD to 218 patients presenting to an emergency department with long-standing headache, abdominal pain, or back pain (patients with known psychiatric illness were excluded from the study). The authors reported that most patients willingly completed the PRIME-MD (median time of 7 minutes), which frequently yielded psychiatric diagnoses among these patients with primary complaints of pain (42% of patients overall).

TREATMENT OF PSYCHIATRIC COMORBIDITY

In the following sections we focus on depression, panic disorder, somatoform disorder, and selected personality disorders, as they are highly prevalent among head pain patients and can prove especially challenging for clinicians. We present recommendations for pharmacologic and non-pharmacologic interventions and suggest that in most instances, a combination of these two therapeutic strategies (often requiring a multidisciplinary intervention) generally is the preferred approach to treating headache complicated by psychiatric comorbidity. For additional details pertaining to management of these and other comorbid psychiatric disorders in headache patients, works by Lipchik and Rains (28), Saper and Lake (42), and Saper and Sheftell (35) are recommended reading.

Major Depression

Major depressive illness is a common disorder with a lifetime prevalence of at least 20% in women and 10% in men (26). It has been characterized as "the neglected major ill-

ness" because of the consistent underrecognition of the disorder and the tremendous costs it engenders (an estimated \$44 billion annually in the United States) (18). The lion's share of the cost of depression is a consequence of inadequate recognition and care of the illness, leading to lowered employment productivity. Although it can be a life-long disorder, the majority of patients with depression can be treated successfully (1,18). On the other hand, efforts to manage head pain are considerably less likely to succeed if comorbid depression is not recognized and effectively treated.

The hallmark of major depressive illness is sad or depressed mood and a loss of interest or pleasure in previously enjoyed activities (anhedonia). The syndrome of depression is defined by a collection of symptoms that includes depressed mood and also results in significant functional impairment (see Table 137-1). Not everyone who is depressed experiences every symptom, with some patients experiencing only few symptoms and others many. The severity of symptoms varies considerably both between individuals and within patients over time. Depressive illness has a high rate of comorbidity with anxiety disorders and substance abuse.

Although full-blown depression with depressed affect, tearfulness, and psychomotor symptoms is not difficult to

TABLE 137-1 Symptoms of Major Depressive Episode

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| <p>A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning. At least one symptom is either depressed mood or loss of interest or pleasure in previously enjoyed activities.</p> <ol style="list-style-type: none">1. Depressed mood (feeling sad or empty, appears tearful; for children or adolescents, can be irritable mood)2. Loss of interest or pleasure in most activities3. Significant weight loss without dieting or decrease in appetite (with atypical depression—weight gain, increased appetite)4. Insomnia or hypersomnia5. Psychomotor agitation or retardation6. Fatigue or loss of energy7. Feelings of worthlessness or excessive, inappropriate guilt8. Impaired concentration, slowed thinking, or indecision9. Suicidal thoughts (with or without a plan) or a suicide attempt <p>B. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>C. The symptoms are not due to:</p> <ol style="list-style-type: none">1. The direct physiologic effects of a substance (medication or drug of abuse)2. A general medical condition (e.g., hypothyroidism)3. A mixed episode of mania and depression4. Bereavement |
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Excerpted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (2).

diagnose, depression may not always be evident without systematic inquiry. Inquiry about all of the symptoms that constitute the criteria for major depression is essential for accurate diagnosis of depression.

Pharmacologic treatment of major depression focuses on the use of adequate doses of antidepressants. Tricyclic and related cyclic antidepressants (TCAs) can be effective in the prophylaxis of headache disorders (17,45), but they are now less often used in treatment of depression because of side effects associated with the high doses required to achieve an adequate clinical response. The newer selective serotonin reuptake inhibitors (SSRIs) have fewer side effects (e.g., less sedation, less likely to cause weight gain) than TCAs and have a lower risk for overdose. There is, however, less evidence of the effectiveness of fluoxetine and other SSRIs (e.g., fluvoxamine, paroxetine, sertraline, venlafaxine) for the prophylaxis of migraine and TTH (8,17,27,45). An SSRI may be worth considering if a tricyclic drug is poorly tolerated or has proved unsuccessful.

Because the overall efficacy of antidepressants does not vary dramatically from one medication choice to the next (within a class), the medication choice should be based on side effect profile and symptom target. For example, TCAs would be preferred for a patient with insomnia, while an SSRI might be preferred for an overweight or obese patient. SSRIs and TCAs are contraindicated when mania is present or suspected. The anticonvulsant valproate is effective in treating migraine and comorbid manic depression (bipolar disorder). The β -blockers, typically used in migraine prophylaxis, are relatively contraindicated when depression is also present. Researchers recently have begun to evaluate the benefits that may be achieved through use of an algorithmic approach to prescribing medications for patients with comorbid headache and psychiatric illness. Kaniecki (25) implemented an algorithm calling for use of SSRIs for migraineurs with depression and anxiety, TCAs for those with insomnia, and antiepileptic drugs (AEDs) for the remaining patients. Approximately two thirds of 367 patients experienced significant reductions in headache frequency and disability at 1 year, leading Kaniecki to conclude that the presence of these comorbidities may help rationally guide the selection of preventive agents for patients with migraine. Table 137-2 offers an overview of the therapeutic opportunities and limitations in treating comorbid migraine and psychiatric disorders.

The U.S. Agency for Healthcare Research and Quality (1) has developed guidelines for treating major depression. Once a diagnosis has been made, treatment should be monitored every few weeks. Response to treatment should be assessed at week 6, and if the patient shows clear improvement the treatment should be continued for an additional 6 weeks. If there is complete remission of symptoms, medication is continued for 4 to 9 months to pre-

TABLE 137-2 Pharmacotherapy for Patients With Migraine and Psychiatric Comorbidities

Disorder	Potentially Beneficial Medications	Potentially Harmful Medications
Migraine plus:		
Depression	TCAs, SSRIs, MAOIs	β -blockers
Bipolar disorder	Divalproex sodium, topiramate, lithium	TCAs, MAOIs
Anxiety disorders	TCAs, SSRIs, MAOIs	
Panic disorder	TCAs, SSRIs, MAOIs, divalproex	
Sleep disturbances	TCAs	
Fibromyalgia	TCAs, SSRIs	
Overweight	Topiramate	TCAs, cyproheptadine, divalproex sodium
Underweight	TCAs, divalproex sodium	Topiramate

MAOIs, monoamine oxidase inhibitors; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants.

vent relapse. Maintenance treatment should be considered because after one episode of depression, the chance of recurrence is at least 50%. Increasing evidence supports ongoing treatment for a period of several years, if not indefinitely, to reduce the likelihood of relapse and recurrence. If a patient is only somewhat better at 6 weeks, a dose adjustment can be made. Treatment should be continued and monitored every 2 weeks. If at week 12 there is not a complete response to medication, a referral for psychotherapy, a referral to psychiatry for medication management, or a change in medication should be considered, although it may be more efficacious to augment SSRI antidepressant medication with bupropion than to switch SSRIs (34).

Combined psychologic and pharmacologic treatment should be considered for patients with comorbid headache and mood and/or anxiety disorders (22). Behavioral interventions, such as maintaining a regular schedule, increasing pleasant activities, getting adequate sleep and exercise, and discontinuing the use of tobacco are often beneficial. Relaxation training, biofeedback training, and cognitive-behavioral therapy, which have been proven to be effective in treating migraine and TTH (14,23,32,36,37), also can help patients manage psychologic symptoms, can provide a nonthreatening way to introduce the patient to the process of psychologic treatment, and can encourage the patient to acknowledge psychologic difficulties and accept treatment for psychologic disorders. Empirically validated cognitive-behavioral interventions for depression (4,15) can be incorporated easily into cognitive-behavioral interventions for headache management.

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Panic Disorder

Panic disorder is an anxiety disorder characterized by unexpected panic attacks (i.e., feelings of terror, impending doom, breathlessness, and chest pain) and high anxiety (35) (see Table 137-3). Epidemiologic studies indicate that panic disorder, with or without agoraphobia (technically, "fear of open spaces"; intense fear of leaving home or familiar settings), has a lifetime prevalence of 1.5 to 3.0% (2). Like depression, panic disorder has two to three times a greater prevalence in women than in men (2). Although total prevalence rates for panic disorder are low, morbidity is high (31). Most patients with panic disorder report significant social impairment and more than half experience comorbid major depression. Panic disorder also commonly co-occurs with other anxiety disorders (e.g., generalized anxiety disorder, phobias, obsessive-compulsive disorder), and frequently is associated with poor health perception, financial dependence, alcohol abuse, and suicide attempts. Patients with panic disorder often present to medical settings seeking diagnosis of their symptoms and amelioration of their distress; unfortunately, this disorder frequently eludes detection or is misdiagnosed because its clinical presentation commonly is mistaken for other medical conditions, (e.g., cardiac events, gastrointestinal disorders).

The TCAs (especially imipramine and clomipramine) and the SSRIs are considered appropriate first-line phar-

macologic treatments for panic disorder, especially when depression is also present (11). The anticonvulsant valproate is effective for migraine prophylaxis as well as in the treatment of panic disorder and is a fine choice for many patients with comorbid bipolar disorder. If major depression is present, treatment with valproate would likely include the addition of an antidepressant. Because of problems with discontinuation, benzodiazepines have been relegated to second- or third-line consideration (53). Benzodiazepines are considered appropriate first-line treatment for panic disorder *only* in cases when rapid symptom relief is needed or to stabilize severe symptoms until another treatment (e.g., an SSRI, cognitive-behavioral therapy) takes effect. Patients with panic disorder or other anxiety disorders often are very sensitive to side effect symptoms, and thus they often require more reassurance throughout pharmacotherapy than other patients do. Acute relapse is commonplace when pharmacotherapy for panic disorder is discontinued.

Cognitive-behavioral therapy is well suited to be the first-line intervention for panic disorder. Meta-analyses of cognitive-behavioral therapies indicate that cognitive-behavioral therapy alone compares favorably with pharmacotherapy and combined therapy (i.e., cognitive-behavioral therapy plus psychotropic medication) (16). In fact, cognitive-behavioral therapy incorporating cognitive restructuring and in vivo exposure to feared stimuli has been found to be superior to pharmacotherapy. Moreover, cognitive-behavioral therapy can effectively reduce medication withdrawal and relapse difficulties associated with the discontinuation of pharmacotherapy for panic disorder. Fortunately, therapy targeting symptoms of panic disorder as well as symptoms of recurrent headache can readily be integrated into a single cognitive-behavioral intervention. With the established efficacy of cognitive-behavioral therapy for migraine and TTH (14,22,23,32,36,37), this approach to head pain management is an obvious choice for patients with comorbid headache and panic disorder.

Somatoform Disorders

Headache sufferers present on occasion with less prevalent psychiatric disorders such as one of the somatoform disorders (e.g., somatization disorder, conversion disorder, hypochondriasis) (2). The comorbidity of recurrent headache and somatoform disorders is not well documented because these disorders seldom have been addressed in epidemiologic or clinical studies of headache patients. We do know, however, those patients with somatization disorder and undifferentiated somatoform disorder very often include headaches on their lengthy list of presenting physical complaints. Furthermore, recurrent headache undoubtedly is among the most common physical symptoms among patients diagnosed with somatoform

TABLE 137-3 Symptoms of Panic Disorder

- A. Presence or recurrence of unexpected panic attacks with at least 1 month concern about having additional attacks
- B. At least two panic attacks have occurred
- C. Panic attacks: four or more of the following symptoms develop abruptly and reach a peak in 10 minutes:
 - 1. Palpitations, pounding heart, accelerated heart rate
 - 2. Chest pain or discomfort
 - 3. Trembling or shaking
 - 4. Sensations of shortness of breath or smothering
 - 5. Feeling of choking
 - 6. Sweating
 - 7. Nausea or abdominal distress
 - 8. Feeling dizzy, unsteady, lightheaded, or faint
 - 9. Chills or hot flushes
 - 10. Paresthesias (numbness or tingling sensations)
 - 11. Fear of dying
 - 12. Fear of losing control or going crazy
 - 13. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- D. Attacks are not due to physiologic effects of a substance (e.g., caffeine), a general medication condition, or other mental disorder.
- E. Patients typically also experience situationally bound panic attacks.

Excerpted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (2).

pain disorder (characterized by pain as the predominant focus of clinical attention and wherein psychologic factors are judged to play an important role in its onset, severity, exacerbation, or maintenance).

Two recent studies of comorbidity in tertiary care medical settings reported that between 6% and 22% of headache sufferers met diagnostic criteria for a somatoform disorder (38,11). Somatoform disorders were equally prevalent among women and men. By a healthy margin, the most common somatoform disorder associated with headache was undifferentiated somatoform disorder (38). Headache was included among patients' lists of varied somatic complaints (e.g., fatigue, loss of appetite, gastrointestinal symptoms, urinary complaints) that were adjudged either "medically unexplained" or excessive based on the history, physical examination, or laboratory findings.

When a somatoform disorder is suspected, a careful evaluation is indicated for psychiatric disorders commonly associated with somatic complaints (e.g., depression, anxiety, substance abuse/dependence, personality disorders). For example, patients who believe they have a disabling medical condition may experience high levels of anxiety and distress, such that disease-like symptoms occur in the absence of objective evidence for the condition. A thorough behavioral assessment of antecedent conditions, temporal relationship between stressors and symptom development, and the consequences of the symptoms (disability, secondary gain, and reinforcement) is warranted. Psychosocial stressors can be examined by inquiring about recent life events as well as the patient's emotional and behavioral responses to these events. Treatment should emphasize dysfunction rather than structural pathology. It can prove helpful to describe and reassure the patient about the *amplification process* associated with somatoform disorders (the patient devotes excessive attention to ordinary bodily sensations to the point they become disturbing and unpleasant; this in turn exacerbates the patient's concern, increases anxiety, and amplifies the sensations) (3).

Antidepressant medications often are prescribed with some benefit to patients with a somatoform disorder. Patients with somatoform disorders characteristically are exquisitely sensitive to medication side effects and will thus need education and ample reassurance. Minimal initial dosing paired with very gradual dose escalation often serves to improve tolerance and compliance. But despite the benefit of these medications, they obviously do not address the core symptoms of somatoform disorders and are not adequate as a sole intervention for these patients.

Cognitive-behavior therapy has demonstrated efficacy in reducing the intensity and frequency of somatic complaints and improving function in somatizing patients, including those with hypochondriasis, somatization dis-

order, and undifferentiated somatoform disorders (30). Relaxation training, biofeedback training, and stress-management training are formulated to reduce physiologic and emotional arousal. Cognitive restructuring teaches patients to modify thoughts, and this training may serve to reduce distortions of perceived physical sensations and assist patients to reattribute sensations to ordinary events rather than imagined pathologic causes. Given the lack of efficacy of medication as a singular intervention for most of the somatoform disorders, cognitive-behavioral therapy should be considered a first-line treatment. Thus, physicians may do well to insist that their patients actively participate in psychologic therapy as a condition of ongoing medical treatment. Fortunately, as is the case for panic disorder, therapy targeting symptoms of somatization disorder as well as symptoms of recurrent headache can readily be integrated into a single cognitive-behavioral intervention.

Personality Disorders

Because personality disorders affect between 10% and 13% of the general population (12), it is not at all uncommon for health care providers treating headache sufferers to encounter patients with a personality disorder. A personality disorder (DSM-IV Axis II) is characterized as an inflexible and pervasive pattern of behavior leading to clinically significant distress or impairment in functioning (2). The disturbed behavior patterns of patients with personality disorders are generally stable and enduring, but may become more intense during times of stress, acute pain, anxiety, or depression. Comorbid personality disorders can substantially complicate headache treatment because of the difficult interpersonal style of the patient (e.g., histrionic patients may greatly exaggerate symptom complaints; borderline patients may be manipulative; passive/dependent patients may rely excessively on the health care provider).

From a patient management perspective, the borderline personality disorder is probably the most difficult of the Axis II disorders. The essential feature of borderline personality disorder is a pervasive pattern of unstable interpersonal relationships, mood, and self-image that is accompanied by at least five of the following: (a) unstable relationships alternating between overidealization and devaluation ("good doctor, bad doctor"); (b) impulsive and reckless behavior (excessive spending, sexual indiscretion, substance abuse, binge eating); (c) recurrent suicidal threats or self-destructive behavior (e.g., recurrent self-inflicted wounds with fingernails or other objects); (d) affective instability or mood shifts; (e) inappropriate intense anger or difficulty controlling anger; (f) persistent identity disturbance (e.g., uncertainty regarding self-image, goals, career, friends, values); (g) chronic emptiness or boredom; and (h) frantic efforts to avoid

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abandonment (2). Borderline personality disorder is found in about 2% of the general population, about 10% of psychiatric outpatients, and close to 20% of psychiatric inpatients (2). Borderline personality disorder appears to be linked to gender, with approximately 75% of patients with borderline personality disorder being female (2). Childhood emotional trauma and abuse (physical, sexual) are reported much more frequently among borderline personality disorder patients (alleged sexual abuse in 40 to 86%) than among the general population (22 to 34%) (46).

There are no epidemiologic studies of headache and comorbid borderline personality disorder. However, significant headaches are a complaint of about 60% of patients with borderline personality disorder (21).

With comorbid personality disorders, especially the borderline personality disorder, engagement in psychotherapy should be a requirement of ongoing medical care. When working with patients with borderline personality disorder, clear expectations of patient responsibilities are necessary and can be facilitated through use of written behavioral treatment contracts (42). Such contracts typically include an agreement from the patient to refrain from behaviors that carry a risk for self-harm, clear specification of unacceptable behaviors, and specification of acceptable means for the patient to express treatment concerns. Behavioral contracts also typically emphasize the patient's responsibility for compliance as a condition of treatment and clearly specify the consequences (e.g., discharge) for failure to abide by the conditions specified in the contract. To any clinician seeking additional information, we highly recommend the recent paper by Saper and Lake (42), which details indispensable strategies for managing recurrent headache patients with comorbid borderline personality disorder.

HEADACHE ATTRIBUTED TO PSYCHIATRIC DISORDER

Whereas headache is frequently comorbid with a variety of psychiatric illnesses, it is only rarely the case that the report of headache is causally associated with a psychiatric illness. The International Classification of Headache Disorders (ICHD-II) (20) for the first time provides specific criteria for Headache attributed to psychiatric disorder (ICHD-II 12. code type), which is reserved for those patients for whom a headache occurs in the context of a psychiatric condition that is known to be symptomatically manifested by headache. The Headache Classification Committee saw fit to formulate diagnostic criteria for only two varieties of this form of headache: Headache attributed to somatization disorder (ICHD-II 12.1) and Headache attributed to psychotic disorder (ICHD-II 12.2; see Table 137-4). They

TABLE 137-4 ICHD-2: Headache Attributed to Psychiatric Disorder: Two Coded Subtypes (12.1, 12.2) and Seven Appendix Listings (A12.3–A12.9)

12.1 Headache attributed to somatization disorder
<ul style="list-style-type: none"> ■ History of many physical complaints beginning before age 30 that occur over a period of several years and result in treatment being sought and/or in significant impairment in functioning ■ At least four pain symptoms, two nonpain gastrointestinal symptoms, one sexual or reproductive symptom, and one pseudoneurologic symptom ■ After appropriate investigation, each of these symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance or medication.
12.2 Headache attributed to psychotic disorder
<ul style="list-style-type: none"> ■ Delusional belief about presence or etiology of headache occurring in the context of a psychotic disorder (e.g., delusional disorder, schizophrenia, major depressive episode with psychotic features, manic episode with psychotic features) ■ Headache occurs only when delusional. ■ Headache resolves when delusions remit. ■ Headache not attributed to another cause
A12.3 Headache attributed to major depressive disorder
A12.4 Headache attributed to panic disorder
A12.5 Headache attributed to generalized anxiety disorder
A12.6 Headache attributed to undifferentiated somatoform disorder
A12.7 Headache attributed to social phobia
A12.8 Headache attributed to separation anxiety disorder
A12.9 Headache attributed to posttraumatic stress disorder

Excerpted from the *International Classification of Headache Disorders*, 2nd edition (20).

specified that when a new headache occurs in close temporal relation to a psychiatric disorder, it is coded as a secondary headache attributed to that disorder (i.e., using the 12. code type). When a pre-existing headache is made worse in close temporal relation to a psychiatric disorder, the patient can be given a diagnosis of either the preexisting headache or both the pre-existing headache diagnosis and a 12. diagnosis. A 12. diagnosis usually becomes definite only when the headache resolves or greatly improves after remission of the psychiatric disorder. If the psychiatric disorder does not remit spontaneously or when there has been insufficient time for this to happen, a diagnosis of Headache probably attributed to a psychiatric disorder is recommended.

As acknowledged in the ICHD-II (20), clinical wisdom dictates that there are cases in which headaches occur exclusively during common psychiatric disorders other than the two varieties characterized above, and that the headache symptoms may best be considered as attributed to these disorders. Examples include major depressive illness, panic disorder, generalized anxiety disorder,

undifferentiated somatoform disorder; and more (see Table 137-4). Given the paucity of empirical evidence addressing these circumstances, the Committee (20) refrained from forming diagnostic codes for these cases, but did include them in the appendix to encourage further research into this area.

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