# WHEN ANXIETY BECOMES PHYSICAL: A CLINICAL GUIDE TO SOMATIC SYMPTOM PRESENTATIONS

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— Maya Angelou

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# ABOUT THE INSTRUCTOR

Gabriel Benaim, LMHC, is a Licensed Mental Health Counselor based in Miami, Florida, specializing in anxiety disorders, trauma, and psychosomatic symptom presentations. He provides psychotherapy to adolescents and adults in both English and Spanish, with a clinical focus on the relationship between emotional distress and physical symptoms. His work integrates cognitive behavioral therapy, somatic approaches, mindfulness-based interventions, and culturally responsive care. Gabriel's professional interests include psychosomatic anxiety, interdisciplinary collaboration with medical providers, and continuing education for healthcare professionals.


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# When Anxiety Becomes Physical:
# A Clinical Guide to Somatic Symptom Presentations

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**After completing this course, participants will be able to:**

1. Describe and distinguish somatic symptom disorder, illness anxiety disorder, and functional neurological symptom disorder within current DSM-5-TR diagnostic frameworks.
2. Explain the neurobiological, cognitive, and behavioral mechanisms through which anxiety can produce and amplify physical symptoms.
3. Apply a biopsychosocial framework to assess and conceptualize individuals presenting with somatic symptom patterns.
4. Select and implement evidence-based interventions for somatic symptom presentations, including psychoeducation, CBT, interoceptive exposure, and mindfulness-based strategies.
5. Identify common therapeutic challenges and use alliance-preserving strategies when working with medically focused or reassurance-seeking individuals.
6. Integrate culturally responsive and interdisciplinary approaches into long-term treatment planning and relapse prevention.

## Introduction

Most healthcare and behavioral health professionals have worked with individuals who report persistent headaches, chest tightness, fatigue, or gastrointestinal symptoms that remain medically unexplained despite appropriate evaluation.

These cases are genuinely hard to navigate. The symptoms are real, the distress is real, but the medical explanation is missing. Clients often worry they are being dismissed or that something serious has been overlooked (Rief & Martin, 2014). Clinicians may not be sure how to explain what is happening, let alone how to help.

The stakes are higher than they might first appear. People with unexplained physical symptoms often cycle through multiple specialists for years before anyone frames the problem in psychological terms. They accumulate medical bills, collect diagnoses that never quite fit, and tend to leave each inconclusive workup feeling more frightened than before (Löwe et al., 2022).

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Research indicates that somatic symptom presentations account for a significant portion of primary care visits and are associated with substantial functional impairment and healthcare costs (Kroenke, 2003; Löwe et al., 2022; Tuttle et al., 2024).

Understanding the connection between anxiety and physical symptoms is not just clinically useful. For many clients, it is the first explanation that makes sense of what they have been living with. Anxiety activates real physiological systems and produces real sensations. When people start interpreting those sensations as signs of serious illness, the anxiety climbs and the symptoms intensify. This course walks through how that cycle works, how to assess it, how to conceptualize it, and what the evidence says about treating it.

The course is organized around six sections, each tied to a learning objective. Section 1 covers how to define and diagnose psychosomatic presentations. Section 2 examines the mechanisms that produce physical symptoms. Section 3 addresses assessment and case conceptualization. Section 4 reviews evidence-based treatments. Section 5 explores common therapeutic challenges. Section 6 addresses cultural considerations and long-term planning. A glossary of key terms and a posttest follow the conclusion.

## Section 1: Understanding Somatic Symptom Presentations

The word psychosomatic gets misused a lot. In everyday language it can imply that symptoms are imaginary or exaggerated. Clinically, the focus should remain on what the term actually describes: real physical experiences shaped by psychological processes, arising from genuine interactions between emotional states, thought patterns, and the body's physiological systems.

Research consistently shows that between 25 and 50 percent of patients presenting to primary care settings have symptoms that cannot be fully explained through medical testing alone (Löwe et al., 2022). In mental health settings, physical complaints are nearly universal among clients with anxiety disorders (Kroenke, 2003; Löwe et al., 2022). These are everyday clinical realities, not rare exceptions.

Despite how common these presentations are, they remain among the most poorly understood and inadequately treated conditions in both medical and mental health settings. Part of the difficulty is structural: the healthcare system is organized around identifying discrete, testable pathologies. When no pathology is found, the system often has little more to offer than reassurance, and reassurance, as we will discuss throughout this course, is rarely sufficient and can actively make things worse.

The history that clients bring to their first therapy appointment matters enormously for how treatment unfolds. Many have been told directly or implicitly that their symptoms are "just stress"


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or "anxiety" without receiving any meaningful explanation of what that means or any guidance about what to do about it (Rief & Martin, 2014; Tuttle et al., 2024). Some have been treated as drug-seeking when they reported pain that could not be verified through imaging or blood work. Others have received diagnoses like fibromyalgia, chronic fatigue syndrome, or irritable bowel syndrome, which are legitimate clinical entities but which some providers deploy as explanatory endpoints rather than starting points for comprehensive care. A few have been explicitly told that their symptoms are psychological in a way that felt dismissive rather than helpful.

These experiences accumulate (Löwe et al., 2022). By the time a person arrives in a therapist's office, they have often developed a complex relationship with the healthcare system, a mix of desperation for answers, distrust of providers who have not taken them seriously, guilt about the costs they have incurred, and a private fear that they are somehow causing their own suffering. Understanding this history is not background information. It is clinical data that directly shapes how the therapeutic relationship needs to be built and how the treatment needs to be framed.

Somatic symptom presentations do not exist in a vacuum (Rief & Martin, 2014). They carry functional consequences that extend across every domain of a person's life. Clients with chronic unexplained symptoms often withdraw from work, social relationships, and physical activity in ways that produce secondary depression, occupational difficulties, and relational strain. The symptom cycle reshapes how clients understand themselves, how they plan their days, and what they believe is possible for them. Treatment that addresses only the physical symptom cycle without attending to these broader functional and identity consequences will often produce clinical improvement that does not translate into genuine recovery in the client's lived experience.

## Functional Impairment and Identity

Somatic symptom presentations do not exist in isolation from the rest of a person's life. When physical symptoms are persistent, unpredictable, and poorly understood, they tend to reorganize how a person lives in ways that extend far beyond the symptoms themselves. Understanding the functional and identity consequences of somatic symptom presentations is an important part of comprehensive clinical assessment and treatment planning.

Functional impairment in this population typically follows a progressive pattern (Löwe et al., 2022; Smakowski et al., 2024). In the early phases, clients begin avoiding specific activities that have been associated with symptom onset or worsening. A client with exercise-induced palpitations stops going to the gym. A client with nausea tied to social settings stops attending gatherings. A client with fatigue that worsens after work demands begins calling in sick more frequently. Each individual avoidance decision feels reasonable and self-protective in the moment, but the cumulative effect over months and years is a dramatically contracted life. Work is affected. Relationships are affected. Physical fitness declines, which produces its own symptom burden through deconditioning. Social engagement diminishes, which removes an important buffer against anxiety and depression. The things that gave the client's life meaning and structure become


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inaccessible, and a secondary depression often develops in the space that the symptoms have carved out.

This progressive contraction also affects how clients understand themselves. Many people with chronic unexplained symptoms develop an identity organized around illness and limitation. They come to think of themselves as sick people, as people who cannot do what others can do, as people whose bodies are fundamentally unreliable. This identity shift is clinically significant because it shapes motivation, treatment engagement, and the interpretation of any symptom change (Smakowski et al., 2024). A client who has come to understand themselves primarily through the lens of their illness may experience symptom improvement with ambivalence, because improvement challenges a self-concept that has become deeply familiar even when it is painful.

Addressing functional impairment and identity is therefore not separate from treating the somatic symptom presentation. It is central to it. Treatment that reduces symptom frequency and intensity without helping clients re-engage with meaningful activities and rebuild a more expansive self-concept will often produce clinical improvement that does not translate into genuine recovery in the client's lived experience. Behavioral activation, which systematically reintroduces avoided activities beginning with those that are most accessible, is as much about rebuilding a life as it is about treating anxiety. And the narrative work of helping clients develop a more flexible and hopeful account of who they are beyond their illness is as clinically significant as any symptom-focused intervention.

## DSM-5-TR Diagnostic Categories

In clinical settings, these presentations fall under the somatic symptom and related disorders category in the DSM-5-TR (American Psychiatric Association, 2022). This framework focuses less on whether symptoms can be medically explained and more on the nature of the client's psychological response to them. The three diagnoses most relevant to practicing clinicians are:

### Somatic Symptom Disorder (SSD)

The client experiences one or more physical symptoms that are distressing or disruptive to daily life, combined with excessive worry, time, and attention devoted to those symptoms. The defining feature is the disproportionate psychological response, not whether the symptoms have a medical explanation. A client can be diagnosed with SSD even when a genuine medical condition is present, if their distress and behaviors around that condition are excessive relative to what the medical findings would suggest.

### Illness Anxiety Disorder (IAD)

The client is preoccupied with the fear of having or developing a serious illness, often with minimal or no physical symptoms. The distress is primarily about what symptoms might mean rather than the symptoms themselves. Clients with IAD often cycle between seeking reassurance from doctors and avoiding medical care altogether out of fear of receiving a serious diagnosis. The reassurance-


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seeking behavior provides brief relief but tends to maintain the anxiety over time (Tyrer et al., 2021).

### Functional Neurological Symptom Disorder (FNSD)

The client presents with neurological symptoms, such as weakness, non-epileptic seizures, tremors, or sensory disturbances, that are inconsistent with recognized neurological disease. Clinical findings typically show internal inconsistency, meaning the symptoms do not follow expected neurological patterns. Psychological stress and trauma history are common contributing factors, and clients often undergo multiple neurological evaluations before receiving this diagnosis (Espay et al., 2018).

## Medically Unexplained Versus Psychologically Amplified Symptoms

An important distinction exists between symptoms that are entirely medically unexplained and symptoms that occur alongside a confirmed medical condition but are significantly worsened by stress or anxiety. A client with confirmed irritable bowel syndrome, for example, may notice their symptoms worsen substantially during periods of conflict or stress. Addressing the psychological dimension does not mean disputing the medical reality. It means taking the full picture seriously.

For clinicians, the goal is not to decide whether symptoms are real or psychological. That framing puts the clinician in an impossible position and tends to put clients on the defensive. The goal is to understand how psychological factors are contributing to what the client is experiencing and to address those factors in treatment.

## Clinical and Financial Burden

Clients with somatic symptom presentations are among the highest utilizers of healthcare resources, often undergoing repeated diagnostic testing and specialist referrals that provide temporary reassurance but do not address the underlying cycle of anxiety and symptom amplification (Kroenke, 2003; Löwe et al., 2022). The personal toll is significant as well. Many clients report feeling dismissed, misunderstood, or stigmatized when medical providers cannot identify a clear cause for their suffering.

By the time these clients arrive in a clinician's office, they often carry years of inconclusive medical encounters and a complicated mix of hope and skepticism about whether anything can actually help (Tyrer et al., 2021). Understanding this history is essential for building an effective therapeutic relationship.

What is perhaps most clinically significant is the gap between how common these presentations are and how infrequently clinicians receive formal training in addressing them. Most graduate programs in mental health devote substantial curriculum to depressive disorders, trauma, and personality pathology, while somatic symptom presentations are covered briefly or not at all. This represents a meaningful training gap with real consequences for client care. This course is designed to close that gap in a practical and clinically grounded way, providing an evidence-based


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framework that clinicians can apply immediately across a wide range of clients and practice settings where physical distress and psychological experience intersect in complex, clinically meaningful ways that benefit from skilled and informed clinical attention.

**Case Example: Somatic Symptom Disorder**

Elena, a 41-year-old teacher, was referred to therapy by her primary care physician after more than a year of persistent gastrointestinal symptoms. Two colonoscopies, multiple blood panels, and a gastroenterology consult all came back normal. She tells her clinician in the first session: "I know something is wrong. The doctors just haven't found it yet." She spends part of every day monitoring her symptoms, researching diagnoses online, and avoiding foods she suspects might trigger a flare. Her social life has contracted significantly.

Her clinician recognizes the presentation as consistent with Somatic Symptom Disorder. Rather than challenging Elena's belief that something medical is being missed, the clinician starts by taking the symptoms seriously and asking detailed questions about when they are better and worse. Elena notices for the first time that her symptoms are almost always worst on Sunday evenings and Monday mornings. This observation opens the door to exploring the connection between stress and her physical experience.

***Personal Reflection***

- *Have you worked with a client whose presentation fits this pattern? How did you approach framing the problem with them?*
- *How do you navigate the tension between validating a client's belief that something medical is wrong and introducing a psychological framework?*

## Section Summary

Section 1 introduced the concept of psychosomatic symptoms and the three main DSM-5-TR diagnoses relevant to this population: Somatic Symptom Disorder, Illness Anxiety Disorder, and Functional Neurological Symptom Disorder. It emphasized that the goal for clinicians is not to determine whether symptoms are "real" but to understand how psychological processes are contributing to the client's experience.

**Key Clinical Takeaways:**

→ Psychosomatic symptoms are real physical experiences, not imagined or exaggerated ones. Saying so directly and early matters.

→ The DSM-5-TR focuses on the client's psychological response to symptoms, not just whether symptoms can be medically explained.

→ Between 25 and 50 percent of primary care visits involve symptoms that cannot be fully explained medically.


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→ Avoid framing symptoms as either "real" or "psychological." Both can be true at the same time and both deserve clinical attention.

→ These clients often arrive in therapy feeling dismissed by medical providers. Leading with validation matters and shapes everything that follows.

→ Somatic symptom presentations often produce progressive functional impairment and identity contraction. Addressing these consequences is as important as addressing the symptom cycle itself.

The next section builds on this foundation by examining the neurobiological and psychological mechanisms through which anxiety actually produces and amplifies physical symptoms.

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# Section 2: How Anxiety Produces Physical Symptoms

One of the most useful things a clinician can do for a client with psychosomatic symptoms is help them understand why their body is doing what it is doing. When the mechanism makes sense, the symptoms become less frightening. Clients who have spent years in medical uncertainty often experience significant relief simply from receiving a clear, scientifically grounded explanation for their experience.

## The Autonomic Nervous System

When the brain perceives a threat, real or imagined, it activates a coordinated response through the autonomic nervous system (ANS). The sympathetic branch of the ANS launches what is often called the fight-or-flight response. Heart rate increases and breathing quickens. Muscles tighten, blood flow shifts away from digestive organs toward large muscle groups, and the body releases stress hormones including cortisol and adrenaline.

These changes are adaptive when the threat is real and brief. The problem is that anxiety can trigger the same response even when there is no physical danger. A worrying thought, an anticipated social situation, or a work deadline can activate the same cascade. When anxiety is chronic, these responses happen often enough that the body stays in a state of persistent low-grade activation. Over time, the nervous system can become sensitized, meaning it takes progressively less to set off a significant reaction (McEwen & Akil, 2020).

The physical sensations this produces are not subtle. Chest tightness, palpitations, stomach distress, fatigue, headaches, dizziness, and muscle tension are all direct physiological consequences of sustained anxiety. They are not imagined.

## The HPA Axis and Chronic Stress

Alongside the rapid fight-or-flight response, chronic stress activates the hypothalamic-pituitary-adrenal (HPA) axis, a hormonal system that manages the body's longer-term stress response. Under sustained stress, this system produces cortisol, which in the short term helps the body manage demands. Over time, however, chronically elevated cortisol is associated with disrupted


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sleep, increased inflammation, gastrointestinal problems, and musculoskeletal symptoms (McEwen & Akil, 2020). Many of the complaints that chronically anxious clients bring to therapy, including fatigue, frequent illness, and widespread pain, can be understood partly as consequences of sustained stress hormone activity. Importantly, these are not secondary or minor effects: HPA dysregulation is increasingly recognized as a central mechanism linking chronic psychological stress to medically documented physical illness.

## The Gut-Brain Connection

The gastrointestinal system has its own extensive network of neurons that communicates continuously with the brain, often called the gut-brain axis (Cryan et al., 2019). Stress and anxiety reliably alter gastrointestinal function, producing symptoms like nausea, bloating, abdominal pain, and changes in bowel habits. Gastrointestinal distress can in turn increase anxiety and worsen mood, tending to create a back-and-forth amplification loop. This helps explain why so many clients with anxiety present with digestive complaints that medical providers cannot fully account for.

## Hypervigilance to Body Sensations

People with anxiety tend to pay unusually close attention to what is happening inside their bodies. This heightened focus, sometimes called somatosensory amplification, is an automatic pattern that develops when someone has learned to treat physical sensations as potential warning signals, not a deliberate choice (Witthöft & Hiller, 2010; Van den Bergh et al., 2017). Monitoring a sensation tends to intensify it. Sensations that most people would never consciously register become prominent and alarming, and the more a person focuses on a symptom, the worse it tends to feel.

## The Anxiety-Symptom Cycle

How a person interprets a physical sensation determines how distressing it will be. If someone notices their heart beating faster and thinks "that's probably stress," their anxiety stays low and the sensation fades. If they think "something might be wrong with my heart," anxiety spikes, which increases the heart rate further, which seems to confirm the fear.

This feedback loop sits at the center of psychosomatic anxiety (Deary et al., 2007). The symptom triggers fear, the fear amplifies the symptom, and the cycle sustains itself. Clients caught in this loop often describe feeling like their body is working against them. For many clients, it is the first framework that makes their physical experience feel coherent rather than terrifying.

The practical implication is that the cycle does not look identical in every client (Deary et al., 2007). Some are primarily driven by catastrophic cognition and respond quickly to cognitive restructuring. Others are more strongly driven by physiological sensitization and respond better to somatic regulation work. Still others are caught in a behavioral avoidance loop that is relatively independent of their cognitions. Knowing which pattern dominates for a given client, which the


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case conceptualization in Section 3 is designed to identify, shapes which interventions will move the work forward most efficiently.

## Emotional Suppression and Somatization

Not every case of psychosomatic anxiety is driven by anxious thinking. For some clients, physical symptoms are the primary way emotional distress gets expressed. People who have difficulty identifying or naming their feelings may experience that distress through the body instead. This pattern, sometimes called somatization, has been documented across many cultures and clinical populations (Kirmayer & Sartorius, 2007).

A related trait called alexithymia describes difficulty identifying and describing emotional states. Clients with significant alexithymia may benefit from interventions that build emotional awareness before or alongside more cognitive approaches.

## Pain Neuroscience and Central Sensitization

For clients whose primary somatic complaints involve chronic pain, a brief understanding of pain neuroscience can be a powerful addition to standard psychoeducation. Pain is not simply a signal that travels from a damaged tissue to the brain. It is an output generated by the brain based on its assessment of threat. When the brain determines that the body is under threat, it produces pain to motivate protective behavior. This means that pain can be generated or amplified in the absence of tissue damage, and it means that factors that increase the brain's threat assessment, including anxiety, fear, and catastrophic cognition, directly increase pain intensity.

Central sensitization is a process in which the central nervous system becomes increasingly reactive to input over time, lowering the threshold at which pain and other physical sensations are generated (Woolf, 2011). In chronically anxious clients, central sensitization can produce widespread pain, heightened sensitivity to touch and temperature, and an expansion of the body areas that produce pain in response to stimulation.

This helps explain why clients with long-standing somatic symptom presentations often experience a gradual broadening of their symptom picture: what began as headaches may expand to include neck pain, shoulder tension, jaw tightness, and gastrointestinal distress over months or years. Central sensitization is not a structural change in the way tissue damage is, but it is a genuine neurobiological process that responds to psychological intervention (Woolf, 2011). Emerging research continues to examine modifiable psychosocial factors that contribute to symptom persistence, including expectations, symptom focusing, and avoidance (Nestoriuc et al., 2024). Explaining this to clients can reduce self-blame and increase engagement with treatment.

## Sleep, Fatigue, and Symptom Amplification

Sleep disruption is one of the most underappreciated contributors to somatic symptom severity and one of the most commonly overlooked factors in clinical assessment. Sleep deprivation, whether


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from insomnia, sleep apnea, disrupted circadian rhythms, or inadequate total sleep time, produces a cascade of physiological effects that directly amplify somatic symptoms. Pain sensitivity increases significantly after even a single night of poor sleep (Finan et al., 2013). Fatigue lowers the threshold for anxiety activation, reduces cognitive flexibility, and impairs the capacity for emotional regulation.

Clients who present with fatigue, widespread pain, and cognitive difficulties, sometimes described as brain fog, warrant direct assessment of their sleep quality and quantity. The Pittsburgh Sleep Quality Index (PSQI) is a brief, validated measure that can be incorporated into routine assessment.

When sleep disruption is identified, addressing it directly, whether through sleep hygiene guidance, stimulus control techniques, or referral for evaluation of obstructive sleep apnea, can produce significant improvements in somatic symptom severity independent of other interventions. The relationship between sleep and somatic symptoms is bidirectional: poor sleep amplifies symptoms, symptoms disrupt sleep, and anxiety drives both. When a client reports that their symptoms are worse in the morning or that they wake during the night with physical distress, sleep should be treated as a primary clinical target rather than an afterthought.

Classical and operant conditioning also play a role in maintaining somatic symptoms. Through classical conditioning, previously neutral body sensations can become automatic triggers for anxiety. A client who experienced a panic attack during exercise, for example, may develop a fear response to any elevation in heart rate, including the normal increase that occurs during physical activity. Over time, an increasingly wide range of stimuli, including environmental cues, emotional states, and even times of day, can become conditioned triggers that reliably activate the anxiety-symptom cycle.

Operant conditioning maintains the cycle through the reinforcing effects of avoidance and reassurance seeking (Vlaeyen et al., 2016). When a client avoids an activity, they feel immediate relief, which reinforces the avoidance. When a client seeks reassurance and receives it, they feel briefly better, which reinforces reassurance seeking. Both behaviors provide short-term relief while preventing the long-term learning that the feared sensations are not dangerous (Craske et al., 2014; Vlaeyen et al., 2016). This is negative reinforcement at work: the behavior is strengthened not by receiving something pleasant but by removing something aversive. Understanding this mechanism helps clinicians explain to clients why the very strategies that feel helpful are maintaining the problem.

The nocebo effect is also clinically relevant here (Petersen et al., 2014). Negative expectations themselves worsen symptoms: when clients read about illness online, receive ambiguous test results framed in alarming language, or discuss their concerns with others who reinforce their fears, genuine symptom worsening can follow. The information environment around a client matters,


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and part of treatment involves helping them become more intentional about how they engage with health-related uncertainty.

Attention functions as a direct amplifier of symptom intensity (Van den Bergh et al., 2017). Directing sustained awareness toward any physical sensation increases both its perceived intensity and the likelihood it will be noticed in the future. A more useful frame for clients is that attention is a legitimate clinical target: redirecting focus away from symptom monitoring, through behavioral engagement and mindfulness, is a direct intervention on the maintenance cycle, not a dismissal of their experience.

**Case Example: The Anxiety-Symptom Cycle**

Marcus, a 34-year-old accountant, comes to therapy describing what he calls "heart episodes." His cardiologist has evaluated him thoroughly and found nothing abnormal. Despite this, Marcus checks his pulse dozens of times daily, wears a heart rate monitor at all times, and has stopped exercising, drinking coffee, and attending social events where he might feel warm or flustered.

His clinician helps Marcus map the pattern of the episodes. Together they notice that the episodes almost always occur during difficult work meetings or while lying awake thinking about deadlines. They almost never happen on weekends. Marcus has never connected them to stress because, as he explains, "I feel stressed all the time, so it never seemed like it should matter." His clinician introduces the anxiety-symptom cycle and explains how sustained sympathetic nervous system activation can produce exactly the cardiac sensations he has been experiencing. Marcus is skeptical at first but genuinely curious. Over the following weeks he begins tracking his stress levels alongside his episodes and notices a clear correlation for the first time.

***Personal Reflection***

- *How would you introduce the anxiety-symptom cycle to a client like Marcus without sounding like you are dismissing their physical concerns?*
- *Have you worked with a client who was avoiding activities out of fear of triggering symptoms? How did you approach reducing that avoidance?*

## Section Summary

Section 2 explained the neurobiological and psychological mechanisms through which anxiety produces physical symptoms. Chronic activation of the autonomic nervous system and HPA axis produces real physical sensations. The gut-brain axis explains why anxiety so reliably produces gastrointestinal symptoms. Central sensitization and sleep disruption both amplify somatic symptom severity in ways that are often overlooked in clinical assessment. Hypervigilance to bodily sensations amplifies perceived symptom intensity, the nocebo effect shows that negative expectations themselves worsen symptoms, and catastrophic interpretations of sensations create a self-sustaining feedback loop.


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Emotional suppression, conditioning, and learned avoidance all contribute to maintaining the cycle once it is established.

**Key Clinical Takeaways:**

→ The fight-or-flight response produces real physical sensations even in the absence of actual danger.

→ Chronic stress keeps the body in a state of low-grade activation, contributing to persistent somatic symptoms.

→ The more clients monitor and worry about symptoms, the more intense those symptoms tend to feel.

→ Explaining the anxiety-symptom cycle in plain language is one of the most powerful early interventions available.

→ Avoidance and reassurance seeking provide short-term relief but maintain the anxiety cycle long-term.

The next section builds on this foundation by examining how clinicians can accurately assess these presentations, avoid common diagnostic pitfalls, and construct a case conceptualization that directly informs treatment.

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# Section 3: Clinical Assessment and Case Conceptualization

Good assessment with this population requires balancing medical awareness, genuine psychological curiosity, and patience with ambiguity. Many of these clients have had repeated experiences of feeling dismissed in medical settings, and they arrive in therapy primed to detect whether their clinician is doing the same thing. Getting assessment right sets the tone for everything that follows.

## Medical Collaboration

Before framing any persistent physical symptom as psychologically driven, confirm that appropriate medical evaluation has taken place. Ask directly about what tests have been done, what the results were, and whether the client is currently under medical care. When symptoms are significant or changing, reaching out to the client's physician is appropriate and usually welcomed by the medical provider as well.

This step matters for the therapeutic relationship. When clients see that you are not dismissing the possibility of a medical cause, they become more open to exploring psychological factors. You are not asking them to choose between explanations. You are helping them build a more complete picture. When clinicians frame medical collaboration as part of the treatment plan rather than a reluctant concession, clients tend to feel more like partners than suspects (Ajluni, 2025; Tuttle et al., 2024).


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Certain features should prompt an immediate medical referral regardless of how strong the psychological picture appears: unexplained weight loss of five percent or more of body weight over a short period, new neurological symptoms such as sudden severe headache or focal weakness, blood in stool or urine, significant changes in vision or hearing, and any symptom that wakes the client from sleep or that is rapidly progressive. When in doubt, refer. A compelling psychological formulation is not a reason to overlook a potential medical diagnosis.

## Helpful Screening Tools

Although the original validation studies for many common screening instruments are older, these tools remain widely used in contemporary assessment and care coordination. Several brief, validated screening instruments can support the assessment process and help track progress over time. Using them consistently also provides objective documentation of symptom severity and change—something that tends to be useful both clinically and when coordinating care with other providers.

- The PHQ-15 (Patient Health Questionnaire-15) measures the severity of fifteen common somatic symptoms, including stomach pain, back pain, chest pain, dizziness, headaches, and fatigue. It takes approximately two minutes to complete. Scores of five, ten, and fifteen represent mild, moderate, and severe somatic symptom burden respectively (Kroenke et al., 2002). Re-administering the PHQ-15 every four to six weeks provides a useful measure of treatment response.
- The Health Anxiety Inventory (HAI) specifically measures health anxiety and reassurance-seeking behaviors, helping clinicians identify clients for whom health anxiety is a primary clinical target rather than a secondary feature of generalized anxiety (Salkovskis et al., 2002). A short form of the HAI is available and suitable for routine clinical use.
- The GAD-7 and PHQ-9 screen for generalized anxiety and depression respectively, both of which commonly co-occur with somatic symptom presentations and may require independent clinical attention (Spitzer et al., 2006; Kroenke et al., 2001). Identifying co-occurring depression is particularly important, as it significantly affects prognosis and may require pharmacological consultation in addition to psychotherapy.
- The PC-PTSD-5 (Primary Care PTSD Screen for DSM-5) provides a brief five-item screen for posttraumatic stress disorder, which is important given the elevated rates of trauma history in clients with somatic symptom presentations (Prins et al., 2016). Unaddressed trauma frequently maintains somatic symptom cycles and may require trauma-focused treatment approaches.


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## Differential Diagnosis Pitfalls

One of the most consequential clinical errors in this population is moving toward a psychological conceptualization before the differential diagnosis has been adequately worked through. Several conditions share symptom profiles with psychosomatic presentations and are commonly mistaken for them. The following pitfalls come up regularly in clinical practice and are worth reviewing carefully before settling on a formulation.

Panic disorder and somatic symptom disorder can look nearly identical on initial presentation. Both involve palpitations, dizziness, chest pressure, shortness of breath, and intense fear. The key distinction lies in the temporal pattern and the focus of the fear. Panic disorder is characterized by discrete, episodic surges of acute fear that peak within minutes and then resolve, with clients primarily fearing the recurrence of another attack. Somatic symptom presentations tend to involve more persistent, chronic preoccupation with symptoms and the belief that those symptoms signal serious underlying illness. In practice, both can co-occur, and treating panic disorder without addressing the accompanying health anxiety often produces incomplete results.

Generalized anxiety disorder (GAD) and health anxiety are frequently confused, and the distinction matters for treatment selection. GAD involves worry that spans multiple life domains: relationships, finances, work performance, health, and safety. Health anxiety is characterized by a more focused and intense preoccupation specifically with the body, symptoms, and illness. A client with GAD may worry about health, but their health worry is one concern among many and tends to be proportionate to their general anxious style. A client with health anxiety devotes disproportionate cognitive and behavioral resources specifically to monitoring, interpreting, and seeking reassurance about their physical state. The two conditions frequently co-occur, and identifying which is primary helps determine whether general anxiety reduction strategies or health-specific interventions should lead treatment.

Trauma-related somatic symptoms deserve particular attention in differential assessment. PTSD and complex trauma can produce a range of physical symptoms that closely mimic somatic symptom disorder, including chronic pain, gastrointestinal distress, fatigue, headaches, and autonomic dysregulation. Trauma-related hyperarousal keeps the body in a state of sustained activation that produces genuine physical symptoms. Somatic re-experiencing, sometimes called body memories, involves physical sensations that emerge in the absence of any current threat and may be connected to traumatic events the client has not yet disclosed. There is also a documented overlap between dissociation and functional neurological symptom presentations, particularly non-epileptic seizures and pseudoneurological symptoms. Clinicians who do not screen routinely for trauma history risk conceptualizing a trauma-driven presentation as primarily anxiety-based and applying interventions that are insufficient or, in some cases, destabilizing.

Medical and medication-related confounds are among the most common sources of premature psychological conceptualization. Sleep disorders, including obstructive sleep apnea and chronic


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insomnia, produce fatigue, cognitive difficulties, and mood dysregulation that can easily be attributed to anxiety or depression. Stimulant medications used for ADHD can produce palpitations, chest pressure, and anxiety that are pharmacological rather than psychological in origin. SSRI activation in the early weeks of treatment is a well-documented phenomenon in which clients experience increased anxiety, restlessness, and somatic distress before therapeutic effects emerge. Thyroid dysfunction, particularly subclinical hypothyroidism or hyperthyroidism, can produce fatigue, weight changes, mood instability, and cardiac symptoms. Hormonal shifts related to perimenopause, testosterone changes, or contraceptive medications contribute to somatic complaints that can be misread as anxiety-driven. Chronic pain conditions, migraines, and autoimmune disorders with variable symptom patterns can all worsen during periods of psychological stress in ways that make it difficult to separate the medical and psychological contributions. The practical implication is straightforward: a thorough medical history and an understanding of current medications are prerequisites, not optional additions, to psychological assessment.

Burnout and lifestyle-related contributors are also frequently overlooked. Sleep deprivation, whether from occupational demands, caregiving responsibilities, or sleep disorders, produces a symptom cluster that overlaps substantially with anxiety and depression, including fatigue, cognitive difficulties, emotional dysregulation, and somatic complaints. Overwork and chronic occupational stress can produce physical symptoms through sustained cortisol elevation even in the absence of any anxiety disorder. High caffeine intake produces palpitations, tremor, and gastrointestinal distress that clients may not connect to their caffeine consumption. Physical deconditioning from prolonged inactivity, which is itself a common consequence of somatic symptom avoidance behaviors, can cause fatigue, breathlessness, and exercise intolerance that further reinforces health anxiety. Clinicians who overlook these lifestyle factors may over-pathologize presentations that have straightforward behavioral contributors.

The clinical bottom line is this: a confident psychological conceptualization should be built only after the diagnostic picture has been carefully examined for these common confounds. Premature conceptualization does not just delay effective treatment. It can damage the therapeutic relationship in ways that are difficult to repair, particularly when a client later discovers that a medical or medication-related factor was contributing to their symptoms all along.

## Exploring Psychological Context

Once serious medical concerns have been addressed or are under appropriate monitoring, begin exploring how psychological factors might be contributing to the client's physical experience. This exploration is most productive when it is genuinely collaborative, following the client's lead rather than imposing a psychological interpretation before the client is ready to receive it.


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Useful areas to assess include the relationship between stressors and when symptoms start or worsen; what the client believes is causing their symptoms and what those symptoms mean to them; how they respond behaviorally, including avoidance, reassurance seeking, and repeated medical visits; how much the symptoms are affecting daily functioning, relationships, and quality of life; and any history of significant loss, trauma, or chronic stress that preceded or coincided with symptom onset.

In clinical work, this often shows up most clearly when you ask clients to trace a timeline. A timeline approach can be especially productive in the early assessment phase. Ask the client to walk you through when symptoms first appeared, what else was happening in their life at that time, and how the symptom picture has changed since then. Many clients have never traced this history explicitly, and doing so in session often surfaces connections that neither the client nor their previous providers had noticed. When a client realizes that their symptoms began within weeks of a major loss, a health scare in a family member, or a period of occupational crisis, the psychological dimension of their experience begins to feel less like a theory and more like observable fact. Timeline mapping also helps clinicians identify whether the presentation is episodic and stress-linked or more chronic and diffuse, which has implications for both conceptualization and treatment sequencing (Tuttle et al., 2024; Van Dessel et al., 2014).

Pay particular attention to the client's own explanation for what is happening, sometimes called their explanatory model. Clients who are firmly convinced that a medical cause will eventually be found tend to resist psychological reframing, and that conviction often makes sense given their history. What often makes the difference is understanding that belief before trying to shift it. Moving too quickly to challenge it often damages the therapeutic alliance without producing any meaningful change in the client's understanding.

Clinicians should also explore what function the symptoms may be serving, even if unintentionally. For some clients, physical symptoms provide a coherent explanation for limitations they find difficult to acknowledge directly. For others, symptoms maintain connection with caregivers or provide a socially acceptable reason for withdrawing from demands. These functions are rarely conscious or deliberate, but recognizing them shapes the treatment plan. If a symptom is serving an important function, addressing only the symptom will not be enough.

## Case Conceptualization Using the Biopsychosocial Framework

Effective treatment begins with a thorough case conceptualization that integrates biological, psychological, and social factors into a coherent account of the client's presentation. The biopsychosocial model, originally articulated by Engel (1977), provides the organizing framework. A practical structure within that framework is the four Ps model: predisposing factors, precipitating factors, perpetuating factors, and protective factors.


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## Predisposing Factors

Predisposing factors are characteristics that increase a person's vulnerability to developing somatic symptom presentations. These include temperamental traits such as anxiety sensitivity and neuroticism, early attachment experiences that shaped how the person relates to their body and to caregiving, a history of trauma or chronic stress during formative years, family patterns around illness behavior, and limited capacity to identify and express emotions. Research identifies anxiety, depression, health anxiety, and alexithymia as the most consistently documented psychological risk factors (Smakowski et al., 2024). Understanding predisposing factors helps clinicians develop genuine empathy for why a client developed their current presentation, and it informs the selection of treatment approaches. A client with significant early trauma, for example, may require trauma-focused interventions as part of the treatment. A client with strong alexithymic traits may benefit from emotion-focused approaches that build emotional vocabulary before cognitive interventions can be effective.

## Precipitating Factors

Precipitating factors are the specific stressors or life events that triggered the onset or significant worsening of symptoms. Common precipitants include bereavement, divorce or relationship rupture, major occupational change, retirement, children leaving home, a health scare in the client or a family member, and financial crises. In some cases the precipitant is a medical event that the client has recovered from physiologically but that has left a residue of health anxiety and heightened body awareness. Identifying precipitating factors is often clinically meaningful for clients as well. Many have not made a conscious connection between significant life stressors and the onset of their physical symptoms. Helping a client recognize that their symptoms began during a particularly difficult period of their life, and that the timing is probably not coincidental, can be a powerful early therapeutic moment.

## Perpetuating Factors

Perpetuating factors are the behavioral, cognitive, and emotional processes that keep the symptom cycle active. These are usually the most important clinical targets because they are the most directly accessible to intervention. Common perpetuating factors include avoidance of activities or situations that might provoke symptoms, repeated reassurance seeking from physicians or family members, excessive symptom monitoring such as frequent pulse checking or body scanning, catastrophic interpretation of normal bodily sensations, and avoidance of emotional material that may be driving the physical distress.

Safety behaviors deserve particular attention as perpetuating factors (Craske et al., 2014). Safety behaviors are actions clients take to prevent feared outcomes or manage anxiety in the moment, such as always sitting near an exit in case they need to leave, carrying medication they rarely actually use, or avoiding physical exertion to prevent a feared symptom. While these behaviors provide short-term relief, they prevent the client from discovering that the feared outcome would


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not have occurred even without the protective action. This prevents the disconfirmation of feared beliefs and maintains the conviction that the sensations are dangerous.

## Protective Factors

Protective factors are the client's strengths and resources that support recovery. These include strong social support networks, meaningful occupational or vocational engagement, a history of successfully coping with adversity, genuine motivation for treatment, and any previous periods of symptom improvement that demonstrate the client's capacity to respond to intervention. Identifying protective factors serves multiple clinical purposes: it helps clinicians design treatment that builds on existing strengths, it challenges the implicit narrative of helplessness that many clients carry, and it provides an important counterbalance to the problem-focused nature of clinical assessment.

**Case Example: Biopsychosocial Conceptualization**

Patricia, a 52-year-old woman, was referred to therapy by her internist after two years of persistent fatigue, diffuse muscle pain, and difficulty concentrating. All medical workups were unremarkable. She arrives tearful. "My doctor thinks this is all in my head. But I know my body, and something is wrong."

Her clinician conducts a thorough biopsychosocial assessment. Predisposing factors include a lifelong tendency toward worry, a family history of anxiety, and limited comfort with naming or expressing emotions. Precipitating factors include a cluster of losses that occurred eighteen months before symptom onset: her youngest child left for college, her mother was diagnosed with Alzheimer's disease, and her husband began traveling extensively for work. Perpetuating factors include daily symptom monitoring, frequent internet searches for possible diagnoses, repeated reassurance seeking from her internist, withdrawal from exercise and social activities due to fatigue, and difficulty acknowledging the grief and anxiety connected to her recent losses. A key safety behavior is her habit of carrying a small notebook to document symptoms throughout the day, which she reviews anxiously each evening. Protective factors include a warm and supportive marriage, close relationships with her adult children, meaningful involvement in her faith community, and a genuine desire to understand what is happening to her.

With Patricia's consent, her clinician contacts her internist to confirm the workup was thorough and to open a line of communication going forward. This step reassures Patricia that her physical experience is being taken seriously and sets the stage for her to engage more openly with the psychological dimensions of her presentation. It also models for Patricia that psychological and medical perspectives can coexist, rather than one invalidating the other.

***Personal Reflection***

- *How do you approach the first session with a client who arrives feeling dismissed by medical providers?*


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- *At what point in the assessment process do you feel comfortable introducing a psychological framework for a client's symptoms?*
- *Can you think of a client whose symptoms may have been serving an important function that was not immediately apparent? How did that shape your treatment approach?*

### Section Summary

Section 3 covered the key elements of clinical assessment for somatic symptom presentations, including the importance of medical collaboration, red flags that require immediate referral, validated screening tools that support assessment and tracking, and how to explore the psychological context of symptoms. It also addressed differential diagnosis pitfalls, describing how panic disorder, generalized anxiety disorder, trauma-related presentations, medical and medication confounds, and lifestyle contributors can all produce symptom profiles that overlap with somatic symptom disorder. Careful differential assessment before settling on a psychological formulation protects clients from premature conceptualization that can delay appropriate treatment. The section concluded with the four Ps biopsychosocial framework, covering predisposing, precipitating, perpetuating, and protective factors, as a practical structure for case conceptualization.

**Key Clinical Takeaways:**

→ Always confirm that appropriate medical evaluation has taken place before framing symptoms as psychologically driven.

→ Several conditions overlap substantially with somatic symptom disorder, including panic disorder, GAD, trauma presentations, and medication side effects. Rule these out carefully before settling on a formulation.

→ Brief validated screening tools like the PHQ-15, GAD-7, PHQ-9, and HAI support assessment and help track progress over time.

→ Understanding the client's own explanation for their symptoms is as important as forming your own conceptualization.

→ The four Ps model organizes clinical information into a coherent framework that directly informs treatment planning.

→ Safety behaviors and the hidden functions of symptoms deserve specific attention in the conceptualization.

The next section builds on this foundation by reviewing the evidence base for treatment and providing practical guidance on selecting and sequencing interventions based on the dominant maintaining factors identified in assessment.

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# Section 4: Evidence-Based Treatment Approaches

Once a clear conceptualization is established, treatment can be more precisely targeted. No single treatment works for every client with psychosomatic anxiety. What shapes the approach most is the client's specific maintaining factors, their readiness to engage with psychological work, their


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cultural background, and what they have tried before. What matters most at the start of treatment is not which technique to use first, but whether the client feels genuinely heard and understood. Without that foundation, even the best-supported interventions tend not to land.

Treatment sequencing is itself a clinical skill. For most clients, psychoeducation comes first because it builds a shared framework. Cognitive work tends to follow once the client has some understanding of the mechanisms involved. Behavioral interventions, including exposure and activation, typically require a solid therapeutic alliance and some degree of cognitive flexibility before they can be introduced effectively. Emotional processing work may run throughout or may become a primary focus for clients whose somatic symptoms are most strongly driven by suppressed emotional experience.

## Psychoeducation

Psychoeducation about the anxiety-symptom cycle is often the single most impactful early intervention for this population. When clients understand why anxiety produces physical symptoms, what the nervous system is doing, and how the attention-interpretation cycle amplifies physical sensations, many experience immediate relief (Van den Bergh et al., 2017). The symptoms stop being mysterious and frightening and start being understandable.

This works best not as a lecture but as a back-and-forth conversation. Explain the mechanism, then check in: "Does this match anything you've noticed in yourself?" When clients start connecting your explanation to their own experience, the engagement deepens noticeably. Drawing a simple diagram of the autonomic nervous system, or sketching the anxiety-symptom feedback loop on a whiteboard, can make abstract concepts more concrete and memorable. It is also worth noting that the psychoeducation itself tends to normalize the client's experience—many feel genuine relief learning that medically unexplained symptoms are common, not a sign that something is uniquely wrong with them.

In practice, psychoeducation should also reframe why reassurance-seeking and avoidance maintain rather than relieve anxiety. Clients who grasp that these strategies are part of what keeps the cycle going are substantially more ready to engage with behavioral interventions, even when those interventions feel counterintuitive at first.

## Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) has the strongest and most consistent evidence base for health anxiety and somatic symptom presentations. Studies and recent reviews suggest that psychological interventions, especially CBT-informed and early intervention approaches, produce meaningful reductions in somatic symptom severity, health anxiety, and functional impairment (Berezowski et al., 2022; Jongsma et al., 2023; Orzechowska et al., 2021; Tyrer et al., 2021). The core components for this population include identifying catastrophic thoughts and automatic interpretations related to physical sensations; cognitive restructuring to help clients develop more


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accurate and proportionate interpretations; behavioral experiments that allow clients to test beliefs through direct experience; and systematic reduction of safety behaviors.

### Cognitive Restructuring

Cognitive restructuring begins with helping clients identify the specific automatic thoughts that occur in response to symptoms (Deary et al., 2007). Many clients are initially unaware of the thoughts that precede their anxiety spikes, and the early work often involves slowing things down enough to catch them. Once identified, the thought can be evaluated by examining the evidence for and against it, considering alternative explanations for the sensation, and assessing whether the catastrophic interpretation is consistent with their broader medical history and the pattern of their symptoms over time.

The goal is not to convince clients that nothing is wrong. It is to help them develop a more balanced and evidence-based way of interpreting their physical experience. A client who notices their heart racing and automatically thinks "something is seriously wrong" can be helped to consider alternative interpretations: stress, caffeine, physical exertion, excitement, or the natural variability of heart rate in all people. Over time, the catastrophic interpretation loses its automatic quality and the client develops more flexibility in how they respond to physical sensations.

### Behavioral Experiments

Behavioral experiments allow clients to test feared beliefs through direct experience rather than discussion alone. A client who believes elevating their heart rate will trigger a dangerous episode can test this by engaging in brief supervised physical activity in session and observing what actually happens. Experiments are designed collaboratively, with the specific belief, predicted outcome, and actual result all documented. Because they engage experiential learning rather than intellectual reasoning, their impact on deeply held health beliefs is often more durable than cognitive restructuring alone.

## Interoceptive Exposure

Interoceptive exposure involves deliberately producing feared bodily sensations in a controlled, graduated way so clients learn through direct experience that the sensations are not dangerous. Common techniques include brief voluntary hyperventilation to produce dizziness and shortness of breath, vigorous stair climbing or jumping jacks to elevate heart rate, spinning in a chair to create mild vestibular sensations, and breathing through a narrow straw to produce the sensation of breathlessness.

The approach follows the same principles as situational exposure in anxiety treatment: repeated, predictable contact with feared stimuli, in the absence of the feared catastrophic outcome, reduces the conditioned fear response over time. Sessions are planned in graduated hierarchies from least to most feared sensations, and the rationale is explained thoroughly before any exercise is attempted. The therapeutic relationship must be sufficiently solid before interoceptive exposure is


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introduced, as clients need to feel genuinely safe with the clinician before they are willing to deliberately induce physical distress in session.

When conducted effectively, interoceptive exposure produces what researchers call inhibitory learning: the client learns at an experiential level, not just an intellectual one, that the sensations are uncomfortable, not dangerous (Craske et al., 2014). Many clients describe this as one of the more surprising discoveries in treatment. This learning is more durable than cognitive insight alone, which is why exposure is often the component of treatment that produces the most significant and lasting change.

## Emotional Awareness and Processing

For clients whose somatic symptoms are rooted in emotional suppression or limited emotional awareness, interventions that directly target the emotional dimension of their experience are often essential. Purely cognitive and behavioral approaches may be insufficient for clients who lack the vocabulary or awareness to engage with cognitive work, or whose physical symptoms are serving important emotional regulatory functions.

Many clinicians find this is where some of the most meaningful shifts happen. A useful starting point is helping clients develop a more differentiated emotional vocabulary. Clients who can only identify that they feel "bad" or "stressed" benefit from learning to distinguish between anxiety, frustration, sadness, grief, and shame. This capacity, sometimes called emotional granularity, supports both self-understanding and clearer communication with others.

A practical and often powerful intervention is helping clients notice the connection between specific emotional stressors and symptom flare-ups. When a client recognizes that their migraines reliably appear the morning after difficult conversations with a parent, or that their gastrointestinal symptoms spike every Sunday evening before the work week begins, something shifts. The symptoms begin to make a different kind of sense, and the client gains a sense of agency that they did not have when the symptoms felt random and beyond their control.

For clients with significant trauma histories, somatic symptoms may represent trauma-related body memories or somatic re-experiencing. In these cases, trauma-focused approaches such as Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing (EMDR), or Somatic Experiencing may need to be integrated into the treatment plan. Clinicians should be appropriately trained in these approaches before using them with trauma survivors, and the pace of any trauma processing work should be carefully calibrated to the client's capacity for affect regulation.

## Mindfulness and Somatic Regulation

Mindfulness-based approaches teach clients to observe bodily sensations with a stance of open, nonjudgmental awareness rather than reactive alarm. Research supports the use of mindfulness-based stress reduction (MBSR) for somatic symptom presentations, with studies showing meaningful reductions in symptom severity and distress that are maintained at long-term follow-up (Cramer et al., 2012; Van den Bergh et al., 2017). The mechanisms through which mindfulness


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reduces somatic symptoms include reduced hypervigilance, decreased catastrophic appraisal, improved affect regulation, and changes in the relationship between attention and physical experience.

Specific practices useful for this population include body scan meditation, mindful breathing, and mindful movement such as yoga or gentle stretching. Diaphragmatic breathing, in which clients inhale slowly to expand the belly and exhale slightly longer than they inhale, directly activates the vagal brake and produces rapid reductions in arousal. Progressive muscle relaxation (PMR), involving systematic tensing and relaxing of major muscle groups, trains the body toward a more relaxed baseline and many clients find it useful both during the day and before sleep.

## When Interventions Are Not Working

When progress is slower than expected or a specific intervention is not producing results, the first step is to revisit the case conceptualization. Slow progress often indicates that a maintaining factor has been missed or underweighted in the treatment plan. Reassessing the client's behavioral patterns, checking for safety behaviors that have not yet been identified, and exploring whether emotional material is being avoided can all reveal factors that are sustaining the cycle.

It is also worth considering whether the therapeutic alliance is limiting the work. Clients who do not feel fully understood or respected may be going through the motions of treatment without genuine engagement. Raising the question directly, with warmth and without defensiveness, often produces important information about the client's experience of the relationship and what might need to shift.

Finally, lack of progress may signal that co-occurring conditions require more direct attention. A client with significant untreated depression, for example, may have limited capacity to engage with behavioral interventions. A client with a complex trauma history may need trauma-focused work before somatic symptom-focused interventions can be effective. Consultation with a colleague or supervisor is appropriate whenever treatment progress stalls and the reasons are not clear.

## Matching Interventions to Clinical Presentation

Selecting the right intervention is as important as delivering it well. Many clinicians default to a fixed treatment sequence regardless of the client's profile, which leads to predictable friction: a client whose primary maintaining factor is emotional suppression will not get much traction from behavioral experiments aimed at catastrophic cognition, and a highly avoidant client may be overwhelmed by interoceptive exposure before behavioral activation has even been established. The following guidelines describe how to match the primary intervention approach to the dominant maintaining factor identified in the case conceptualization.

When health anxiety is the dominant presenting feature, the treatment priority is disrupting the reassurance-seeking and monitoring cycle. CBT is the first-line approach, with particular emphasis on cognitive restructuring of illness-focused catastrophic thoughts, behavioral experiments that test feared health beliefs, and structured reduction of safety behaviors including internet symptom


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searching and repeat medical consultations. Psychoeducation about the reassurance cycle itself, explaining how seeking reassurance temporarily relieves anxiety but reliably rebuilds it, is often a critical early intervention. Clients with dominant health anxiety tend to be relatively cognitively engaged and often respond well to the logical structure of CBT once they trust the clinician enough to engage with it genuinely.

When emotional suppression or limited emotional awareness is the dominant feature, cognitive interventions tend to produce limited results until emotional processing capacity has been developed. The treatment priority in these cases is building the client's ability to identify, tolerate, and communicate emotional states. Practical starting points include emotional labeling exercises in session, affect identification using structured tools like emotion wheels or written mood tracking, reflective journaling (Rief & Martin, 2014) that prompts the client to connect physical experiences to emotional states, and somatic tracking that links specific symptoms to relational or situational triggers. Emotionally focused work, including psychodynamic exploration of avoided emotional content, becomes more accessible once clients have developed a basic working vocabulary for their inner experience.

When trauma is a significant contributing factor to somatic symptoms, stabilization must come before processing. Clinicians should not attempt to address traumatic content directly until the client has reliable access to grounding and affect regulation skills. Grounding techniques, including sensory anchoring, paced breathing, and orienting exercises, help clients maintain a window of tolerance during sessions that involve body awareness work. Trauma-informed pacing means following the client's capacity rather than the treatment timeline, and it means being prepared to step back from exposure-oriented work when arousal levels rise above the therapeutic range. Trauma processing using EMDR, TF-CBT, or Somatic Experiencing should be undertaken only by clinicians with specific training in those modalities, and only after a stable regulatory foundation has been established.

When clients have genuine co-occurring medical conditions, treatment must be paced around their real physical capacity and coordinated with their medical providers. The practical implication is that psychological work should be framed as additive, not dismissive, and clinicians should take care not to apply a psychological conceptualization in ways that discourage clients from reporting new or changing symptoms to their medical team (Ajluni, 2025).

When avoidance is the dominant maintaining behavior and the client has limited confidence to engage with exposure-based work, graded behavioral activation is the starting point. Clinicians build a hierarchy from least to most feared activities, moving slowly enough that each step produces a genuine success experience. Micro-exposures, very brief contacts with avoided activities, are useful for clients who feel overwhelmed by even moderate challenge. Rebuilding the client's confidence in their capacity to tolerate discomfort is the primary goal at this stage, and that foundation makes more direct symptom-focused work substantially more tractable.


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When progress is slow, the more productive question is whether the intervention matches the dominant maintaining factor, not how to push harder. In this population, slow progress most often reflects a mismatch between approach and presentation. Revisiting the conceptualization with that lens, and being willing to shift, tends to produce more reliable movement than intensifying an approach that is not fitting the clinical picture.

**Case Example: Treatment in Practice**

David, a 29-year-old graduate student, presents with chronic headaches and dizziness that have not responded to medical treatment. His neurologist has cleared him and suggested therapy. David is politely skeptical: "I am willing to try this, but I want you to know I am not convinced this is a mental health problem."

His clinician accepts this without argument and begins with psychoeducation, drawing a simple diagram of the autonomic nervous system and explaining what happens physiologically when the body stays in sustained stress. David is a researcher by temperament and finds the information interesting. He starts asking questions rather than defending his skepticism. The clinician also explains why the avoidance David has developed around physical activity is likely maintaining his symptoms, framing this carefully as a discovery rather than an accusation.

Over the next few sessions the clinician introduces a symptom diary. Within three weeks a clear pattern emerges: headaches are worst during dissertation writing sessions and evenings before his weekly lab meeting. The dizziness spikes whenever he has a conflict with his partner. This pattern becomes the foundation for a shared conceptualization that David finds genuinely persuasive because it emerged from his own data.

His clinician then introduces progressive muscle relaxation and diaphragmatic breathing, framing them explicitly as tools for regulating a physiological response rather than as relaxation exercises, which David had already dismissed as unscientific. He practices daily. By the eighth session his headache frequency has dropped by more than half. His clinician then designs a behavioral experiment: David agrees to resume light aerobic exercise, something he had stopped fearing it would worsen his dizziness. He completes the experiment without the feared outcome, which further consolidates his understanding that the sensations are uncomfortable but not dangerous.

***Personal Reflection***

- *Which of the treatment approaches described in this section do you use most often with this population? Are there any you have been hesitant to try?*
- *How do you sequence treatment components? What guides your decision about where to start?*


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- *Have you encountered a situation where treatment was not progressing as expected? What did you do to reassess and redirect the work?*

### Section Summary

Section 4 reviewed the main evidence-based treatment approaches for somatic symptom presentations: psychoeducation, cognitive behavioral therapy including cognitive restructuring and behavioral experiments, interoceptive exposure, emotional awareness and processing, and mindfulness and somatic regulation including diaphragmatic breathing and progressive muscle relaxation. It addressed treatment sequencing, what to do when progress stalls, and the importance of the therapeutic relationship as the foundation for all other interventions. It also introduced the critical clinical skill of matching interventions to the dominant maintaining factor, explaining how health anxiety dominant presentations, emotionally suppressed presentations, trauma-linked presentations, medically complex presentations, and highly avoidant clients each call for a different primary approach.

**Key Clinical Takeaways:**

→ Psychoeducation about the anxiety-symptom cycle is often the most impactful early intervention. Use it as a conversation, not a lecture.

→ CBT for this population focuses on catastrophic interpretations, behavioral experiments, and reducing safety behaviors.

→ Behavioral experiments engage experiential learning and often produce more durable change than cognitive discussion alone.

→ Interoceptive exposure teaches clients through direct experience that feared sensations are not dangerous.

→ When treatment stalls, revisit the conceptualization, the alliance, and whether co-occurring conditions need more direct attention.

The next section builds on this foundation by addressing the therapeutic challenges that emerge once evidence-based interventions are underway, including the alliance strain, reassurance pressure, and medical focus that frequently become the next major barriers to progress.

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# Section 5: Therapeutic Challenges and Alliance Maintenance

When evidence-based interventions begin to take hold, clinicians often encounter a new set of pressures: clients who feel understood for the first time but who push back when behavioral change is introduced, alliance strain that surfaces as reassurance-seeking intensifies before it reduces, and a renewed insistence on medical causes when symptom reduction temporarily stalls. What makes this work genuinely difficult is not the complexity of the interventions but the relational demands that arise alongside them.


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## Resistance to Psychological Explanations

Many clients with somatic symptom presentations have already been told, sometimes bluntly and sometimes gently, that their symptoms are stress related. By the time they arrive in a clinician's office they may have a strong resistance to anything that sounds like "it's all in your head." This resistance is not simply defensiveness. It is often a reasonable response to having been dismissed or inadequately treated in previous healthcare encounters (Tuttle et al., 2024). Treating it as an obstacle to overcome usually makes things worse.

In practice, the response that tends to work best is taking the symptoms seriously before introducing any psychological framework—and staying there longer than feels necessary. This means asking detailed questions about the symptoms themselves, their history, their timing, and their impact, without rushing toward interpretation. Once a solid foundation of trust has been established, psychological mechanisms can be introduced as additional information that helps explain the pattern, rather than as a replacement for the medical explanation the client has been seeking.

## Maintaining the Therapeutic Alliance

The therapeutic relationship with this population is more fragile than it can appear at first. Clients who feel labeled, pathologized, or dismissed tend to disengage quietly. They often do not say anything about it. They just stop coming. Because many of these clients have had previous experiences of feeling unheard in professional settings, they may be particularly sensitive to any perceived repetition of that experience in therapy.

Effective alliance maintenance requires regular check-ins and communication strategies that keep the client engaged without reinforcing avoidance (Ajluni, 2025). Asking "How is this landing for you?" or "Does this feel relevant to what you've been going through?" communicates respect and creates opportunities to address misunderstandings before they become ruptures. When ruptures do occur, raising them directly and promptly, rather than waiting for the client to bring them up, tends to preserve the relationship more effectively.

## Managing Reassurance Seeking and Avoidance

Reassurance seeking and avoidance are the two maintaining behaviors that most reliably keep the anxiety-symptom cycle going, and both require direct clinical attention. Left unaddressed, they will sustain the cycle regardless of how much insight and understanding clients develop in therapy.

Reassurance seeking in this population may involve frequent medical consultations, repeated emergency room visits, online symptom research, and in-session requests for the clinician to confirm that symptoms are not dangerous. Research has documented that high-frequency reassurance-seeking cycles are among the strongest predictors of chronic healthcare overutilization and sustained health anxiety (Tyrer et al., 2021). Abruptly refusing to provide reassurance can feel invalidating. A more effective approach involves helping clients understand the mechanism through which reassurance seeking maintains their anxiety, collaboratively agreeing on a plan to


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gradually reduce these behaviors, and identifying alternative coping strategies they can use when the urge to seek reassurance arises.

Avoidance behaviors are typically addressed through graduated behavioral activation, reintroducing avoided activities beginning with those that are most accessible. Framing this as an experiment rather than an instruction to push through symptoms tends to be more acceptable to clients who are genuinely uncertain about whether their symptoms are medically driven.

## Working with Clients Who Stay Medically Focused

Some clients never fully accept a psychological framework, even after genuine therapeutic progress. They may continue seeking new medical opinions throughout therapy and maintain a strong conviction that a diagnosis is still forthcoming. This does not require a confrontational challenge.

A more productive approach involves meeting clients where they are while gently expanding their frame of reference. This might involve explicitly agreeing that psychological treatment is being offered alongside, not instead of, medical care. It might involve helping clients notice, without directly confronting their beliefs, that their symptoms have responded to stress reduction or behavioral changes. Motivational interviewing techniques can be helpful in exploring what the continued medical focus is providing for the client and what it might be costing them.

Motivational interviewing is well-suited here because it is explicitly non-confrontational and treats ambivalence as a normal part of change. Open-ended questions like "What do you notice about how you feel after each new appointment?" or "What would it mean if the next evaluation also came back normal?" invite reflection that directive approaches tend to close off. Evoking the client's own ambivalence about continued medical seeking tends to produce more durable shifts than arguing against it directly.

It is also worth acknowledging explicitly that some degree of ongoing medical contact is appropriate and healthy for this population. The clinical goal is not to eliminate all medical engagement but to reduce the reassurance-seeking pattern that drives the anxiety cycle. A client who schedules one routine follow-up with their primary care physician annually is doing something different from a client who visits three emergency rooms in a month seeking reassurance after each normal result. Helping clients develop their own clear criteria for when a symptom warrants medical evaluation, and when it is more productively addressed through their self-regulation tools, gives them a framework that supports both appropriate health monitoring and reduced anxiety-driven healthcare utilization.

## Countertransference and Clinician Self-Awareness

Working with clients whose symptoms are persistent, whose progress is slow, and whose engagement with psychological explanations is ambivalent creates distinctive treatment challenges for psychotherapists (Weigel et al., 2020). Clinicians who work regularly with somatic symptom presentations report a range of reactions that, if unexamined, can undermine treatment


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effectiveness. Recognizing these reactions and addressing them through supervision and self-reflection is an important part of professional competence in this area.

One common countertransference pattern is frustration with clients who seem to resist psychological explanations after they have been offered clearly and repeatedly. This frustration, understandable as it is, often signals that the clinician has moved into an advocacy stance rather than a genuinely curious one. When a clinician feels they are trying to convince a client of something the client does not want to hear, it is worth stepping back and considering whether the resistance is communicating something important about the client's experience of the relationship, the pacing of the work, or a factor in the formulation that has not yet been fully understood.

A related reaction is the diagnostic uncertainty that somatic presentations reliably produce. The discomfort of not knowing whether a symptom is psychologically driven or medically significant can pull clinicians toward over-referring to manage their own anxiety, or toward under-referring once committed to a psychological formulation. In practice, clinicians should prioritize developing a comfortable working relationship with ambiguity and building reliable consultation habits for moments when uncertainty becomes clinically significant.

A pattern that becomes clear over time, particularly in supervision conversations, is the pull toward providing reassurance that goes beyond what is therapeutically appropriate. When a client is visibly distressed and seeking confirmation that their symptoms are not dangerous, it can be difficult to resist offering that reassurance, particularly in the context of a relationship the clinician values. Understanding that providing reassurance in this moment, while compassionate in intention, maintains the client's anxiety rather than resolving it, can help clinicians hold a therapeutic stance rather than a caregiving one. This distinction is worth naming explicitly in supervision, as it is one of the places where clinical skill and natural human compassion can pull in opposite directions.

Finally, clinicians working with this population often find that the work activates their own relationship to their body, health, and mortality. Working regularly with clients who are preoccupied with serious illness can produce health anxiety in clinicians themselves, or surface unresolved experiences with illness in their own lives or families. This is not unusual and does not indicate unsuitability for the work. It does indicate the value of regular supervision, peer consultation, and the kind of self-reflective practice that allows clinicians to distinguish their own material from their clients'.

**Case Example: Navigating Resistance**

Renata, a 47-year-old marketing executive, comes to therapy after her physician strongly recommended it. She makes clear from the first session that she does not believe her symptoms are psychological and that she is attending mainly to prove to her doctor she has ruled everything


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out. Her chief complaints are chronic fatigue and frequent chest pressure, both extensively evaluated by cardiology and pulmonology with no findings.

Her clinician does not introduce any psychological framing in the first two sessions. Instead, she asks detailed questions about Renata's symptoms, her work, her history, and her life. Renata begins talking about how exhausted she has been since her company reorganized eighteen months ago, around the same time the symptoms started. In the third session, Renata says without prompting: "I know the stress at work has been bad. I just don't understand how stress could make me feel this physically awful." Her clinician responds: "That's actually a really important question, and there's solid science behind it. Would you like me to walk you through what we know about how stress affects the body?" Renata says yes. That conversation becomes the turning point in the treatment.

***Personal Reflection***

- *Have you ever had a client disengage from treatment because they felt their physical symptoms were not being taken seriously? How did you recognize and respond to that?*
- *What is your approach when a client continues seeking new medical opinions while in therapy? Where do you draw the line between respecting autonomy and addressing a maintaining behavior?*

## Section Summary

Section 5 addressed the most common therapeutic challenges when working with somatic symptom presentations: resistance to psychological explanations, maintaining the therapeutic alliance, managing reassurance seeking and avoidance, working with clients who remain medically focused, and the countertransference dynamics that clinicians need to monitor in themselves. It emphasized patience, transparency, and genuine curiosity as foundational clinical stances throughout this work. It also addressed the importance of helping clients develop their own criteria for when medical contact is appropriate versus when self-regulation tools should be the first response, which is a skill that supports both appropriate health monitoring and reduced anxiety-driven healthcare utilization after treatment concludes.

**Key Clinical Takeaways:**

→ Take symptoms seriously before introducing any psychological framework. Validation must come first.

→ Check in regularly about how the client is experiencing the work. Do not wait for them to raise concerns.

→ Address alliance ruptures directly and promptly rather than waiting for them to resolve on their own.

→ Help clients understand how reassurance seeking maintains anxiety before collaboratively planning to reduce it.


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→ Motivational interviewing is useful with clients who are ambivalent about accepting a psychological framework.

→ Monitor countertransference reactions actively. Frustration, diagnostic uncertainty, and the pull toward providing inappropriate reassurance are all common in this population and are worth examining regularly in supervision or peer consultation.

The next section builds on this foundation by addressing the cultural context that shapes how somatic distress is expressed, how treatment is received, and how long-term planning can be adapted to support durable recovery across diverse client populations.

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# Section 6: Cultural Considerations and Long-Term Planning

Effective clinical work with somatic symptom presentations requires cultural awareness and humility. Culture shapes how distress is expressed, how symptoms are understood, and what forms of help feel acceptable. Clinicians who overlook cultural context risk misinterpreting normal cultural expressions of distress as pathology, and they miss important opportunities to build meaningful therapeutic relationships.

## Culture and Somatic Expression

The relationship between psychological distress and physical symptoms is not the same across cultures. Research documents significant variation in how distress is communicated and understood (Kirmayer & Sartorius, 2007). In many cultural contexts, including those common in Latin American, Asian, Middle Eastern, and African communities, the separation between physical and psychological experience that is assumed in Western biomedical frameworks is not a prominent cultural concept. Distress is often experienced and expressed through the body, and this is normative, not pathological.

Among Latino populations, the concept of nervios, which translates roughly as “nerves,” is a culturally meaningful way of describing a range of physical and emotional symptoms including headaches, trembling, palpitations, fatigue, and gastrointestinal distress (Guarnaccia et al., 2003). Similar culturally specific expressions of distress exist across many communities. Recognizing these as meaningful cultural communication rather than as symptoms to be corrected is fundamental to culturally responsive practice.

Clinicians should also be aware of the ways that racism, discrimination, and systemic marginalization contribute to somatic symptom burden. Research documents elevated rates of somatic symptoms and health anxiety in populations that have experienced racial and ethnic discrimination, and chronic experiences of racism produce physiological stress responses that contribute to the same symptom patterns described throughout this course (Paradies et al., 2015).


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## Cultural Factors in Help-Seeking

Cultural background shapes not only how distress is expressed but also how help is sought and what treatment feels acceptable. Mental health stigma varies considerably across communities, and clients from backgrounds where psychological treatment is unfamiliar or stigmatized may be particularly reluctant to accept psychological explanations for physical symptoms. Medical explanations may be more culturally congruent and carry less stigma, which is one reason clients from certain backgrounds may hold more strongly to medical framings of their experience.

Family and community involvement in health decisions is another important variable. In many cultural communities, health decisions are made collectively, and the involvement of family members in understanding a client's symptoms may be both expected and therapeutically significant. Clinicians who understand and work with this context, rather than against it, are better positioned to build the therapeutic relationships that make effective treatment possible (Ajluni, 2025; Tuttle et al., 2024).

## Adapting Treatment for Cultural Responsiveness

Culturally responsive treatment begins with recognizing that the clinician's own cultural assumptions, including ideas about the separation of mind and body and the value of individual psychological insight, are themselves culturally specific. Cultural humility, defined as an ongoing commitment to self-reflection and openness to learning, is a foundational requirement for this work (Hook et al., 2017; Tervalon & Murray-Garcia, 1998).

Practical adaptations include using language that the client finds accessible and meaningful, exploring the client's cultural understanding of their symptoms before introducing clinical frameworks, and being willing to work within the client's explanatory model rather than immediately attempting to replace it. Psychoeducation framed in biological terms, emphasizing the real physiological effects of stress on the body, may be more acceptable to clients who are uncomfortable with explicitly psychological language and still remains clinically accurate.

The pacing of treatment may also need to be adapted for clients from cultural backgrounds where the therapeutic frame itself is unfamiliar. Individual weekly psychotherapy is a culturally specific format that many clients have no prior experience with and no cultural context for understanding. Spending additional early sessions explaining what therapy is, what confidentiality means in this context, and what the client can realistically expect can dramatically improve engagement and reduce dropout. Clinicians should treat this orientation work as foundational rather than preliminary, because it shapes everything that follows.

Involving family members, with appropriate consent and clinical judgment, can also be an important adaptation for clients from collectivist cultural backgrounds. In many communities, illness and recovery are understood as family experiences rather than individual ones. A client whose family does not understand the nature of their treatment, or who actively discourages it, may face significant practical and relational barriers to engaging fully. Including family members


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in psychoeducation sessions, when the client is open to this, can reduce those barriers and build a more supportive home environment for the work.

Clinicians should also be attentive to the role of spirituality and religion in how clients understand and cope with illness. For many clients, religious frameworks provide a primary lens through which suffering is interpreted and given meaning. These frameworks should be explored respectfully and, where possible, incorporated into treatment. A client who finds meaning and comfort in prayer, community ritual, or spiritual practices is drawing on genuine coping resources. Treatment that dismisses or ignores these resources, or that frames them as obstacles to psychological insight, misses an opportunity to work with something that is already meaningful and motivating for the client.

Finally, clinicians working with clients from backgrounds that have been historically marginalized should be particularly attentive to the ways that medical mistrust, shaped by real historical and ongoing experiences of discrimination in healthcare, may affect the client's willingness to engage with both medical collaboration and psychological treatment. Building trust with these clients requires explicit acknowledgment that their skepticism is historically grounded and clinically understandable, not a symptom to be corrected. It requires consistency, transparency, and a genuine commitment to the client's welfare that is demonstrated through actions over time, not assumed from the therapeutic frame.

## Long-Term Planning and Relapse Prevention

Somatic symptom presentations often follow a chronic course, with periods of improvement alternating with periods of exacerbation. Effective treatment includes explicit attention to long-term maintenance, not only symptom reduction during the active treatment phase.

Relapse prevention begins with helping clients identify the specific triggers most likely to restart the anxiety-symptom cycle for them (Rief & Martin, 2014; Tyrer et al., 2021), including high-risk stressors such as occupational changes, interpersonal conflicts, or health-related events in the family. Clients should also recognize the early warning signs that the cycle is beginning to re-establish and have a clear plan for responding before symptoms escalate.

Building a sustainable self-care and regulation repertoire is an important treatment goal. This includes the practices developed during treatment, such as regular mindfulness or relaxation practice, consistent physical exercise, adequate sleep, and meaningful social and occupational engagement. The question of when to conclude treatment is worth addressing explicitly with clients, as termination itself can trigger anxiety, particularly for clients who have come to rely on the therapeutic relationship as an important source of support.

## Building a Written Maintenance Plan

Relapse prevention is most effective when it is made concrete rather than left as a general concept. One of the most useful tools for this is a written maintenance plan, developed collaboratively with the client during the final phase of treatment. This document serves as both a summary of what the


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client has learned and a practical guide for what to do when difficulties arise after formal treatment has ended. Creating it together communicates that the clinician takes long-term wellbeing seriously and helps clients internalize the skills they have developed rather than attributing their progress to the therapeutic relationship alone.

A well-constructed maintenance plan addresses several specific areas. It identifies the client's top three relapse triggers: the specific stressors, situations, or life events that are most likely to restart the anxiety-symptom cycle for that individual. These should be drawn from the client's own history and conceptualization rather than generic lists. The plan also documents the client's early warning signs, the subtle shifts in thought, behavior, or physical experience that signal the cycle is beginning to re-establish before it has reached full intensity. Common early warning signs include the return of safety behaviors that had been reduced, increased symptom monitoring, or renewed reassurance seeking. Naming these specifically gives the client a concrete signal to act on rather than waiting until symptoms have escalated significantly.

The plan should also list the client's preferred regulation tools, the specific practices they found most effective during treatment, such as diaphragmatic breathing, progressive muscle relaxation, mindful movement, or journaling, along with brief notes on when and how to use them. It should identify two or three trusted support people the client can contact when symptoms worsen, and it should include a clear criterion for when to schedule a booster session with the clinician. A booster session criterion might be as specific as: "If I notice that I have been monitoring my symptoms daily for more than one week, or if I have returned to seeking medical reassurance more than twice in a month." Having a concrete threshold reduces the client's ambivalence about reaching out and normalizes the possibility of occasional check-ins as part of ongoing health management rather than as a sign of treatment failure.

For clients with genuine co-occurring medical conditions, the maintenance plan should also address coordination with their primary care physician or relevant specialists. This might include a note about how to communicate with their medical provider when somatic symptoms flare, a reminder to distinguish between anxiety-amplified symptoms and symptoms that warrant medical evaluation, and clarity about what circumstances would justify contacting their physician versus managing the experience with their self-regulation tools. Addressing this explicitly helps clients navigate the line between appropriate health monitoring and the reassurance-seeking cycle, which can be particularly difficult to maintain after treatment has ended and the clinician is no longer available as a collaborative guide.

**Case Example: Cultural Responsiveness**

Carmen, a 38-year-old woman who emigrated from Colombia fifteen years ago, presents for therapy at the urging of her primary care physician, who has been evaluating her for persistent headaches, fatigue, and what Carmen describes as feeling like her nerves are always on edge. She is hesitant in the first session. In her family, talking about emotional problems with a stranger feels


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strange and potentially embarrassing. She is more comfortable describing her physical symptoms than anything she might be feeling emotionally.

Her clinician, who is familiar with nervios as a culturally meaningful idiom of distress in Latin American communities, does not attempt to immediately reframe Carmen's experience in psychological terms. Instead, she asks Carmen to describe what nervios means to her and how it affects her daily life. Carmen relaxes visibly and describes a constellation of symptoms connected to family stress, financial worry, and the experience of living far from her family of origin. Her clinician introduces the body's stress response using biological language, which resonates with Carmen's understanding of nervios as a real physical condition with real physical effects. Over the course of treatment, Carmen gradually becomes more comfortable connecting her physical symptoms to specific emotional stressors.

***Personal Reflection***

- *How does cultural background influence the way you approach somatic symptom presentations? Are there cultural groups you feel less equipped to work with in this area?*
- *What steps do you take in your practice to develop and maintain cultural humility?*

## Section Summary

Section 6 addressed the role of cultural context in somatic symptom presentation and treatment. It highlighted that somatic expression of distress is normative in many cultural communities, not pathological, and that culturally specific idioms of distress like nervios reflect genuine experiences that deserve clinical respect. It introduced culturally responsive adaptations to assessment and treatment, including adjusting pacing, involving family members where appropriate, working with spirituality and religious frameworks as genuine coping resources, and addressing medical mistrust rooted in historical discrimination with consistency and transparency rather than reassurance. It also addressed long-term planning, relapse prevention, and the concrete written maintenance plan as tools that help clients sustain their gains after formal treatment concludes.

**Key Clinical Takeaways:**

→ Somatic expression of distress is normative in many cultural communities. Understand the cultural context before interpreting symptoms.

→ Culturally meaningful idioms of distress like nervios reflect real experiences and deserve clinical respect.

→ Racism and discrimination produce real physiological stress responses that contribute to somatic symptom burden.

→ Psychoeducation framed in biological terms may be more accessible and less stigmatizing for some clients.

→ Relapse prevention should identify specific triggers, early warning signs, and a concrete self-care plan.


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# Conclusion

Psychosomatic anxiety is not a niche presentation. It shows up in therapy offices, primary care waiting rooms, and specialist clinics on a regular basis. By the time these clients reach a clinician, they have often been suffering for a long time and have largely run out of other explanations.

The good news is that the mechanisms driving these presentations are well understood, and the interventions available for addressing them work. CBT, interoceptive exposure, psychoeducation, mindfulness-based approaches, and emotionally focused interventions all have meaningful evidence behind them (Berezowski et al., 2022; Löwe et al., 2022). What makes this work genuinely challenging is not primarily the clinical complexity, though that is real. It is the relational demands. Working with clients who have repeatedly felt dismissed requires a sustained commitment to validation, transparency, and patience that goes beyond what many other presenting problems require.

This course has covered a lot of ground. It began with the diagnostic landscape: the three primary DSM-5-TR diagnoses relevant to somatic symptom presentations, the important distinction between medically unexplained symptoms and psychologically amplified ones, and the clinical and financial burden that these presentations carry. Section 2 examined the mechanisms through which anxiety produces and amplifies physical symptoms, from autonomic nervous system activation and HPA axis dysregulation to the gut-brain axis, central sensitization, sleep disruption, hypervigilance, catastrophic cognition, emotional suppression, and the conditioning processes that lock these patterns in place.

Section 3 addressed assessment: the necessity of medical collaboration before psychological conceptualization, the differential diagnosis pitfalls that lead to premature psychological framing, validated screening tools that support ongoing tracking, and the four Ps biopsychosocial model as a practical structure for making sense of why this particular client developed these particular symptoms at this particular time. Section 4 reviewed the evidence base for treatment, covering psychoeducation, cognitive behavioral therapy, behavioral experiments, interoceptive exposure, emotional awareness and processing, mindfulness and somatic regulation, and the critical question of how to match interventions to the dominant maintaining factor. It also addressed what to do when treatment stalls, which is as important a clinical skill as knowing how to begin.

Section 5 addressed the therapeutic challenges that make this work distinctively demanding: resistance to psychological explanations, the fragility of the therapeutic alliance with clients who have been dismissed before, the clinical management of reassurance seeking and avoidance, the use of motivational interviewing with clients who remain medically focused, and the countertransference dynamics that clinicians need to monitor in themselves to practice effectively. Section 6 placed all of this in cultural context, examining how culture shapes somatic expression, help-seeking behavior, and the acceptability of psychological treatment, and offering concrete


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guidance on culturally responsive adaptations including language, pacing, family involvement, spirituality, and the management of medical mistrust rooted in historical discrimination.

Cultural awareness adds another essential layer throughout. The expression of distress through the body is not a clinical anomaly to be corrected. In many cultural contexts it is a normative and meaningful form of communication. Clinicians who approach somatic symptom presentations with cultural humility, adapting their language and approach to the realities of individual clients, are substantially more likely to build the kind of therapeutic relationship that makes effective treatment possible.

There is one thing this course cannot fully convey, which is the experience of sitting with a client who has spent years feeling frightened by their own body and who, in the course of treatment, begins to experience their physical sensations differently. Not as alarms, not as evidence of hidden disease, not as proof that something is fundamentally wrong with them, but as understandable signals from a nervous system that has been under sustained strain. That shift, from fear to curiosity, from mystery to comprehension, from helplessness to agency, is what this work is ultimately about. It does not happen in every case, and it does not happen quickly in any case. But it happens often enough, and meaningfully enough, that it is worth developing genuine competence in these presentations.

The clients who present with chronic unexplained symptoms are among the most underserved populations in both medical and mental health settings. They are frequently dismissed, undertreated, and left to cycle through a healthcare system that is not well-designed to address the complexity of their experience. Clinicians who can offer them a coherent explanation for what is happening, a credible treatment framework, and a therapeutic relationship built on genuine validation are offering something that many of these clients have never received before. That is not a small thing. It is exactly what this field exists to provide.

Future directions in this area increasingly include integrated behavioral health collaboration, digital symptom tracking, and earlier intervention within primary care settings.

## Glossary of Key Terms

**Alexithymia:** A personality trait characterized by difficulty identifying, describing, and processing emotional states. Associated with elevated rates of somatic symptom reporting.

**Autonomic nervous system (ANS):** The part of the nervous system that regulates involuntary body functions such as heart rate, breathing, digestion, and the stress response. It has two main branches: the sympathetic (fight-or-flight) and the parasympathetic (rest and recovery).


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**Behavioral experiment:** A CBT technique in which clients test the accuracy of a feared belief through direct experience rather than discussion alone.

**Biopsychosocial model:** A framework for understanding health and illness that integrates biological, psychological, and social factors rather than viewing them as separate.

**Body scanning:** A mindfulness practice in which attention is directed systematically to different parts of the body to build awareness of physical sensations. When performed with a nonjudgmental attitude, body scanning can reduce hypervigilance over time; when performed anxiously, it can amplify symptom awareness.

**Central sensitization:** A neurobiological process in which the central nervous system becomes increasingly reactive to input over time, lowering the threshold at which pain and other physical sensations are generated. Associated with chronic anxiety and chronic pain conditions.

**Classical conditioning:** A learning process in which a previously neutral stimulus comes to trigger a response after repeated association with a stimulus that naturally produces that response.

**Cognitive restructuring:** A CBT technique that helps clients identify inaccurate or unhelpful thoughts and develop more balanced, realistic interpretations.

**Cortisol:** A hormone released by the adrenal glands in response to stress. Helpful in the short term, but chronically elevated cortisol is associated with a range of adverse physical effects.

**Countertransference:** The clinician's emotional and psychological reactions to a client, shaped by the clinician's own history, values, and unresolved experiences. In somatic symptom work, countertransference commonly includes frustration, diagnostic uncertainty, and a pull toward providing inappropriate reassurance.

**Cultural humility:** An ongoing commitment to self-reflection, openness to learning, and recognition of the limits of one's cultural knowledge in clinical practice.

**Emotional granularity:** The ability to distinguish between different emotional states with precision, rather than experiencing emotions as a general sense of feeling good or bad.

**Explanatory model:** A client's own understanding of why they are experiencing their symptoms, including their beliefs about cause, meaning, and appropriate treatment. Understanding the client's explanatory model is essential before attempting any reframing.

**Exposure hierarchy:** A ranked list of feared situations or sensations arranged from least to most distressing, used to guide graduated exposure work. Clients work up the hierarchy systematically, consolidating success at each step before advancing.

**Fight-or-flight response:** The body's automatic physiological response to perceived threat, involving activation of the sympathetic nervous system and release of stress hormones.

**Four Ps model:** A biopsychosocial framework for case conceptualization that organizes clinical information into predisposing, precipitating, perpetuating, and protective factors.


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**Functional Neurological Symptom Disorder (FNSD):** A DSM-5-TR diagnosis involving neurological symptoms (such as weakness, non-epileptic seizures, or tremors) that are inconsistent with known neurological disease and appear related to psychological stress.

**GAD-7:** A validated self-report measure designed to assess generalized anxiety severity.

**Gut-brain axis:** The bidirectional communication system between the gastrointestinal tract and the brain, which explains why stress and anxiety reliably produce digestive symptoms.

**Health anxiety:** Persistent and excessive preoccupation with having or developing a serious illness, accompanied by heightened monitoring of bodily sensations and significant functional impairment. Health anxiety exists on a spectrum and can occur as a primary diagnosis or alongside other anxiety and somatic symptom presentations.

**Health Anxiety Inventory (HAI):** A validated self-report measure designed to assess health anxiety, illness-related worry, and reassurance-seeking behaviors.

**HPA axis:** The hypothalamic-pituitary-adrenal axis, a hormonal system that regulates the body's longer-term stress response through the release of cortisol.

**Idiom of distress:** A culturally specific way of expressing suffering or emotional distress that may not map directly onto Western diagnostic categories. Examples include nervios in Latin American communities.

**Illness Anxiety Disorder (IAD):** A DSM-5-TR diagnosis characterized by preoccupation with the fear of having or developing a serious illness, often with minimal or no physical symptoms.

**Inhibitory learning:** A process in exposure therapy in which new, non-threatening associations with a feared stimulus are formed, reducing the conditioned fear response over time.

**Interoceptive exposure:** A behavioral technique that involves deliberately inducing feared bodily sensations in a controlled, graduated way to reduce the conditioned fear response to those sensations.

**Mindfulness:** A practice of paying attention to present-moment experience, including bodily sensations, with an attitude of openness and nonjudgmental awareness.

**Negative reinforcement:** The strengthening of a behavior through the removal of an aversive stimulus. In somatic symptom presentations, avoidance and reassurance seeking are negatively reinforced because they temporarily reduce anxiety, which makes them more likely to recur.

**Nervios:** A culturally meaningful idiom of distress common in Latin American communities, describing a range of physical and emotional symptoms including headaches, palpitations, fatigue, and gastrointestinal distress.

**Operant conditioning:** A learning process in which behavior is shaped by its consequences. Behaviors that produce relief or reward are reinforced and become more likely to recur.

**PHQ-15:** The Patient Health Questionnaire-15, a brief validated self-report measure of somatic symptom severity that assesses fifteen common physical complaints.


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**Progressive muscle relaxation (PMR):** A somatic regulation technique involving systematic tensing and relaxing of major muscle groups to reduce physiological arousal.

**Psychoeducation:** A clinical intervention that provides clients with clear, accurate information about the mechanisms underlying their symptoms to support understanding and engagement with treatment.

**Psychosomatic:** Referring to physical symptoms that are significantly influenced by psychological processes. Psychosomatic symptoms are real and not imaginary.

**Reassurance seeking:** A behavioral pattern in which clients repeatedly seek confirmation from medical providers, clinicians, or others that their symptoms are not dangerous. While providing brief relief, reassurance seeking maintains health anxiety by preventing the client from learning to tolerate uncertainty independently.

**Safety behaviors:** Actions clients take to prevent feared outcomes or manage anxiety in the moment, such as avoiding exercise or always carrying medication. While providing short-term relief, safety behaviors maintain anxiety by preventing disconfirmation of feared beliefs.

**Sensitization:** A process in which repeated activation of the stress response lowers the threshold for future activation, meaning progressively smaller triggers can produce significant physiological reactions.

**Somatic Symptom Disorder (SSD):** A DSM-5-TR diagnosis characterized by one or more distressing physical symptoms combined with excessive psychological response to those symptoms, regardless of whether the symptoms have a medical explanation.

**Somatization:** The expression of psychological distress primarily through physical symptoms, rather than through emotional or verbal communication.

**Somatosensory amplification:** Heightened attentional focus on internal physical sensations that increases their perceived intensity. Common in anxiety disorders and somatic symptom presentations.

**Sympathetic nervous system:** The branch of the autonomic nervous system responsible for activating the fight-or-flight response during perceived threat.

**Symptom diary:** A structured self-monitoring tool in which clients record the timing, intensity, and context of their physical symptoms alongside relevant psychological and situational variables. Symptom diaries help identify patterns connecting symptoms to stressors, emotions, and behaviors.

**Vagal brake:** The mechanism by which the vagus nerve activates the parasympathetic nervous system to reduce physiological arousal. Slow, diaphragmatic exhalation engages the vagal brake and can produce rapid reductions in heart rate and anxiety.


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