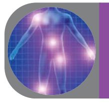
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Fibromyalgia syndrome—a bodily distress disorder/somatic symptom disorder?

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Abstract

Introduction: The debate addressing the classification of chronic widespread pain as a physical disorder (fibromyalgia syndrome) [FMS] or a somatoform disorder according to psychiatric classification systems has continued for decades.
Objectives: The review aims to line out the new perspectives introduced by the 11th version of the International Classification of Diseases (ICD 11) of the World Health Organization (WHO).
Methods: Critical review of the classification criteria of fibromyalgia syndrome and bodily distress disorder in ICD 11.
Results: Fibromyalgia syndrome has been eliminated from the chapter of diseases of the musculoskeletal system and is now included in a chapter "Symptoms, signs, clinical forms, and abnormal clinical and laboratory findings, not elsewhere classified". Previously, the ICD-10 diagnosis of somatoform disorder was often used by mental health care disciplines instead of the label FMS. Somatoform disorders category has been eliminated as a diagnostic category in the ICD-11 and the 5th version Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (APA) and has been replaced with the new categories of bodily distress disorder (BDD) and somatic symptom disorder (SSD) respectively. For diagnosis, these latter mental disorders require at least one distressing somatic symptom (e.g. pain) plus positive psychobehavioral criteria, namely „excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns", without the condition that distressing somatic symptoms have to be medically unexplained.
Conclusion: We argue that the psychobehavioral criteria of BDD/SSD are imprecisely defined and can be misinterpreted as for „Excessive health concerns" which may occur due to the many uncertainties surrounding FMS or „Excessive time devoted to the symptoms" which may be related to patient self-management strategies.

Keywords: Fibromyalgia syndrome, Bodily distress disorder, Somatic symptom disorder, International Classification of Diseases, World Health Organization, Diagnostic and Statistical Manual of Mental Disorders

1. The wars on the taxonomy of fibromyalgia syndrome

Traditional medical diagnosis is grounded in objective findings that could include abnormalities on physical, laboratory, or radiographic examination. There are, however, some validated syndromes without such abnormalities but with a constellation of consistent and recognizable clinical symptoms pointing to a specific diagnosis, such as migraine headaches. This is unfortunately not the case for fibromyalgia syndrome (FMS) for a number of reasons: chronic widespread pain (CWP), the cardinal symptom of FMS, is not pathognomonic of FMS, and other conditions may present similarly with CWP, requiring consideration of a differential diagnosis[18]; symptoms of FMS can be heterogenous and vary amongst patients; individual symptoms can fluctuate; and there is currently no single biomarker that can accurately pin the diagnosis.[35]

These features have contributed to the uncertainties, disbeliefs, and debates surrounding the classification of FMS. The diagnostic label "medically unexplained somatic symptoms" is frequently used in family medicine. In general medicine and at

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times in psychosomatic medicine, the terms "functional disorders" or "functional somatic syndromes" are familiar. These terms are applied to syndromes that are defined more by symptoms, suffering, and disability rather than demonstrable tissue abnormality. These terms do not assume psychogenesis but only a disturbance in bodily functioning.[4,36] They were previously listed in the respective chapters of somatic diseases in the International Classification of Diseases (ICD) of the World Health Organization (WHO). In ICD 9 and ICD 10, "Fibromyalgia" was listed in the chapter on diseases of the musculoskeletal system or connective tissue.[21]

Having had a long history of contention, with many in the early years believing that this condition was a nondisease and rather a manifestation of a psychological disorder, this concept has prevailed within the medical community. There remains a reluctance for some in mostly mental healthcare specialties (psychiatry, psychosomatic medicine, psychology) even to use the diagnostic label FMS. It has been claimed that CWP should be understood as a surrogate complaint for psychosocial confounders to coping.[14] Others contend that FMS is an unhelpful diagnosis[5] leading to the "medicalization of misery" that should be managed by psychological therapies that focus towards unlearning illness behaviors.[14] These diagnostic labels within the ICD-10 and Diagnostic and Statistical Manual of Psychiatric Diseases (DSM) of "somatoform pain disorder" or "somatization disorder" have been used by mental healthcare specialists for people with CWP not fully explained by a general medical condition or by the direct effect of a substance, and not attributable to another mental disorder.[16]

The ICD-11 and DSM-5 have introduced substantial changes to the definition of these disorders. The diagnostic category of somatoform and related disorders has been deleted following debate on the underlying concept of somatization and the uncertainties about excluding a physiological process or a physical disorder to explain the pain.[23] The 2 new diagnostic labels are "bodily distress disorder" (BDD) in the ICD-11 (WHO)[41] and "somatic symptom disorder" (SSD) in the DSM-5 defined by distressing bodily complaints plus psychobehavioral criteria.[1] As expected, the discussion addressing FMS as a mental disorder, namely SSD, has been initiated.[26]

In view of the changes in ICD-11 and DSM-5, and with ongoing discussions on the classification of FMS (somatic disease vs mental disorder), the aims of this study are as follows:

(1) To critically discuss the new concepts of BDD in the ICD-11 and SSD in the DSM-5 pertaining to FMS
(2) To outline similarities and differences between the new taxonomies
(3) To present data on the prevalence of the overlap of FMS with BDD and SSD
(4) To review if therapeutic approaches for BDD and SSD might be helpful for patients diagnosed with FMS

2. The new taxonomies

2.1. Fibromyalgia syndrome in the International Classification of Disease-11

In ICD-11, FMS has been removed from the chapter on diseases of the musculoskeletal system or connective tissue and has been shifted to the chapter "Symptoms, signs, clinical forms, and abnormal clinical and laboratory findings, not elsewhere classified." Categories in this chapter include less well-defined conditions and symptoms that could be designated "not otherwise specified," "unknown aetiology," or "transient." This chapter comprises 7 categories for chronic pain, with FMS included under the category of chronic primary pain. Within this category, CWP is defined as diffuse pain in at least 4 of 5 body regions and associated with significant emotional distress (anxiety, anger/frustration, or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). The diagnosis is appropriate when the pain is not directly attributable to a nociceptive process in these regions, there are features consistent with nociplastic pain "such as spontaneous or evoked pain in the affected regions, accompanied by allodynia and/or hyperalgesia, and there are also identified psychological and social contributors (Code MG30.01)." Fibromyalgia syndrome is identified as a subcategory of "CWP," but without a unique code.[30,42] Similar to other diagnoses according to the ICD 11, additional optional specifiers may be added such as the presence of psychological and social features, pain intensity (psychological) distress, and disability. It is important to note that the definition of CWP explicitly states that biological, psychological, and social factors contribute to the pain syndrome (WHO) thus overcoming the dichotomy between a somatic disease vs a mental disorder.[42]

2.2. Bodily distress disorder according to the International Classification of Diseases-11

Bodily distress disorder is characterised by the presence of bodily symptoms that are distressing to the individual and cause excessive attention directed towards the symptoms, which may manifest as repeated contact with healthcare providers. Symptoms are not required to be "medically unexplained" and may be associated with a specific health condition, but with excessive attention in relation to the nature and progression of the condition. This excessive attention is not alleviated by appropriate clinical examination, investigations, and reassurance. Bodily symptoms are persistent, being present on most days for at least several months. Typically, BDD involves multiple bodily symptoms that may vary over time, although occasionally a single symptom—usually pain or fatigue—may predominate. The symptoms and associated distress and preoccupation have at least some impacts on the individual's functioning (eg, strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities).[41]

2.3. Somatic symptom disorder according to the Diagnostic and Statistical Manual-5

The DSM-5 has changed the diagnostic category previously known as somatoform disorders to somatic symptoms and related disorders. The diagnostic criteria for somatic symptom disorder noted in DSM-5 are the following:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least 1 of the following:
   (1) Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   (2) Persistently high level of anxiety about health or symptoms.
   (3) Excessive time and energy devoted to these symptoms or health concerns.
C. Although any 1 somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

There is a specifier applicable when the predominant somatic symptom is pain. A further specification addresses severity according to the number of symptoms identified or the severity of a specific somatic symptom with grading as mild, moderate, or severe. Somatic symptom disorder symptoms may or may not be associated with another medical condition.[1]

2.4. Similarities and differences between the somatic symptom disorder and bodily distress disorder

One of the important differences between the DSM-5 and the ICD-11 approaches is the terminology of the prototype disorder (**Table 1**). While the DSM-5 has retained the word "somatic," the ICD-11 has avoided this term altogether. The WHO has argued that while no label can completely prevent the risk of negative connotations and misinterpretations, a more descriptive label that avoids the term "somatic" might prove more acceptable to both patients and primary care clinicians.[13]

The most fundamental revision for both the SSD and BDD has been to eliminate the distinction between medically explained and unexplained somatic complaints. Removing the criterion of "medically unexplained" has been criticized in the SSD as a risk that patients may receive an inappropriate psychiatric diagnosis in the setting of a medical condition with a justifiable reason for somatic complaints and with the possibility of stigmatization.[15] This concern has been addressed by the specification in BDD that "if a medical condition is causing or contributing to the

Table 1

Comparison of key features of fibromyalgia syndrome, bodily distress disorder, and somatic symptom disorder.

Term	Fibromyalgia syndrome[42]	Bodily distress disorder[41]	Somatic symptom disorder[1]
Developed for	ICD-11	ICD-11	DSM-5
Developed by	Working group of IASP and WHO	Working group of WHO	Working group of American Psychiatric Association
Defined as a mental disorder	No	Yes	Yes
Somatic key features	Diffuse pain in at least 4 of 5 body regions	Presence of bodily symptoms that are distressing to the individual (typically multiple bodily symptoms that may vary over time, occasionally limited to a single symptom, usually pain or fatigue)	One or more distressing somatic symptoms
Psychological key features	Significant emotional distress (anxiety, anger/frustration, or depressed mood) Extension code "presence of psychosocial factors," eg, problematic cognitive (eg, catastrophizing, excessive worry), emotional (fear, anger), behavioral (eg, avoidance, endurance), and social factors	Excessive attention is directed toward the symptoms, which may manifest in Persistent preoccupation with the severity of the symptoms or their negative consequences Repeated contacts with healthcare providers related to bodily symptoms that are substantially in excess of what would be considered medically necessary	Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least 1 of the following: 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms 2. Persistently high level of anxiety about health or symptoms 3. Excessive time and energy devoted to these symptoms or health concerns
Importance of adequate medical assessment and reassurance	No	Excessive attention to the bodily symptoms persists despite appropriate clinical examination and investigations or appropriate reassurance by a healthcare provider	No
Impairment	Facultative: functional disability (interference in daily life activities and reduced participation in social roles)	Obligatory: significant impairment in personal, family, social, educational, occupational, or other important areas of functioning	Facultative: significant disruption of daily life
Time frame	Persistent or recurrent pain for at least 3 mo	Symptoms are present (though not necessarily the same symptoms) on most days during a period of at least several months (eg, 3 mo or more)	The state of being symptomatic is persistent (typically more than 6 mo)
Grading of severity of the somatic symptom	None, mild, moderate, severe	No	Mild, moderate, and severe
Symptoms medically explained or not	The pain is not directly attributable to a nociceptive process in these regions	Both medically unexplained and medically explained physical symptoms	Both medically unexplained and medically explained physical symptoms
Specifier for established medical conditions	Not applicable	In individuals who have an established medical condition that may be causing or contributing to the symptoms, the degree of attention related to the symptoms is clearly excessive in relation to the nature and severity of the medical condition	None
Exclusion of diagnoses of other mental disorders	Not applicable	Other mental disorders (eg, Schizophrenia or other primary psychotic disorder, a mood disorder, or an anxiety or fear-related disorder)	Not required
Hypothesized aetiology	Biopsychosocial model	No assumptions about aetiology	No assumptions about aetiology

DSM, Diagnostic and Statistical Manual; FMS, fibromyalgia syndrome; IASP, International Association for the Study of Pain; ICD, International Classification of Diseases; WHO, World Health Organization.

symptoms, the degree of attention is clearly excessive in relation to its nature and progression."[41]

Finally, the concept of BDD requires—in contrast to SSD—that the diagnosis can be only established if "excessive health concerns" are not alleviated by appropriate clinical examination and investigations and appropriate reassurance.[41]

Scoping reviews on the reliability, validity, and clinical utility and research gaps of SSD are available in contrast to a paucity of studies on BDD.[25,28]

An advantage for both diagnoses, the SSD and BDD, is the requirement for patient input regarding the subjective experience, and notation of thoughts and feelings concerning the bodily complaints. The diagnoses also take into account the whole range of possible bodily symptoms. It is however notable that a specific diagnosis of FMS does not require an assessment of the patient's subjective experience or the whole range of bodily symptoms beyond those specified in the diagnostic criteria.[39,40] Nevertheless, exploring the global patient experience represents good clinical practice and empathetic patient care supported by guideline recommendations.[32,35]

2.5. Overlap of fibromyalgia syndrome with somatic symptom disorder and bodily distress disorder

How do the criteria of SSD and BDD align with those of FMS? The ICD-11 requires that the extension code for the presence of psychological and social features should be used only in cases in which there is positive evidence that psychosocial factors contribute to the cause, the maintenance, or the exacerbation of the pain or the associated disability, or when the chronic pain results in negative psychobehavioral consequences.

The prevalence of SSD was recently assessed in a cohort of 156 patients with FMS, diagnosed by the 2011 criteria,[39] in a single German outpatient pain medicine center.[17] Patients were evaluated by medical examination, psychiatric interview, and self-report questionnaires. Somatic symptom disorder was defined as follows: Patients were required to report "to be bothered a lot" by at least 1 symptom of the Patient Health Questionnaire 15.[27] Criterion B2 of the DSM-5 (persistently high level of anxiety about health or symptoms) was defined by a score of 8 or more on the Whiteley Index.[7] The authors chose the cutoff score of 8 rather than the usual of 6 because 2 items of the Whiteley Index, namely to be bothered "by many different pains and aches" and "by many different symptoms" are diagnostic features of FMS. The authors did not assess whether patients had previously been provided with information about FMS, nor was any FMS-related education provided before the onset of this study. The SSD B2 criterion was met by 25.6% of the whole group, and the criterion for current anxiety or depressive disorder was met for 95.0% of patients with SSD and 71.6% without SSD. B1 and B3 criteria were not assessed. Patients meeting SSD criteria scored significantly higher on a self-report measure of disability and pain catastrophizing, but without significant differences between groups for numbers on sick leave, applying for disability pension, or self-reported doctor or physiotherapy visits in the previous 6 months. Following medical record review by 2 clinicians blinded as to the purpose of this study, a need for psychotherapy, based on the German FMS—guideline recommendations,[32] would have been recommended for 80.0% of patients with SSD and 66.7% of patients without SSD.[17]

Similar findings were noted in a study by Axelsson et al.[3] in Sweden. Thirty-five percent of 140 participants in a clinical trial involving self-referred individuals with a self-reported physician diagnosis met the SSD B2 criterion and was associated with a higher symptom burden. Diagnostic assessment of the SSD B2 was based on the Health Preoccupation Diagnostic Interview.[2] B1 and B3 criteria were not assessed. The authors did not assess whether patients had previously received information about FMS nor was FMS-related education provided before the start of this study.[3]

Klaus et al. examined symptoms associated with SSD in 28 German FMS outpatients according to the 2011 criteria[39] with 6 patient entries a day on an iPod over 14 consecutive days. Somatic symptom disorder B1 to B3 criteria were assessed by the following prompts to be reported in real time: "I am convinced that my pain has solely somatic causes; I am anxious about my health; and I devote time and/or energy to my pain or health concerns." Additional information was provided in the instruction manual, for example, about which causes are regarded as somatic (ie, in the presence of medical diseases such as arthritis, osteoporosis, a tumor, typhlitis, or injuries as a result of an accident) and which are not (eg, muscle tenseness, stress) or about the aspects of devoting time/energy (eg, visits to the doctor, searching online, health-related rumination). In consideration of psychological SSD symptoms with at least mild severity, somatic illness beliefs were reported by 71%, health anxiety by 57%, and devoted time/energy by 64% of the participants at least once daily over the course of the 14-day assessment. According to these findings, the psychological B criterion (at least 1 of B1 to B3) was met by 82% of the participants with FMS. Somatic symptom disorder symptoms were both concurrently and prospectively associated with momentary pain intensity and subjective impairment by pain. The authors did not assess previous information about FMS nor did they provide education before the start of this study.[26]

In a cross-sectional nationally representative German population, distressing somatic symptoms were assessed by the Somatic Symptom Scale SSS-8[12] and health anxieties by the Whiteley Index 7 (WI-7),[7] with 4.5% of participants meeting the criteria for SSD (SSS-8 at least 1 item "bothered very much" and WI-7 total score $\geq$1). The prevalence of FMS according to 2016 criteria[40] was 3.4%. Somatic symptom disorder criteria were satisfied by 28.1% of FMS cases.[20]

In sum, there is no standardised questionnaire to assess all SSD criteria available until now, and there is a great range of people with FMS meeting the criteria of SSD in the studies available.

2.6. A critical view on fibromyalgia syndrome in International Classification of Disease-11

Fibromyalgia syndrome experts have expressed concerns that the ICD-11 definition has transformed FMS into a multisystem pain disorder distinct from the musculoskeletal system.[21] The current definition of chronic widespread pain requires that pain involves at least 4 of 5 body regions. Notably, the International Association for the Study of Pain (IASP) had proposed to the WHO that ICD 11 defines FMS as chronic widespread musculoskeletal pain.[24] However, the term "musculoskeletal" was not included in the widespread pain definition of the ICD-11 by the WHO.[41] Some FMS-patient self-help organisations and FMS experts have submitted suggestions for changes to the ICD-11 and to the WHO ICD-11 platform: FMS should be defined as chronic widespread primary musculoskeletal pain—according to the meaning of the term "fibromyalgia." It should be possible to give a code identified in the chapter on diseases of the musculoskeletal system or connective tissue, for FMS (so-called double parenting).[21]

When abdominal (visceral) pain or headache, commonly associated symptoms in patients with FMS, meet criteria for irritable bowel syndrome or tension headache, they should not be counted as a body region for the CWP criterion "pain in at least 4 of 5 body regions." The 2016 criteria for FMS explicitly require state that jaw, chest, and abdominal pain are not included in the generalized pain definition of FMS, once again attesting to the musculoskeletal component of FMS pain.[40] This specification should be added to the ICD-11 definition of FMS.[21]

Although "significant" emotional distress or functional disability commonly occurs in patients with more severe FMS, such as those seen in secondary and tertiary care, many in primary care or in community cases may not be emotionally distressed or disabled.[19,32] The postcoordination system of ICD-11 allows the coding of FMS without emotional distress or disability. We suggest that the qualifier "is frequently associated" should be added to "significant emotional distress" or "functional disability" in the ICD-11 definition of FMS.[21]

2.7. A critical view on somatic symptom disorder in Diagnostic and Statistical Manual-5

The DSM-5 as a whole has been heavily criticized in the psychosocial medicine community for a number of reasons; for presenting a culturally biased perspective of normality; for pathologizing common human experiences; and for the promotion of first-line pharmacological treatment and overmedicalization.[33] The British Psychology Society expressed a major concern that "clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences which demand helping responses, but which do not reflect illnesses so much as normal individual variation."[8] Major concerns with regards to the SSD designation have been raised due to the overlap between SSD criterion B1 (Disproportionate and persistent thoughts about the seriousness of one's symptoms) and B2 (persistently high level of anxiety about health or symptoms) and the question of when to rate thoughts, feelings, and behaviors as excessive.[15,33,34]

With this background, we will now discuss problems when applying SSD B1 to B3 criteria for people with FMS. As outlined earlier, SSD B1 and B2 do not require that "disproportionate thoughts about the seriousness of one's symptoms and persistently high level of anxiety about health" are not alleviated by appropriate clinical examination and investigations and appropriate reassurance—in contrast to BDD. Current guidelines and position papers recommend that patients be informed that FMS is not fully explained by damage to peripheral tissues, is not progressive, and is not an invalidating condition and people with FMS have a normal life expectancy.[32,35] However, people with FMS might receive contradictory information from healthcare professionals and the media. It can be speculated that the current discussion pertaining to an autoimmune disease[10] or a small fiber neuropathy[31] related to FMS can boost "disproportionate and persistent thoughts about the seriousness of one's symptoms" and "persistently high level of anxiety about health." Furthermore, recommended self-management techniques such as aerobic exercise, meditative movement therapies, warmth applications, and relaxation[32,35] are time consuming and may occupy a considerable time in the day for some patients. Therefore, a valid question is to know the daily time duration that defines "excessive time and energy devoted to these symptoms" (SSD B3 criterion).

2.8. Can the concepts of and therapies for bodily distress disorder and somatic symptom disorder improve the management of people with fibromyalgia syndrome?

There are limited studies available on the efficacy of psychological interventions in SSD.[23] Cognitive-behavioural therapy delivered as therapist-guided or unguided internet treatment or as unguided bibliotherapy was superior to waiting list control in reducing health anxieties in 132 Swedish patients diagnosed with SSD or illness anxiety disorder.[22] Integrative group psychotherapy has been studied in a randomised controlled trial with 120 Chinese patients meeting the criteria of SSD. Integrative group psychotherapy based on CBT, combined with techniques of psychodynamic therapy and mindful body and emotional awareness, was superior to nonspecific supportive group psychotherapy and treatment as usual alone in reducing somatic symptom burden at 4, 8, and 12-week follow-ups.[38]

A current position paper and guidelines recommend screening patients with FMS for psychological distress and inadequate coping (eg, excessive protective behavior). When positive, an assessment by a mental healthcare specialist is recommended as well as psychological treatments should comorbidities of mental disorders and/or inadequate illness behaviour be identified.[32,35] The concept of pain catastrophizing is well established in FMS research and clinical care,[11] with overlap with the SSD B1 and B2 criteria. Modification of maladaptive reactions to pain or dysfunctional coping strategies (ie, pain avoidance patterns) represents a central treatment goal of cognitive behavioral interventions.[32] Systematic reviews of randomised controlled trials have demonstrated that cognitive therapies can reduce pain catastrophizing and increase physical activity in people with FMS.[6] A randomised controlled trial with 240 patients with FMS found that emotional awareness and expression therapy related to psychosocial adversities and emotional conflicts was more effective than a basic educational intervention and comparable to the effects of CBT on overall symptoms, widespread pain, physical functioning, cognitive dysfunction, anxiety, depression, positive affect, and life satisfaction at posttreatment of 6 months follow-up.[29]

3. Conclusions

Ideal care for FMS incorporates the principles of a biopsychosocial approach and the value of psychological therapies and stresses the importance of psychosocial factors in the predisposition, triggering, and perpetuation of FMS symptoms and associated disability. These concepts have been repeatedly expressed in the FMS literature over the years[19] and emphasized in current position papers[35] and guidelines on FMS.[32] Psychological profiles based on symptom-associated thoughts, feelings, and behaviours have also been suggested to allow for the subgrouping of patients with FMS.[19,37] Therefore, the authors contend that the concepts of BDD/SSD do not seem to offer new approaches for psychological diagnostics and management of FMS. Until there is more precision in the definition of the content and cut-offs for the B-criteria in future editions of the DSM, we recommend against using this diagnostic label for people with FMS.

Furthermore, there is currently a confusing abundance of terms and criteria around bodily distress disorders in ICD-11 and DSM-5. Collaboration of the various working groups of the WHO (IASP, WHO Somatic Distress and Dissociative Disorders Working Group, WHO Working Group consisting of primary care physicians with a special interest in mental illness) is urgently

needed to achieve a consistent terminology. We believe that reconciliation can be achieved by the introduction of the concept of functional somatic disorder (FSD) to overcome the dichotomy of taxonomies of somatic and psychosocial medicine. According to Burton et al., FSD should occupy a neutral space within disease classifications, favouring neither somatic disease aetiology nor mental disorder. Functional somatic disorder should be subclassified as (1) multisystem, (2) single system, or (3) single symptom. Additional specifiers can be added to take account of psychological features or co-occurring diseases. Where currently defined syndromes fall within the FSD spectrum—and also within organ system-specific chapters of a classification—they should be afforded dual parentage (eg, FMS can belong to both musculoskeletal disorders and FSD).[9] The concept of functional somatic disorder—overcoming the narrower specialist view of rheumatology ("fibromyalgia") and pain medicine ("chronic primary widespread pain")—can open new avenues for shared underlying mechanisms and treatments and offer a common paradigm for a wide range of symptoms/syndromes beyond FMS.

Fibromyalgia syndrome will remain a challenge for healthcare providers and patients alike, but clinical care should not be compromised by the nuances and debates around taxonomy.

Disclosures

W.H. is a member of the medical advisory board of the European Network of Fibromyalgia Associations and was a member of the German guidelines group on the management of FMS. W.H. has received a consulting honorarium by UCB for the design of a study on FMS. The other authors have no conflict of interest to declare.

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