

## A CLINICAL CASE STUDY OF SOMATIC SYMPTOM DISORDER IN A 35-YEAR-OLD MALE PATIENT

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### Abstract

M.A., a 35-year-old man, was referred from the male ward for psychiatric evaluation and psychological treatment. He arrived with complaints of anger and other forms of physical aches, such as headaches, stomach discomfort, rib pain, neck pain, and pain in various parts of his body. He also complained about dryness in his throat. His assessment included behavioral observations, a clinical interview, a mental state examination, baseline charts (for anxiety, anger, frequent negative thoughts, and sleep), and subjective ratings of physical symptoms. A behavioral checklist and Thematic Apperception Test (TAT) were also used. The assessment revealed that his worry about his physical problems was extremely high (he scored it 9 out of 10). His sleep was mainly normal, although he had occasional difficulties sleeping due to physical discomfort.

Management strategies included rapport building, psychoeducation, anger management, relaxation exercises, distraction techniques, stress management, grief therapy and sleep hygiene. Following 10 sessions, the client was discharged from the hospital. By that time, his anxiety about his physical symptoms had reduced. He had also gotten a better understanding of his health condition and learned efficient approaches and strategies for managing his symptoms. An improvement in anger control was also noted.

### INTRODUCTION

Somatic Symptom Disorder refers to a mental health condition in which the person has significant distress about the physical symptoms. The stress about these physical symptoms starts impacting the daily life of the person and thus the person might have whole procedure of frequent visits to different physicians. In this disorder, clients experience distress and dysfunction due to the somatic symptoms and clients usually have persistent thoughts about these symptoms. These symptoms are the focus of this disorder such as pain, fatigue and discomfort which makes them unable to do any daily task. In

this disorder, clients face a high level of anxiety about their health or their symptoms. So, their physical and mental health are impaired and it affects their quality of life (DSM-5-TR, 2022).

This disorder was less common in previous years and according to DSM IV it was named as "Somatization disorder" but now in DSM V TR it is called "Somatic Symptom disorder". These days researchers are working on this disorder as according to Mayo clinic on Somatic disorders (2026), they explained that the actual cause of this disorder is not clear but there are some of them such as genetic, extreme stress, less

sensitivity for pain and unable to process emotions. The further explained the risk factors, complications and preventions.

According to DSM V TR the prevalence of somatic disorder is unknown but in general the adult population is estimated around 5%-7%. Females are more vulnerable to this disorder than males and its prevalence is likely to be higher in females. In the article D'Souza<sup>1</sup> & Hooten<sup>2</sup> (2023) they said that the prevalence of the primary care patient population has increased about 17% and the prevalence is higher in certain patient population such as functional disorders, including fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome.

According to D'Souza & Hooten (2023) in their article about "Somatic Symptom Disorder they explained the etiology of the SSD. Somatic symptom disorder (SSD) develops from an increased sensitivity to various physical sensations, coupled with a tendency to view these sensations as signs of a medical condition. The cause of SSD remains unclear, research has examined several risk factors such as childhood neglect, sexual abuse, disorganized lifestyle, and a history of alcohol and substance dependency. Additionally, significant somatization has been linked to axis II personality disorders, especially avoidant, paranoid, self-defeating, and obsessive-compulsive disorders. Psycho-social stress factors, like unemployment and reduced ability to perform occupational duties, have also been associated with the condition.

After so much consideration we concluded that somatic symptom disorder is difficult to diagnose and clients come to mental health professionals after so many medical procedures which makes their condition worse. Awareness about SSD must be given around the globe because it is essential that physicians and mental health professionals must know the depth of this disorder and about other disorders because a right diagnosis makes treatment easy and clients recover quickly.

Several theories in psychology tend to explain why somatic symptoms occur and persist. In psychodynamic theory, symptoms are considered as symbolic reflections of unconscious emotional conflicts, such as unresolved grief or trauma, which manifest as physical suffering (Maroti, 2025). Freud's early work on "hysteria" set the framework for this viewpoint, implying that repressed emotions might be expressed somatically when direct emotional expression is impossible. Based on Cognitive-Behavioral Theory (CBT), maladaptive beliefs about body sensations, hypersensitivity to physical changes, and negative interpretations all contribute to and exacerbate symptom discomfort. Additionally, Learning theories emphasize how avoidance strategies and reinforcement, such as greater attention to symptoms, can prolong a cycle of physical discomfort (Kleinstäuber et al., 2025). Moreover, according to stress and trauma models, life stressors and traumatic experiences predispose individuals to increased body distress by chronically activating emotional and physiological systems (Zanotta, 2024).

To summarize, Somatic Symptom Disorder is a complicated disorder characterized by emotional distress, maladaptive beliefs, stress exposure, and cultural factors that influence how psychological pain manifests as physical symptoms. This case report focuses on a middle-aged Pakistani male from a lower socioeconomic and collectivistic family background who presented with long-standing somatic complaints, interpersonal stress, unresolved grief, and emotional suppression, demonstrating how psycho-social stressors and limited emotional expression can contribute to the development and maintenance of SSD. The case emphasizes the importance of culturally sensitive, low-literacy-friendly, and practical psychological interventions, demonstrating how simple cognitive-behavioral, emotional regulation, grief counseling, and family-based strategies can result in significant symptom reduction and improved daily functioning.

**Identifying Data**

**Client's Initials:** M.A  
**Age:** 35  
**Gender:** Male  
**Education:** 8  
**No of Sessions:** 10  
**Marital Status:** Married  
**Date Seen:** 11 Nov, 2023  
**Last Date Scene:** 25<sup>th</sup> Nov, 2023

**Source and Reason for referral**

Client was referred by a Senior Clinical Psychologist for psychological assessment and psychotherapy of the client's somatic problems and physical pains which have no medical reason.

**Table 1.**  
**Presenting Complaints and its Duration as Reported by Client**

Presenting Complaints	Duration
I have body aches	5 Years
I get angry	5 Years
I have stiffness in neck	5 Years
Headache and dizziness	5 Years
Dry throat	1 Year

**Initial Observation**

As observed, the client was seated on the bed with crossed legs in a comfortable manner. He maintained proper eye contact. The client seemed to be an average heighten man with average weight. His weight and height seemed appropriate to his age. The client appeared to be well dressed and well groomed.

His clothes were tidy and ironed well. His hairs were combed properly. He was clean and tidy except for the teeth which were unclean and red. The client's speech was rapid and loud and he was quite talkative and responsive towards the Clinical Psychologist. The client complained toward the junior Clinical Psychologist instructions. The client's attitude towards the Clinical Psychologist seemed cooperative. In the initial session the client should have anxiety, concerns and seemed panic about his somatic complaints.

**Case History**

**Developmental History of the Problem**

The source of the information was the client and his wife. The client had multiple somatic complaints and physical pains such as pain in neck, head, ribs and stomach. The client reported having eating problems at times and had difficulty swallowing the food. He also had anger issues. According to the client, he gets angry frequently when things someone doesn't obey him and things are not according to his wish and need and then he gets out of control. The client said that he got really angry with the attendant because he was not provided proper breakfast and was provided with only a piece of bread. As mentioned by the client he got really angry at the attendant and got into a verbal argument with him and was about to hit him. Afterwards he realized that it was not the mistake of the attendant as he is just working there. He also has problems sleeping at times due to his bodily pains. The client has been experiencing this problem since the past 5 years. There are a number of psycho-social factors and stressful situations that

have made the client vulnerable towards the problem such a death of both parents, dispute with family over the land, financial issues and no social support. Currently the client has many somatic symptoms and anger issues. Both of the problems are severe according to the client. Both of his parents died a few years ago. The client was very close to both of his parents especially his mother and misses his mother and cries for their parents often, as reported by his wife. The client was married and his relationship with his wife was good as reported by the client but according to the wife he gets angry at her now and then. His relationships with his siblings were not good. He is having issues and fighting with his siblings over a piece of land and a legal case was also going on.

#### **History of Present Illness**

The client had a history of multiple somatic complaints for the past 2 years. Additionally he also has anger issues and gets out of control during the anger. He belongs to a lower middle class family. His financial condition is not stable.

#### **Personal History**

Client's current routine was talking with other ward patients, making others laugh, walking, and using mobile. The client had interest in reading books, newspapers and magazines, singing songs and reciting and talking and chit chatting with others. The client mentioned that he likes to eat fish. The client seemed religiously inclined because he seemed to have strong beliefs in God (Allah). He does not offer prayer regularly or perform any other religious activity but he has a strong faith in Allah which was evident in his communication such as he mentioned that whatever God has created is good and whatever God does, we accept it. According to the client, most of his wishes are fulfilled such as the client likes to drive which is also fulfilled.

#### **Premorbid History**

The Premorbid personality of the client was lovable, jolly, friendly, caring and sociable and outgoing according to the client and his wife. He had a plethora of friends and used to hang out

and spend time with them. The client used to help other people financially. He used to sing songs and recite naat as well. He was an ambitious and hardworking person and used to fulfill his duties and do his work with full dedication. He had a good relationship with his family, friends and coworkers.

#### **Family History**

The client was from a lower middle class family. The client was married and lived in a nuclear family with his wife and children. He had three children, two daughters aged 14 and 9 and had two sons aged 9 and 6. His wife worked as a maid in a house. The client said that he had a good relationship with his wife and loved his children. The client had a conflicting relationship with his wife as reported by his wife. His wife reported that he often got very angry at times. His children call him frequently and ask how he is doing and tell him to come back home. Both of his parents had passed away. His father was a farmer while his mother was a housewife. Both of his parents were uneducated. The client's father was a farmer and used to work in the village. His father used to plant two seasoned vegetables. His father was social and had a jolly personality just like him. His mother was calm by nature and used to do all the household chores and took care of the family and children and therefore she was entirely responsible for the home tasks.

The client had a very nice relationship with both the parents. The client was very attached to his parents, especially his mother. The client's wife also revealed the client misses his parents, especially his mother. He cries a lot. She also revealed that whenever the client misses his mother he says "Ami aap mujhe khu chor ke chali gayi ho? Mujhe bhi apne saath le jati" which roughly translates in English as "Mom, why did you leave me alone. You could have taken me with you too". The client had 10 siblings and he had an unhealthy relationship with his siblings especially with his brothers. He has conflicts and disputes going on with them over land. The client reported that his siblings backbite about him with others to create a bad image of him. They visit his neighbors but not him to tease him.

### **Sexual History**

The client's puberty started around the age of 12 and 13. His attitude towards these changes was normal. He got knowledge of these from friends and family. According to him, the physical and sexual relationship between the couple were good.

### **Marital History**

The client had an arranged marriage. The duration of his marriage is 15 years old. His wife is not educated and works as a maid in a house. His relationship with his wife is healthy and good, according to the client. The client's wife mentioned that he gets angry often at her and shouts at her in anger and tells her to go from there in the state of anger. But according to the wife she is also happy with him.

### **Educational History**

The client's education was till 8<sup>th</sup> class. As mentioned by the client he wasn't much interested in the studies so he left it. His performance in the school was below average. His interaction with teachers and class fellows was good. He had a good number of friends whom he used to hang around and play with.

### **Occupational History**

The client used to do farming now. Earlier he drove a truck for a few years at the age of 20 and afterwards he drove a rickshaw for a few years. The client loves to drive but left this work because he used to feel pain in the body. He used to feel pain if the tractor or rickshaw got a jerk and that is why he left these jobs. After this he used to work in his farm. He had few farm animals such as cows, hens etc. When these pains got increased he was admitted to the hospital and as for now the client doesn't do any work.

### **History of family psychiatric/medical Illness**

There is no such illness in the family. The reason of the death was not told by the client or his wife. The client mentioned that they were ill so they died.

### **Provisional Formulation**

The predisposing factors in this case are the temperament of the client. Another predisposing factor is the traumatic or stressful life event such as a dispute between siblings over a piece of land. The precipitating factor is loss of both parents whom the client was very much attached to, especially his mother. The perpetuating factors include the client did not share his even his wife and remained silent. The client does not talk about his problem and tries to keep it with himself. Additionally, lack of social support and guidance can also be another factor. Finally, protective factors can be the combination of psychotherapy, counseling, psycho education, wife and family's concern.

### **Assessment**

The following assessment tools were used in order to assess the client's problem.

1. Behavioral Observation
2. Clinical Interview
3. Mental Status Examination (MSE)
4. Baseline Charts of Anxiety, sleep, anger and recurring negative thoughts
5. Rating of Somatic Symptoms

### **Behavioral Observation**

The purpose of behavioral observation is to assess the dimensions of behavior in both structured and unstructured manners. Behavior observation was done to assess the client's behavior during the session. Through behavior observation it would help to assess the level of functioning and the problematic behavior that client has so that through this it would help the junior clinical psychologist to formulate a better management plan.

The client seemed to be an average heighten man with average weight. His weight and height seemed appropriate to his age. The client appeared to be well dressed and well groomed. He seemed to be tidy and ironed well. His hairs were combed properly. He was clean and tidy except for the teeth which were unclean and red. The client's speech was rapid and loud and he was quite talkative and responsive towards the junior clinical psychologist. Whenever the client

talks about his somatic symptoms he there was a kind of distress and anxiety on his face.

### **The Clinical Interview**

A clinical interview is a primary assessment strategy which is employed to gather information, develop rapport and to inform and motivate the client about receiving treatment for his presenting complaints (Allen & Becker, 2016). Face to face Clinical interview was conducted with the client in which questions were asked related to the client's problem and history taking was also taken. The rationale of this was to build a rapport with the client and conduct further sessions with the clients. The client was allowed to talk freely. Moreover, the interview was conducted to obtain comprehensive information of the client i.e. family history, educational history, early developmental history, social history etc. interview was conducted to obtain predisposing, precipitating and maintain factors of client's illness.

### **Mental Status Examination**

Mental Status Examination (MSE) is defined as it is a combination of all medical exams and it is the psychological equivalent of the physical exam (Robert, 2014). Mental state examination was done to know the current mental state and to assess different dimensions of the client's behavior.

### **Appearance**

The client appeared to be an average heighten person. He appeared to be slim but was not underweight. His hygiene was well maintained. His clothes were neat and tidy and were properly ironed. He was wearing shalwar kameez. The client's hair was combed properly, and was oiled as well. He was clean shaved and had a smile on the face while talking to the junior Clinical Psychologist. The client seemed anxious and worried while talking about his physical and somatic symptoms.

### **Mood**

The mood of the client seemed stressed and worried. The client showed worries for his

somatic symptoms. The client explained that he is not feeling well and feels pain in various parts of the body. Other than that the client mentioned about his anger issues that he gets angry often. His mood was congruent with his behavior. His expressions were tense and worried when he would talk about his medical concerns and why he is worried. Other than that he would smile when talking to the junior Clinical Psychologist about other things such as work, his routine etc.

### **Speech**

The speech of the client was rapid and fast. The client was talkative and open with the therapist and his rapport with the client was good and well established. The tone of the client was loud and clear.

### **Thoughts**

The client had a flight of thoughts related to his symptoms. He also has thoughts related to financial issues and other health concerns. He would talk continuously on one topic for a long period of time. He believes that something must be wrong with him because he has multiple somatic complaints but is also worried that if all his medical reports are clear then why he feels pain in parts of body. There was mostly talk about God many times. The client often mentioned that "I am happy in the situation God has placed me in".

### **Perception**

No hallucinations were noted during the sessions or reported by the client. No delusions were observed during the session. His vision, touch, smell, hearing and taste are normal as observed and reported by the client.

### **Cognition**

The client had awareness about self and the environment. His orientation of time, space and place were good.

### **Inside/Judgment**

The inside of the client related to his problem was very minimal.

**Ratings of Somatic Symptoms**

Rating was taken of somatic symptoms of the client from 1 to 10. It was done because the client has multiple somatic complaints and it was important to know how severe they are. He gave 10 to all the somatic symptoms.

**Somatic Symptoms Scale-8 (SSS-8)**

The Somatic Symptom Scale-8 (SSS-8) is a short self-report instrument that assesses the severity of somatic symptoms encountered in the previous week. It contains eight typical physical symptoms, such as pain, exhaustion, gastrointestinal

discomfort, and sleep issues, and divides symptom burden into five levels: minimum, low, medium, high, and extremely high (Gierk et al. 2014). In this case, the SSS-8 was administered to the client as part of the psychological examination, and the client obtained a score of 25, indicating a very high symptom burden. The result shows severe somatic discomfort and is consistent with the client's numerous physical complaints, confirming the diagnosis of Somatic Symptom Disorder.

**Depression Anxiety Stress Scale-21 (DASS-21)**

**Table 2.**  
**DASS-21 Severity Rating of the Client (Scores Multiplied by 2)**

Subscale	Total Score (x2)	Severity Level
Depression	8	Normal
Anxiety	6	Normal
Stress	18	Moderate

Note. DASS-21= Depression, Anxiety, and Stress Scales-21. Values are doubled to be comparable to DASS-42.

**Values are doubled to be comparable to DASS-42.**

The Depression Anxiety Stress Scale-21 (DASS-21) is a brief self-report questionnaire that measures the level of emotional discomfort in three areas: depression, anxiety, and stress in the previous week. It was created by Peter F. Lovibond and Simon H. Lovibond in 1995. Each subscale has seven items, and the stress subscale measures persistent tension, difficulty relaxing, irritability, nervous arousal, and being easily upset or overwhelmed, all of which indicate poor stress coping ability rather than occasional pressure or worry (Arab Psychology Scales Database, 2025; Cherry, 2024). In this case, the DASS-21 was administered during the initial assessment, and the client scored in the moderate range for stress, indicating that he was experiencing notable stress symptoms even though clinical depression and anxiety were not prominent. Elevated stress levels like these are important in somatic symptom

disorder because research shows that stress and emotional distress are often associated with increased reporting of physical symptoms and greater functional impairment, making stress assessment and management a key part of treatment planning (Gebreegziabher et al., 2024). The DASS-21 therefore provided useful information on the client's emotional state and helped guide interventions aimed at improving his stress tolerance and overall psychological well-being.

**Baseline Charts**

The baseline charts were done of anger, sleep, and frequent thoughts charts. The rationale was that the client reported anger, sleep issues and frequent thoughts about the symptoms so it is important to know the functional analysis of all these. This will be helpful in getting to know The ABC of all these and will be helpful in getting to know the severity of all these problems.

### **Thematic Apperception Test (TAT)**

The Thematic Apperception Test (TAT) was used to explore the client's unconscious thoughts, feelings, and perceptions, particularly those about his relationship with his wife. The TAT is a projective psychological test made up of 31 ambiguous cards. Each picture is shown to the client one at a time, and the client is instructed to construct a full story with a beginning, middle, and end based on what they see. Henry A. Murray and Christina D. Morgan developed the test at Harvard University in the 1930s (Cherry, 2020).

At the beginning of the assessment, the client hesitated, therefore he was reminded to explain an entire story with a clear order of events. Throughout the story, the wife was the second significant character. The topics focused on conflict in marriage, emotional distance, and a longing for reconciliation. Toward the end, the client openly acknowledged that the story represented his own life and that the couple in the image looked like him and his wife.

During the assessment, the client was shown an image of a man and a woman. The client identified them as a husband and wife who had recently argued. According to his story, both of them were angry with each other. The wife wanted to apologize and settle the dispute since she felt helpless and didn't want to leave the house. She believed the dispute could have been

her fault and wished to reconcile. The client went on to describe that the spouse, who appeared to be the primary character or "hero" in the story, began to feel guilty. The husband realized he had talked rudely to his wife and should have used a softer, more gentle expression in his eyes and tone.

### **Personal Hygiene Checklist**

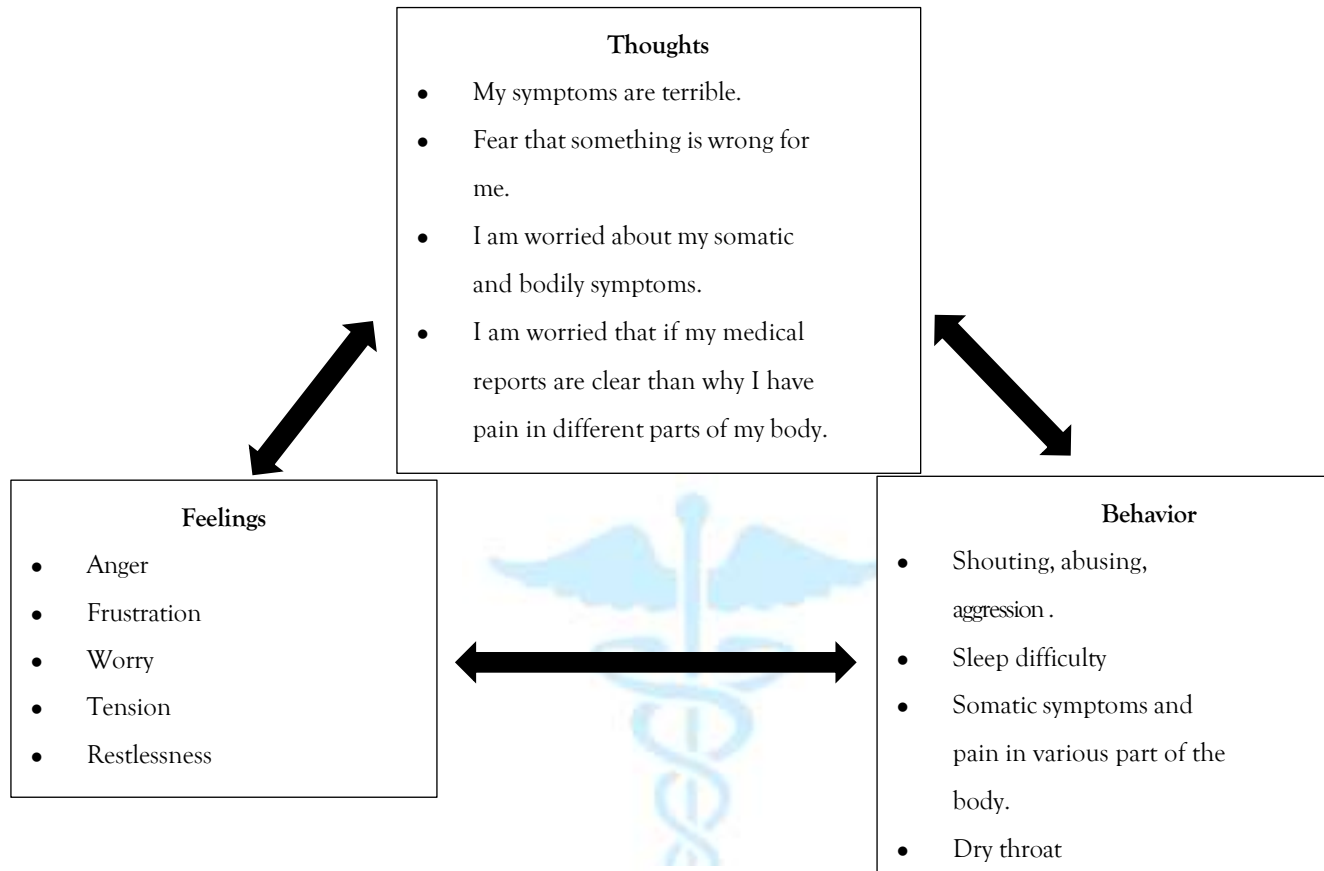
It was conducted to know the client's personal hygiene state. The client was a hygienic person and he took care of his hygiene except for his teeth which were red. Most of the statements were checked.

### **Social Checklist**

Social Hygiene Checklist was done in order to know the socialization skills of the client. The client has good socialization skills and most of the statements were checked.

### **Cognitive Triangle Model**

In the cognitive triangle model, the client mentioned how his thoughts (negative and irrational beliefs) have affected his behavior and life. The rationale of this model was explained to the client to help the client understand his irrational thoughts and to replace the irrational and dysfunctional beliefs to more rational ones. The client's cognitive triangle model is depicted below.



**Figure 1**  
The figure represents the Cognitive Triangle of the client.

The client was a born in a village and was a thirty five years old male. He was married and had children and was spending his life in a village but recently shifted to a city because of his medical conditions. He was in severe pain (headache, neck, rib,shoulders) when came to hospital but as his wife said that he has gone through various medical procedures but his medical records were normal and no issue related to his body. Physicians give him some painkillers but no recovery has been seen.

The clients complained about pain in various parts of the body and were very worried about the pain in his body. He was worried and thought that what if something serious happened to him.like if he will be diagnosed with the dangerous disease. He feared about his symptoms

and showed aggressive behaviour that why nothing has come out and why medicines were not working on him. Due to these pains he was unable to do any kind of work and he was unemployed , his wife was taking care of him. His married life is going good according to him but his wife said that he did not listen to him and do what pleases him. The client himself belongs to a village background and has a conservative mind set. His wife further said that he misses his parents and grief about them as they are no more in his world. After their death his siblings dislike their brother and there are disputes going on between them on property matters. These are the few stressors which can be the cause of his pain. So after the normal medical reports the client was under observation and the case was shifted to the

psychiatric ward because the pain was still there and normal medicines were not working. The client was reluctant and hesitant in conversation with the psychologist. He did not tell the truth and hid things from the psychologists and many major stressors came out after coming sessions like (his dispute with his siblings, worry about livelihood and his grief about his parents). After a few sessions the client was given the diagnosis of somatic disorders as he was actually worried about his symptoms and there are many stressors which are the contributors.

According to Freud, somatic symptoms were merely the expression of defense mechanisms and were a method to ease or minimize inner conflict. He also believed that somatic symptoms can be emotions themselves such as unpleasant experiences related to anxiety and depression. Moreover, these somatic symptoms can be a negative or incorrect interpretation of one's feelings. (Zeng et al., 2016)

The predisposing factor in this case is the temperament of the client. Another predisposing factor is the traumatic or stressful life event such as a dispute between siblings over a piece of land. Many researches

and studies have found the link between somatoform disorder, environmental factors and stressful life events. Ammati et al. (2019) explains that many stressful life events are associated with somatoform and somatic symptom disorder such as financial issues, marital conflicts, family conflicts etc and further they mentioned that somatoform influences the quality of life of the patients.

The precipitating factor is loss of both parents whom the client was very much attached to, especially his mother. Many studies have shown the result between bereavement and somatic symptoms. During a grieving period or after a loss of a loved one a person can feel somatic symptoms such as headache, dizziness, chest pain and pain in various parts of the body (Thege, 2012).

The perpetuating factors include the client did not share his even his wife and remained silent. The client does not talk about his problem and tries to keep it with himself. Additionally, lack of

social support and guidance can also be another factor.

Finally, protective factors can be the combination of psychotherapy, counseling, psycho education, wife and family's concern.

### Diagnosis

The client's condition was identified as Somatic Symptom Disorder (severe) following a thorough evaluation by clinical psychologists in collaboration with a senior clinical psychologist and a medical doctors. The diagnosis was made after ruling out other probable mental and physical conditions using differential diagnosis, as described in the DSM-5-TR. The client met the majority of the DSM-5-TR criteria for Somatic Symptom Disorder (A, B, and C), including many somatic symptoms and the presence of two or more elements listed in Criterion B. Moreover, SSS-8 scores revealed that client had a very high somatic symptoms burden. Additionally, the DASS-21 assessment revealed moderate levels of stress, which were considered secondary to the client's somatic symptoms.

### Intervention Plan Goals

- To Psycho-educate the client and his wife about the psychological aspect of the illness and possible reason of client somatic complain.
- Build insight to the client about the problem
- To conduct stress management to cope up with stress.
- Anger management
- Sleep Hygiene
- Catharsis
- Grief Therapy

### Management Strategies

Following management strategies were used with the client.

- Rapport Building
- Anger Management
- Sleep Hygiene
- Distraction Techniques
- Stress Management
- Grief Therapy

### **Rapport Building**

Rapport Building refers to a good understanding between a therapist and a client. It consists of mutual trust, respect, being empathetic, being nonjudgmental and overall creating a comfortable therapeutic environment (Fritscher, 2021). First of all rapport will be built with client the client. The rationale of this is so that the client will be comfortable in sharing the information with the junior Clinical Psychologist.

### **Anger Management**

Anger management is used to reduce anger and to reduce emotional feelings and physiological arousal associated with anger. (American Psychological Association, n.d.) Anger management was done because the client has anger issues and he rated his anger at 9 out of 10 on baseline. For anger management and few of the following listed anger management and coping techniques were used with the client.

**Breathing technique.** Breathing technique was used with the client to control his anger. The client was told to breathe in and count till five and then breathe out and hold it for five seconds and count till five in the state of anger. This technique wasn't affected with the client as he complained that he feels pain in his stomach. The next day the client was taught breathing technique in a different way he was told to close his eyes and relax his mind and body. Then he was told to place his hand on his chest. Then he was told to breathe in for five seconds and imagine his favorite scenario and that all the positivity is going inside his body. Then breathe out and think that all the bad things, negativity, pains and worries are releasing from his body. This breathing exercise was done for five times. Pre and post ratings were taken and client rated that out of 100 as the client uses to give ratings in percentage. The pre rating which client gave was that before this technique his problem was 90% and now after this it is reduced to 50%.

**Backward counting.** The client was told to count to ten when he is angry and try not to react in the situations. The client was told that in the situation he feels anger or gets angry thoughts he can

practice backwards counting from 10 to 1.

**Hand/Wrist-pressing exercise.** The client was taught hand and wrist pressing exercise which he can use in the state of anger. He has to make a fist and press his hand whenever he gets angry. He can also try this with a rubber ball. He would take a ball in his hand and whenever he is angry he will press it tightly. The hand pressing technique was practically demonstrated in the session and was taught to the client.

**Time out.** The client gets really furious in the state of anger so he was taught time out which he agreed on trying next time he gets angry. A time-out basically involves removing yourself from a triggering situation, so you have time to cool off and gain clearer perspective. (Healthpsych, 2017). The rationale of this is to teach the client to remove and withdraw from the situation which makes the client angry. It means removing yourself from the triggering situation and not reacting suddenly. Then the client was explained that when he is calm down he can talk to the person related to the situation.

**Distraction Techniques.** The client was asked to educate that he can distract himself in the state of anger or somatic complaints. He can use the 54321 method, do exercise, physical activity, read a book, listen to music or do whatever he likes to do.

### **Stress Management**

Stress management is making your life stress free and controlling the stress in your life (Study.com, 2021). The rationale of stress management was to make the client cope up with the stressors in his life as he wasn't able to cope up with them. The client was taught different stress management skills such as getting a morning walk, deep breathing and relaxation technique, doing exercise, spending time with loved one, spending time with nature, listening to music in the case of client he likes to sing songs and recite naat. The client recited naat in the last session.

### **Grief Therapy**

Grief therapy was provided in order to help the client in processing unresolved feelings associated with the death of his parents. During these sessions, the client was encouraged to open up about his memories, attachment, and the emotional impact of losing his parents, which he had previously avoided discussing. The client was able to express previously suppressed feelings of despair, helplessness, and longing. The process of emotional catharsis reduced his internal emotional burden and resulted in a noticeable decrease in emotional tension and physical discomfort, establishing the link between unresolved grief and somatic symptoms.

### **Sleep Hygiene**

Sleep hygiene refers to having a comfortable environment for sleep, comfortable bed and a proper sleep schedule. (Suni & Vyas, 2020) Sleep Hygiene was taught to the client in order to improve his sleep. The client was taught sleep hygiene tips. The client was told about sleep hygiene that he has to make a proper and comfortable bed, wearing comfortable clothes before sleeping, read a book before sleeping etc.

### **Outcome**

The outcome was that the client has insight about his problem triggers. He got to recognize and accepted his psycho-social stressors which were the root cause of the client's problem. The client got to know ways to control his anger, manage stress and anxiety about his symptoms.

### **Session Reports**

#### **Session 1**

The junior Clinical Psychologist explained the therapy procedure and the client's current somatic issues. Rapport was developed, and a baseline anger level was obtained.

#### **Session 2**

Detailed clinical history was taken, and supportive counseling was provided for emotional expression. Baseline measures of sleep problems and recurrent negative thoughts were administered.

#### **Session 3**

Anger management techniques such as deep breathing and behavioral pause were introduced to reduce emotional arousal. Practice was done during the session.

#### **Session 4**

Further psychosocial history was explored, and sleep hygiene education was provided. The client was guided on improving sleep routine and relaxation.

#### **Session 5**

A combine session with the client's wife was conducted to assess relationship stressors. Psychoeducation and relationship counseling were initiated.

#### **Session 6**

Stress management was provided using simple physical and distraction-based techniques. The aim was to reduce focus on physical symptoms.

#### **Session 7**

The Thematic Apperception Test (TAT) was administered to explore emotional conflicts and marital dynamics. Findings were used for treatment planning.

#### **Session 8**

Cognitive restructuring was introduced through verbal discussion and role-play. The CBT triangle model was used to explain the mind-body link.

#### **Session 9**

Grief counseling and emotional catharsis were provided for unresolved parental loss. The previously taught techniques were reviewed and reinforced.

#### **Session 10**

Post-treatment ratings showed significant symptom reduction, with complaints reduced to 5/10. Therapy was terminated at the client's request, and he was discharged.

### **Discussion**

In the current case, the client's prominent manifestation of somatic and physical aches such as headache, stomachache, pain in neck and ribs and throat dryness combined with high anxiety and negative thoughts represents are features of somatic symptom disorder. It is the expression of psychological distress as physical or bodily symptoms. After ruling out various

medical and psychiatric diseases, the client was diagnosed with somatic symptom disorder (SSD) after consulting with his doctor and observing him during a few therapy sessions. The client demonstrated compliance with the psychologist but was initially hesitant to perform therapy exercises or do homework, most likely due to low awareness of psychological treatment and discomfort with structured activities, which is common in the Pakistani cultural context where mental health stigma exists (Husain et al., 2020). This phenomenon has been well-documented and studied in Pakistani and other non-Western contexts, where emotional or psychological trauma is commonly converted into physical symptoms due to cultural expressions of suffering and where people don't understand or accept mental illness (Wazir et al., 2023).

Somatic symptom disorder (SSD) refers to a mental condition in which a person experiences physical symptoms that are distressing, interfere with daily living, and cause excessive worry or attention on the symptoms. These symptoms may have a medical origin or no apparent explanation, but what matters most is how much they impair the person's emotions and daily functioning (Morie et al., 2022).

The DSM-5 defines somatic symptom disorder (SSD) as a condition in which a person has one or more physical symptoms that cause them to spend an excessive amount of time, energy, or worry on those symptoms, even if the symptoms have no obvious medical reason. SSD differs from prior DSM diagnoses like somatization disorder or hypochondriasis in that it focuses on how the person thinks and feels about their symptoms rather than whether they are medically explainable. Many people who were previously diagnosed with these earlier diseases now qualify for SSD. This improved knowledge emphasizes the importance of careful assessment and collaboration among healthcare providers when treating such patients (D'Souza & Hooten, 2023). In such situations, clients may prefer to report physical symptoms over emotional, mood, or psychological one. This is due to the fact that somatic symptoms are perceived to be more

legitimate, acceptable and less stigmatized than mental health issues (Wazir, et al., 2023).

According to Sigmund Freud's psychoanalytic theory, unconscious emotional conflicts manifest physically as somatic symptoms. According to Freud, the mind transforms emotional stress into physical symptoms through a process called conversion or somatization when unpleasant ideas, unresolved grief, or inappropriate emotions like wrath, fear, or guilt are forced out of consciousness repressed. According to Freud, unresolved internal conflicts or traumatic past events might manifest as headaches, pain, or other physical symptoms because the body speaks when the mind is unable to express. According to this theory, physical symptoms are unconscious attempts to transfer mental distress into the body in order to reduce it (Yasky, 2023).

Somatic symptom disorder is not diagnosed simply because a person's physical symptoms are not medically explainable. A person is not given this diagnosis just because doctors can't discover a medical explanation. Instead, SSD evaluates how much a person thinks about, worries about, and reacts to their symptoms. It is diagnosed when someone becomes excessively preoccupied with physical symptoms, such as pain, weakness, or breathing problems, to the point where it causes significant stress or difficulty in everyday life. The person's thoughts, feelings, and behaviors about the symptoms are excessive or out of proportion, even if the symptoms may have a legitimate medical explanation (Kleinstäuber et al, 2025; Dunphy et al., 2019).

Globally, somatic symptom and related disorders (SSRD), including somatic symptom disorder (SSD), are recognized as widespread mental health disorders affecting a significant section of the population, with gender disparities in prevalence and clinical presentation. According to research, the prevalence of SSRD varies greatly depending on the situation, with estimates ranging from 5% to 7% in the general population and greater rates among therapeutic populations. Females are diagnosed at a higher rate than males, and women report higher levels of somatic complaints and symptom load, which may contribute to the observed gender

discrepancy (Agarwal & Nagaraj, 2025; Wazir et al., 2023). This is consistent with international results indicating that in healthcare facilities, a higher proportion of females present with physical symptoms and related psychological distress than males (Nazzal et al., 2021).

In Pakistan, research reveals a significant prevalence of somatic symptom presentations as well as gender inequalities influenced by culture and societal norms. A recent research of university students in Pakistan indicated that around 48.8% fulfilled SSD criteria, with female students (65.6%) having much higher rates than males (31.9%), revealing a gender difference consistent with global trends (Zahid & Ahmad, 2024). These data show that Pakistani women may suffer or report somatic distress more frequently, which could be impacted by cultural expectations, gender roles, and educational and social stressors.

Furthermore, research indicates that in Pakistani culture, emotional distress is frequently manifested as physical symptoms because mental health issues are widely stigmatized and viewed as less acceptable than physical disease. For instance, a study in Pakistan discovered that mental illness carries significant stigma, and people are more likely to regard physical illness as being real while distancing themselves from psychological problems, which can lead to individuals presenting emotional distress through bodily complaints and avoiding seeking mental-health care (Husain et al., 2020).

The holistic psychological treatment approach utilized in this case, which included psychoeducation, supportive therapy, relaxation exercises, stress management, sleep hygiene, distraction strategies, and projective testing such as TAT, appeared to be effective for somatically manifested discomfort. Studies also supports the use of multiple psychotherapy in the treatment of somatization disorder and patients frequently benefit from therapies that combine cognitive, behavioral, and supportive elements to alleviate physical symptoms and related anxiety (Kumar & Jahan, 2021).

First, psychoeducation and supportive counseling were provided, using simple language and verbal

discussion to explain the relationship between stress, emotions, and physiological sensations and helping the client in understanding that his physical symptoms were influenced by psychological variables. Individual counseling was provided which included catharsis by enabling the client to express his emotions verbally in which he share recollections of his late parents, and discuss personal concerns, all of which helped reduce emotional tension. Moreover, emotional regulation skills were taught through simple exercises like guided breathing, short relaxation sessions, and pausing before reacting to strong emotions, which helped him control aggression and frustration.

Moreover, cognitive behavioral therapy and cognitive restructuring were carried out through verbal discussion and role-playing, allowing the client to recognize and adjust negative attitudes regarding his symptoms. Aaron T. Beck developed Cognitive Behavioral Therapy (CBT), which uses this technique to help clients confront negative and irrational thinking, improve emotions, and cope better with symptoms. CBT therapies can help clients with somatic symptoms and related disorders by explaining how thoughts, feelings, and behaviors are linked and reducing symptom distress (Cherry, 2025). Cognitive behavioral therapy (CBT) is a prevalent and highly effective intervention technique for dealing with a variety of mental health issues i.e overthinking, anxiety & depression (Early & Grady, 2017; Yarwood et al., 2024).

A current study of CBT group treatment for somatic symptom disorder found that structured CBT interventions led to decreases in somatic symptom severity, anxiety, and stress, indicating that helping clients understand and change unhelpful thoughts and behaviors can reduce physical symptoms and emotional distress (Jongsma et al., 2023). Therefore client was also shown the CBT triangle model, which describes how thoughts, feelings, and behaviors interact and impact one another (Sutton, 2024). This helped him realize how negative thoughts and powerful emotions may cause his physical

symptoms, helping him to grasp the connection between his mind and body.

Anger management, stress management, and relaxation techniques were employed to assist the client in dealing with his somatic complaints and anxieties. Simple strategies for reducing frustration and stress included counting slowly, pausing before reacting, deep breathing, light physical activity, walking, listening to music, and performing short relaxation exercises. Relationship counseling and couple therapy helped him communicate better with his wife, handle issues more calmly, and lessen emotional triggers for physical symptoms. Grief therapy was implemented, which encouraged him to relate recollections of his late parents and express his emotions verbally, thereby assisting him in processing loss. During therapy, the client claimed that his anger, somatic symptoms, and related anxiety had greatly lessened, which his wife also observed.

In a post-symptom rating, he rated each complaint 5 out of 10, indicating significant improvement. Following this progress, he chose to discontinue therapy and was discharged on his own choice with noted changes in his behaviors and symptoms.

M.A.'s physical symptoms are better accepted given the context of his Asian, collectivistic, and Pakistani cultural background, as well as his lower socioeconomic status. Emotional distress is rarely openly acknowledged in Pakistani society due to stigma, societal expectations, and a lack of mental health understanding, particularly among those from lower educational and economic backgrounds. As a result, psychological stress is frequently expressed as physical complaints like pain and discomfort, which make them more accepted (Husain et al., 2020).

As a member of a collectivistic society, the client faced numerous stressors such as family responsibilities, marital relationship troubles, financial pressures, and unresolved grief while putting family needs over his own emotional expression. According to research from South Asian contexts, people from lower socioeconomic families are more sensitive to somatic symptom disorder due to persistent stress, a lack of coping

mechanisms, and limited access to mental health care (Rizvi et al., 2021; Henningsen et al., 2022). According to studies, culturally sensitive, supportive, and practical psychological interventions are especially effective in such populations because they help clients gradually understand the relationship between emotional distress and physical symptoms while respecting cultural values (Naeem et al., 2020). Thus, M.A.'s presentation and positive response to therapy demonstrate how somatic symptoms can be a culturally shaped manifestation of distress in Pakistan, emphasizing the significance of culturally competent psychological care (Kohrt et al., 2021; Naeem et al., 2020).

#### Limitation

1. The limitations faced initially were that the client was in denial he used to say that everything is fine and didn't accept the reality.
2. After probing and taking sessions that client was probed and client revealed his psychosocial stressors.
3. In the last session the client's wife told that his husband at times cries for his parents and says that why have you left me, take me with you. Moreover, the client revealed anger and conflict with his wife in TAT in the very 7<sup>th</sup> session which should have been applied earlier.
4. The sessions were conducted in ward and there were many patients, staffs and attendants which might have hampered the privacy and confidentiality.

#### Recommendation

- Couple counseling can be provided to the client to resolve their conflicts.
- Emotional Regulation can be provided to the client to process the unhealthy emotions.
- Personality can be assessed for proper management related to personality.

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