Review Articles

Revising the Classification of Somatoform Disorders: Key Questions and Preliminary Recommendations

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As the DSM-V process unfolds, Somatoform Disorders are a diagnostic category for which major revisions seem warranted. The Conceptual Issues in Somatoform and Similar Disorders (CISSD) project recently convened three workshops, involving 24 experts. The CISSD identified key questions related to stakeholders; terminology; appropriate axis (I versus III); medically unexplained criteria; status of functional somatic syndromes; and symptom counts, grouping, lifetime recall, and checklists. Preliminary recommendations include substantial revision of the category of Somatization Disorder, elimination of Undifferentiated Somatoform Disorder and Pain Disorder, terminology changes, and potential shifting of certain disorders to different DSM categories or axes.
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The American Psychiatric Association's *Diagnostic and Statistical Manual for Mental Disorders* (DSM) has been an important nomenclature device to operationalize psychiatric diagnoses for clinicians, researchers, and patients. The APA has revised its original DSM classification three times and is in the planning stages for its fourth revision (DSM-V), expected to be completed in the next 6 to 8 years. A large-scale revision is planned. One of the categories that will need to be considered is that of Somatoform Disorders. The category of Somatoform Disorders was first introduced in DSM-III after the abolition of the category of a group of "neurotic" conditions that present with somatic symptoms but are considered not to be explained by a general-medical condition.

Central to the category was Somatization Disorder, a condition defined by many somatic symptoms occurring over many years. The Somatoform Disorder category also included a disparate group of other diagnoses, united only by the fact they present as somatic symptoms. These diagnoses were the following: Conversion Disorder, Hypochondriasis, and Psychogenic Pain Disorder. Also, there was the residual category of "Atypical Somatoform Dis-

order." In the subsequent revisions, DSM-III-R and DSM-IV, minor changes to the definitions of these disorders were made. There was also one major change: the introduction of the diagnosis of "Undifferentiated Somatoform Disorder." The addition of this new diagnosis had been necessitated in order to provide a category for the large number of patients who, although clearly ill, did not fall within the existing somatoform criteria. As a result, between DSM-III and DSM-IV, the category of Somatoform Disorders changed from a small grouping of relatively uncommon conditions to a general category that covered a large range of illnesses.

The somatoform disorders listed in DSM-IV are shown in Table 1. This category has been controversial ever since DSM-IV was released¹ and has prompted nu-

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Classifying Somatoform Disorders

merous calls from experts in the field to reconsider the category. These calls have ranged in scope from radical reformulation^{2,3} to substantial revision⁴⁻¹⁴ to merely modest refinement.¹⁵⁻¹⁸ Characterized primarily by physical rather than psychological symptoms, most patients present in medical rather than mental health settings, and a somatoform diagnosis confronts the clinician with the often-difficult decision of whether to attach a psychiatric label to a person with somatic complaints. Moreover, patients with somatoform disorders are even more reluctant than patients with other mental disorders to accept a psychiatric diagnosis.

The Conceptual Issues in Somatoform and Similar Disorders (CISSD)

The Conceptual Issues in Somatoform and Similar Disorders (CISSD) Project (see Acknowledgment) was launched several years ago by Richard Sykes to stimulate a multidisciplinary dialogue about the taxonomy of somatoform disorders and the medical diagnoses of functional somatic syndromes (e.g., irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia). A series of three CISSD workshops, spanning a total of 6 days were held in London, UK (May 20, 2005), Oxford, UK (March 29-31,

2006), and Indianapolis, IN (May 10-11, 2006). Proceedings of the 2005 Workshop have recently been published.¹⁹⁻²⁶ The 2006 workshops brought together American and European experts to further consider the key questions and potential changes to be addressed in any revision of the Somatoform Disorders category, with the explicit aim of informing the development of DSM-V.

The key questions and preliminary recommendations are not completely aligned because the questions represent areas of divergence, whereas the recommendations reflect areas of greater agreement, although not complete consensus. Certain terms, such as *psychiatric*, *mental*, and *psychological*, are used interchangeably, even as we acknowledge important distinctions and the fact that somatoform disorders are treated by a broad range of mental health and medical clinicians.

Key Questions

1. Who should be the stakeholders for DSM-V?

A traditional audience for the DSM classification has been mental health professionals, including clinicians, educators, and researchers. However, there are two other important groups of stakeholders: First, patients with somatic symptoms that meet criteria for a somatoform disorder are mostly seen by clinicians in the primary-care as well as medical and surgical subspecialty settings, where somatoform diagnoses are seldom used. Second, and explicitly mentioned in the introductory chapter of DSM-IV,²⁷ are the patients who increasingly have an interest in the diagnosis they receive. Patients often resist having somatic problems labeled as a psychiatric disorder, with the consequent stigma and negative financial implications. In summary, an important question is the extent to which the views of non-psychiatric clinicians and patients should be considered in the process of designing a revised classification of these conditions.

2. Should we abolish some terms and concepts, such as "somatization" and "somatoform"?

Related to Question 1, it was strongly argued that we should change the currently used terms such as Somatoform, Somatization, and Hypochondriasis, and pay more attention to their acceptability to patients. A counter-argument was that the terms have an agreed-upon usage, and to change them would be unnecessarily disruptive. Furthermore, it was anticipated that the stigma will simply reattach to any new name unless the concept of mental causation (and therefore personal responsibility) is changed.¹⁹ Also, there may be cultural differences. For ex-

TABLE 1. DSM-IV Somatoform Disorders^a

- **Somatization Disorder** is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.
- **Undifferentiated Somatoform Disorder** is characterized by unexplained physical complaints, lasting at least 6 months, that are below the threshold for a diagnosis of Somatization Disorder.
- **Conversion Disorder** involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general-medical condition. Psychological factors are judged to be associated with the symptoms or deficits.
- **Pain Disorder** is characterized by pain as the predominant focus of clinical attention. Also, psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance.
- **Hypochondriasis** is the preoccupation with the fear of having, or the idea that one has, a serious disease on the basis of the person's misinterpretation of bodily symptoms or bodily functions.
- **Body Dysmorphic Disorder** is the preoccupation with an imagined or exaggerated defect in physical appearance.
- **Somatoform Disorder, Not Otherwise Specified** is included for coding disorders with somatoform symptoms that do not meet the criteria for any of the specific Somatoform Disorders.

^aFrom *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*, Washington, DC, American Psychiatric Association, 1994.

ample, a diagnosis of Somatoform Disorder may be more acceptable to patients in Germany than in some other countries, partly because of the specialty of psychosomatic medicine, which takes a special interest in providing care to this group of patients.²⁴ Likewise, labels such as “functional” may be less stigmatizing in some countries than in others.^{12,28} Still, general terms, such as “functional,” “medically unexplained,” and “psychosomatic” are currently less satisfying to many patients than the diagnosis of a particular medical disorder.²⁸

3. *Should the conditions currently diagnosed as Somatoform Disorders remain psychiatric disorders on Axis I in DSM-V?*

DSM classifications use multiple axes. Axis I refers to psychiatric diagnoses, Axis II to personality disorders, and Axis III to general-medical conditions. Is it therefore appropriate that conditions defined by somatic symptoms be regarded as psychiatric and placed on Axis I, or that they be considered medical and placed with other medical conditions on Axis III? Does an Axis I diagnosis imply that the somatic symptoms are psychologically caused, or just that psychological or psychiatric management is appropriate? Regarding the latter, an Axis I diagnosis is required in some healthcare systems to justify treatment by and financial reimbursement to a mental health professional. At the same time, it can be argued that assigning somatic-symptom disorders to Axis III is preferable for non-mental health practitioners, who regard them as a medical problem and for patients who do not want to be stigmatized by a psychiatric diagnosis or disadvantaged by healthcare reimbursement, employment, and disability policies that are often prejudicial to a mental-disorder diagnosis.²³ Conversely, some have argued that stigma should not dictate the axis on which somatic symptoms are located, but, instead, that it should be combated as part of the negative stereotyping of mental disorders in general.

Not everyone agreed with the dichotomous position that psychological symptoms should be classified under Axis I, and somatic symptoms under Axis III. Many physically-defined symptoms are classified under Axis I (e.g., panic disorder, anorexia nervosa, and others). Furthermore, the assumption that patients with somatoform disorders visit mental health specialists less frequently than patients with other mental disorders, such as depression and anxiety, may be overstated.²⁹ Additional considerations for assigning a particular diagnosis to Axis I might be that psychiatric and other mental health specialists offer the most profound understanding of the disorder, or have developed the most successful treatments.

4. *Should “explanation” remain a core construct in diagnosing somatoform disorders?*

An essential criterion for a somatoform diagnosis is the presence of somatic symptoms that are considered to be “disproportionate to” or “medically unexplained” by a medical disorder or that are “not better accounted for” by a general-medical condition. However, the concept of explanation of somatic symptoms by a medical condition was noted to create several problems. First, patients with somatoform diagnoses often have comorbid medical conditions, and determining what symptoms are “disproportionate to” or “not fully explained by” these conditions can be difficult. Indeed, recent studies have demonstrated that disease-specific somatic symptoms (e.g., angina in patients with coronary artery disease, dyspnea in patients with asthma, joint pain in patients with arthritis) are often explained as much by psychological factors as by objective parameters of medical disease severity.^{30,31} Second, all psychiatric symptoms are considered to have a biopsychosocial development, some of them being perhaps even more “biological” than somatoform disorders (e.g., schizophrenia). Third, total symptom count (including explained and unexplained symptoms) may be as good a marker for outcomes as unexplained symptoms^{32–34} and may bypass the methodological difficulties in arbitrating symptom etiology. In short, symptom etiology has important shortcomings for dictating axis assignment.

There were several different stances with respect to the explanation criterion that were advocated by experts. One was to maintain the status quo, with the contention that lack of a disease explanation was the essential feature differentiating somatoform disorders from general-medical diagnoses. A second was to abandon the concept, and simply list somatic symptoms on Axis III while coding qualifying psychological factors (e.g., psychological factors affecting the general-medical condition) on Axis I. A third was to retain some physical-symptom disorders on Axis I, and regard these as unexplained, while also requiring some positive psychological criteria.

5. *How should functional somatic syndromes be classified?*

These so-called functional somatic syndromes include conditions such as irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, interstitial cystitis, and others. These syndromes are overlapping and frequently coexist.³⁵ Also, there are individual symptoms, such as tension headache, low back pain, non-ulcer dyspepsia, and atypical chest pain, to name a few, for which the etiology is unknown. These functional syndromes and somatic symp-

Classifying Somatoform Disorders

tom-defined conditions, if regarded as medical, would properly be placed on Axis III as general-medical conditions. However, this practice can be seen as inconsistent if a patient with the same symptoms seen by a psychiatrist is diagnosed with a somatoform disorder on Axis I. Expert opinion differs about whether functional somatic syndromes and somatoform symptoms should be combined in a new classification system¹² or whether, in the absence of clear linkage to psychological factors, the default should be to code somatic symptoms and syndromes on Axis III.^{22,23}

6. Should we use symptom counts to define somatization disorder?

Should we continue to use a definition of somatization disorder based on a somatic symptom count and choose a certain number as defining this diagnosis? A number of studies have indicated that there is a continuous relationship between increasing somatic symptom counts and functional impairment, childhood and family risk factors, psychiatric comorbidity, healthcare use, and other measures of construct validity.^{32–34,36–38} There does not appear to be a clear-cut symptom-count threshold that would justify a specific cut-point; at the same time, however, operational cut-points are established for other continuous psychiatric (e.g., depression, anxiety) and medical (e.g., hypertension, diabetes, hyperlipidemia) disorders. Countering this approach, it was argued that symptom counts are a bizarre way to make a diagnosis, and any choice of a threshold would be arbitrary. Rather, “positive” psychological/behavioral criteria in addition to medically unexplained symptoms might be considered mandatory for a somatoform diagnosis. Thus, it remains a key question whether to have a symptom-count cut-point for defining somatoform disorder, rather than using symptom count as just one of the dimensional severity measures.

7. Is symptom grouping, lifetime symptom recall, or a symptom checklist useful for diagnosing somatization disorder?

Symptom grouping was formalized in DSM–IV, when the DSM–III–R requirement for at least 13 from an exhaustive list of 35 somatoform symptoms was replaced with a requirement for a pattern of symptoms drawn from different types (i.e., at least four pain symptoms, two gastrointestinal, one sexual, and one pseudo-neurological). In essence, a trade-off occurred by lowering the symptom-count but making it necessary to “fill” four symptom groups for the diagnosis. Although proponents of this change believed it would make diagnosing somatoform disorder less cumbersome, the clinical usefulness³⁹ of this

revision has not been tested. Although some studies have suggested that certain types of symptoms may cluster,^{12,40–42} the results are mixed,^{38,43–45} and most research has revealed a single predominant somatization factor. Finally, studies have not shown any substantial difference between the low base rates of somatization disorder defined according to DSM–IV versus DSM–III criteria, suggesting that both are equally restrictive.¹⁵

Counting “lifetime” symptoms is particularly problematic. First, it is not practical in busy clinical settings. More importantly, lifetime recall of specific symptoms is very unstable, with exceedingly poor reliability between two time-points.^{46–48} Counting only current symptoms but requiring a lower symptom threshold has been shown to capture most patients with somatization disorder.³⁸

What is the role of symptom checklists? Earlier versions of DSM had included a specific symptom checklist, which was deleted from DSM–IV. Symptom checklists may have operational value,^{38,49} but their actual role in criteria sets is uncertain. Although symptom-checklist results could also be more difficult to interpret in patients who have diseases affecting multiple organs (e.g., systemic lupus, thyroid disorders, metastatic cancer), multi-system diseases usually have objective manifestations as well, and are not commonly misdiagnosed as somatoform disorders.

Recommendations

Preliminary recommendations emerging from the CISSD Workshops are summarized in Table 2. Considerable attention was devoted to somatization disorder. Although it has the longest legacy among somatization disorders, the term Somatization Disorder identifies only a minority of patients suffering from medically unexplained symptoms (MUS). For example, the prevalence of somatization disorder in primary care is 1% or less, whereas the prevalence of patients with clinically relevant MUS is 10%–15% or greater.^{49–55} For this reason, some researchers have abandoned Somatization Disorder in favor of more practical definitions.^{56,57} At the same time, the “default” diagnosis of Undifferentiated Somatization Disorder (USD) is too broad and is neither well-validated nor widely-used. Thus, if Somatoform Disorder is retained in DSM–V, there was general agreement that either its criteria should be revised to make it more inclusive, or a second, lower-threshold category should be added, such as “Abridged Somatization Disorder,”^{52,58} “Multi-Somatization Disorder,”^{50,59–61} “Bodily Distress Disorder,”¹² or other variants, as previously described.^{4,15,16,22,54} There

was also a consensus that USD should be deleted from DSM–V. Many patients previously coded as USD would in fact meet criteria for the more-inclusive Somatization Disorder category.

It was also felt that a psychiatric diagnosis (somatoform or otherwise) should not be made solely on the basis of MUS. “Unexplained” can mean psychologically as well as medically unexplained; that is, an idiopathic symptom.

Thus, Somatization Disorder diagnostic criteria should require positive psychological criteria in addition to language about how well the somatic symptoms are accounted for by another medical or psychiatric disorder. Table 3 provides an example of a “placeholder” Somatization Disorder category, for which group consensus was not attempted, but which exemplifies some of the other criteria that might be considered in addition to MUS.

TABLE 2. Recommendations for Revising Somatoform Disorders in DSM–V

I. Somatization Disorder

General Agreement

1. Make this a more inclusive (less restrictive) diagnosis, since DSM–IV somatization disorder identifies only a small proportion of the patients with clinically-relevant persistent somatic symptoms seen in clinical practice. This can be done by either:
 - a. Broadening the definition of somatization disorder to include a lesser number of symptoms.
 - b. Retaining Somatization Disorder as currently formulated, but add a new, lower threshold category (see #3).

Issues with Divergent Viewpoints

2. Some argue for moving all conditions manifested principally by medically unexplained symptoms to Axis III;^{3,22} others disagree.^{18,19}
3. Remove “Somatization” from the name of the disorder. Examples include, but are not limited to, “physical symptom disorder,” “somatic symptom disorder,” “bodily symptom (or distress) disorder,” “multisomatoform disorder.”
4. Although there is agreement that a lower threshold category is warranted, there are a variety of options for constituting such a category. Several conditions have some empirical data supporting their validity, such as Abridged Somatization Disorder,⁵³ Multisomatoform Disorder,⁴⁸ and Bodily Distress Disorder.⁴¹ There are other published proposals, as well.^{4,12,15,16,22} Finally, example criteria were discussed by CISSD participants and outlined in Table 3 to stimulate ongoing discussion and refinement.

II. Undifferentiated Somatoform Disorder

1. Delete as a disorder.

III. Pain Disorder

1. Move to Axis III, and code the specific type of pain condition or conditions (e.g., low back pain, headache, fibromyalgia, noncardiac chest pain).
2. If psychological factors are also present, code these as a dual diagnosis on Axis I, either as a discrete disorder (e.g., Major Depression, Panic Disorder) or as Psychological Factors Affecting a General-Medical Condition.

IV. Hypochondriasis

1. Change the name to “Health Anxiety Disorder.”
2. Refine the criteria on the basis of recent empirical research.^{57,58}
3. Either keep category in Somatoform Disorders or move to Anxiety Disorders.

V. Conversion Disorder

1. Either keep category in Somatoform Disorders or move to Dissociative Disorders.

VI. Body Dysmorphic Disorder

1. Either keep category in Somatoform Disorders or move to Obsessive-Compulsive Disorder.

VII. Other Recommendations

1. Mono-syndromic/symptomatic conditions (e.g., individual somatic symptoms, such as back pain or dizziness, or individual somatic syndromes, such as irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia) should remain on Axis III.
2. Remove language that is potentially pejorative to patients from text. Examples that are found in the DSM–IV chapter on Somatoform Disorders include the following:
 - a. “Doctor-shopping”
 - b. Pseudo-neurological
 - c. “Specific factual information is often lacking.”
 - d. Inconsistent historians
 - e. Misinterpretation of bodily symptoms
 - f. Use “colorful, exaggerated terms.”
3. The APA and WHO should work together to make DSM–V and ICD–11 compatible with respect to the categories, disorders, and criteria for mental disorders. One recommendation is to delete Neurasthenia and Somatoform Autonomic Dysfunction as discrete disorders from ICD.

Classifying Somatoform Disorders

A second important recommendation for which there was widespread agreement was the deletion of the category Pain Disorder. Although DSM-IV was intended to be largely atheoretical and free of unsupported mechanisms as part of diagnostic criteria, the terms Pain Disorder and Conversion Disorder violate this principle. Criterion C for Pain Disorder specifies that “psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.” There is extensive literature showing substantial comorbidity ($\geq 50\%$) between chronic pain and depression, their bidirectional dependency, and central nervous system linkages.⁶² Pain Disorder has been infrequently researched as a discrete diagnosis, and even experts in the pain community do not favor this Axis I diagnosis.^{63,64} Assigning an Axis I diagnosis to a small subset of chronic pain is highly arbitrary and is not only stigmatizing to them but presumes that there is a whole class of chronic pain patients for whom physiologic factors are irrelevant. Thus, the recommendation is to code all pain symptoms on Axis III, with concomitant psychiatric comorbidity coded on Axis I.

An overarching question is whether patients would be classified on Axis III when they are mono-symptomatic or have a single functional somatic syndrome but then reclassified to Axis I when they become poly-symptomatic. For example, are pain symptoms “medical” when they occur on their own and “psychiatric” when they occur with other unexplained physical symptoms? One approach, as shown in Table 3, would be to require “positive” psychological/

behavioral criteria in addition to MUS for a somatoform diagnosis. Simple back pain or irritable bowel syndrome would be coded on Axis III, whereas additional criteria such as those in Table 3 would qualify a patient for an Axis I Somatization Disorder.

There have been several evidence-based reviews on the criteria for Hypochondriasis that should be considered when revising DSM-V.^{65,66} For example, the ineffectiveness of medical reassurance has been shown to be an unreliable criterion for hypochondriasis.^{65,67} One consensus CISSD recommendation is that the term itself has become so pejorative that the name should be changed, possibly to Health Anxiety Disorder. There is disagreement as to whether the condition should remain in the Somatoform Disorder category or be moved to the Anxiety Disorders category. There are also differing opinions as to whether Hypochondriasis/Health Anxiety Disorder should remain a discrete disorder or be rolled into Somatization Disorder, with its variants as one of the criteria or domains.

There are several issues regarding Conversion Disorder. First, some experts believe it should be moved from Somatoform Disorders to Dissociative Disorders. Second, if Conversion Disorder is moved out of the Somatoform Disorder category, would individual pseudo-neurological symptoms not meeting full criteria for Conversion Disorder still count toward a diagnosis of Somatization Disorder? Third, some wonder why neurological symptoms warrant a separate disorder distinct from other medically unexplained symptoms. However, others argue that there is a

TABLE 3. Example Criteria for a More Inclusive Definition of Somatization Disorder^{a,b}

- A. Physical symptoms that are currently bothersome and not better explained by another medical or psychiatric disorder. Somatic symptoms that are core criteria for depressive or anxiety disorders are not counted toward diagnosis of somatic symptom disorder.
- B. Symptoms cause significant occupational or social impairment.
- C. One or more of the symptoms has been present most of the time for at least 6 months.
- D. Two or more of the following are present:
 - 1) Multiple physical symptoms. Symptoms that cluster in a single somatic syndrome, such as irritable bowel syndrome or fibromyalgia, count as one rather than multiple symptoms.
 - 2) Attributional component: continues to attribute the symptoms to an undiagnosed general-medical disorder, despite an adequate or repeated medical work-up.
 - 3) Affective component: health-anxiety, manifested by fear of having a serious disease (but not intense or persistent enough to fulfill the criteria for Health Anxiety Disorder).
 - 4) Cognitive component, such as rumination about bodily symptoms, selective attention to or frequent checking of symptoms, or catastrophizing (i.e., fearing progression or bad outcomes despite reassurance).
 - 5) Behavioral component, such as high number of healthcare visits, requests for repeated testing, seeking care from multiple providers for the same symptoms.

^aThere was not unanimous agreement on these criteria, but, rather, these were initial suggestions from CISSD Workshop participants. Also, various names were proposed (e.g., somatic symptom disorder, physical symptom disorder, multisomatoform disorder, polysomatoform disorder) but no consensus was achieved.

^bAdditional specifiers might be duration (e.g., “chronic” defined as >2 years) and severity (e.g., defined by scores on a somatic-symptom rating scale).

fundamental practical difference between neurological symptoms and other MUS, which is that, for many neurological symptoms, one can better demonstrate a low likelihood of a pathophysiological explanation (e.g., a paralyzed leg in which the flexor muscles move when extensors of the other leg are tested; or a seizure video-recorded and showing a normal EEG). Fourth, Conversion Disorder is the one condition besides Pain Disorder that requires a decision regarding the role of psychological factors, a criterion that is hard to verify, not required for other somatoform disorders, and divergent from the largely atheoretical, phenomenological nature of DSM-IV. One participant felt that DSM-III's "Adjustment Disorder With Physical Symptoms" (subsequently abandoned) may have been preferable to "Conversion Disorder," since it captures the notion of a relatively transient physical symptom triggered by a nonspecific stressor without invoking the outdated concept that physical symptoms are substituted for emotional distress. Fifth, it is notable that pseudo-neurological symptoms have a strong association with psychopathology,⁶⁸ yet are also the least likely to persist.⁴⁷

Body Dysmorphic Disorder is not commonly diagnosed in general-medical settings, yet has been the focus of a surprising number of published studies in the past decade. Some experts believe it should be subsumed under Obsessive-Compulsive Disorder, as a subtype, rather than remain a somatoform disorder, but there is no consensus on this issue.

Several general recommendations are summarized in Table 2, one of which deserves special emphasis. Patients

with poorly explained somatic symptoms are often sensitive to disease labels and language, making it important to carefully amend potentially pejorative language; some examples from DSM-IV are provided in Table 2. Finally, the substantial comorbidity of unexplained somatic symptoms with depressive and anxiety disorders^{31,54,59,61,69} was not an explicit CISSD agenda item but is essential to consider in both diagnosing and classifying somatoform disorders.

In summary, the CISSD process is only an initial, grass-roots step along the journey toward revising the Somatoform Disorders category for DSM-V. After the proceedings, some CISSD participants, as well as external reviewers, were surprised by the number of divergent views held within the areas of consensus, an observation also expressed by others.⁷⁰ One participant noted that this period may reflect practice variation: always observable, even among experts, until there are sufficient studies to sway the field. Nonetheless, the key questions and preliminary recommendations described in this article and the background literature that is cited should be useful as the official deliberations unfold.

The Conceptual Issues in Somatoform and Similar Disorders Work-Group includes, in addition to the authors, the following individuals: Natalie Banner, Arthur Barsky, John Bradfield, Richard Brown, Frankie Campling, Francis Creed, Veronique de Gucht, Charles Engel, Javier Escobar, Per Fink, Peter Henningsen, Wolfgang Hiller, Kari Ann Leiknes, James Levenson, Bernd Löwe, Richard Mayou, Winfried Rief, Kathryn Rost, Robert C. Smith, Mark Sullivan, Michael Trimble.

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Classifying Somatoform Disorders

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