

Psychogenic Headache (2004)

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The term “psychogenic headache” has been used to mean many different things. A survey of 105 physicians revealed that the leading definition for psychogenic headache was “tension headache” followed by a headache with “no organic basis.” It has been suggested that the term should be limited to patients where headache is the main or most prominent symptom of a psychiatric disorder. The 1988 International Headache Society (IHS) classification system did not recognize psychiatrically caused headaches as a form of secondary headache. Instead, such headaches were considered a form of tension-type headache [1]. The clinical characteristics of psychiatrically caused headaches, though, do not always conform to those of tension-type headache.

“Headache attributed to psychiatric disorder” is a new category of secondary headache introduced in the 2004 revision of the International Classification of Headache Disorders (ICHD)[1]. In this classification, the Headache Classification Subcommittee of the International Headache Society (IHS) recognizes somatization disorder and psychotic disorder as psychiatric causes of headache, while commenting that “...there is very limited evidence supporting psychiatric causes of headache...the vast majority of headaches that occur in association with psychiatric disorders are not causally related to them but instead represent comorbidity...” Other psychiatric disorders are not recognized in the main body of the classification as causative, but “candidate criteria” are contained in an appendix “to facilitate research into the possible causal relationships between certain psychiatric disorders and headache.”

Experts revising the International Headache Society (IHS) diagnostic system commented that although they believed headache attributable to psychiatric disorder does exist, they had difficulty finding reasonable evidence for it in the scientific literature. It is true that few such credible case reports appear in medical journals. In my work in an inpatient hospital unit devoted to pain rehabilitation, though, I have encountered many patients over the years in whom headaches seemed clearly attributable to psychiatric disorders. Dr. David Biondi and I have recently described a series of these patients that will be published in an upcoming issue of the Journal of Neurology, Neurosurgery and Psychiatry [4]. In that series, we describe seven patient cases. Several meet the criteria established by the ICHD for “headache attributable to somatization disorder,” and several meet the candidate criteria for “headache attributable to depression.” We also describe cases of headache due to malingering and factitious disorder. The cases in this series all provide the strong and compelling evidence of psychiatric causation desired by the IHS classification subcommittee: the headache occurs exclusively during the course of the psychiatric disorder, resolves or greatly improves as the disorder improves, and is not attributable to any other cause. In several cases, patients were headache-free during periods of remission from their psychiatric disorder, only to have recurrence of an identical headache problem with recurrence of the psychiatric disorder.

The details of the cases we chose to present are extraordinarily convincing, because we wanted to describe patients in whom the causal relationship between the psychiatric disorder and headache was not in doubt. The case histories support the view that psychiatric factors can cause headache and suggest that among patients refractory to treatment, this cause of headache may be more common than generally appreciated. In some cases, primary headache disorders may coexist with headache attributable to psychiatric disorder. Just as many patients with pseudoseizures also have true epileptic seizures, so many patients with psychiatrically caused headache have real headache disorders. In fact, headache attributed to psychiatric disorder may be more likely to occur in patients with pre-existing headache, just as patients who have a pre-existing headache problem such as migraine are more likely to develop a headache in response to hypertension.

It seems possible that headaches of psychiatric origin, especially in patients with treatment-refractory headache, are not rare, just rarely recognized. The prevailing view is that psychiatric problems are only associated or influencing elements in the majority of recurrent, benign headache syndromes.⁵ Even if this is the most common relationship between psychiatric illnesses and headache disorders, though, it does not eliminate the possibility of a causal relationship in some circumstances. My review of those few cases of psychiatrically caused headache that are in the literature, combined with clinical experience, suggests that certain characteristics are often associated with headaches of psychiatric origin and can be used to narrow the diagnostic focus earlier. (See [Table](#).)

References

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