

The Lived Experience of Chinese Patients With Somatic Symptom Disorder: An Interpretative Phenomenological Analysis

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Research Article

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Abstract

Aim

To deeply explore the subjective illness experience of patients with Somatic Symptom Disorder (SSD) throughout the entire course from the initial onset of symptoms and repeated medical consultations to receiving psychological interventions.

Methods

Interpretative Phenomenological Analysis (IPA) was adopted. Purposive sampling was used to recruit 8 patients meeting the diagnostic criteria for somatic symptom disorder in DSM-5 from the clinical psychology department of a tertiary general hospital between June 2025 and December 2025. Semi-structured in-depth interviews were conducted with these patients. After verbatim transcription of interview recordings, data analysis was carried out in accordance with the six-step coding procedure of IPA.

Results

Four main superordinate themes emerged from data analysis: (a) Embodied processing of distress and enduring somatic imprinting; (b) An unsafe living world co-existing with Symptoms; (c) Tracing symptom origins and the journey of help-seeking; (d) Self-growth within the lived experience of symptom co-existence

Conclusion

The underlying driving force for patients with SSD is fear of death. These individuals frequently endure intense feelings of helplessness and insecurity, yet they consistently attribute their symptoms to physical pathology. Healthcare providers may obtain medical histories from patients with SSD to assess their emotional difficulties, family-related factors, personality traits, and illness-related beliefs. Furthermore, clinicians ought to provide feedback on physical-examination findings, refrain from redundant investigations, and validate patients' distress through empathic responding. It is essential to reframe the meaning of symptoms: draw connections between symptoms and stress- or lifestyle-related triggers; illustrate the anxiety-to-illness transition pathway, alongside the vicious cycle that sustains somatic symptom responses.

Introduction

There are many patients in medical setting complain of symptoms which cannot be attributed to any conventionally defined medical disease or mental disorder. Many terms have been used for this

condition e.g. medically unexplained symptoms, somatoform disorders, functional symptoms, functional somatic syndromes, neurasthenia or nervous autonomic function disorder. Following the latest revisions of diagnostic criteria for persistent and bothersome somatic symptoms, psycho-behavioural features are now a necessary criterion for a diagnosis of Somatic Symptom Disorder (SSD) according to DSM-5 and Bodily Distress Disorder (BDD) according to ICD-11 (APA, 2013) (WHO, 2019).

SSD was the most frequently investigated disorder, with prevalence ranging from 12% to 46%(Eid, Kheir, Bizri, Larnaout, & El Hayek, 2025). In China, the mean frequency of SSD was 4.5% in the general population, 25.2% in the primary care population and 33.5% in diverse specialized care settings (Wu et al., 2023). Patients endure long-lasting distressing somatic complaints including palpitations, persistent cough, epigastric pain, dizziness, generalized bodily aches, panic-induced chest tightness and insomnia, accompanied by disproportionate, enduring health anxiety and repeated medical consultations (Seo et al., 2024). Even after comprehensive negative laboratory and imaging examinations, patients cannot relieve their persistent fear of physical illness. The burden of these kinds of disorders is high and associated with impaired physical and mental quality of life(Wu et al., 2023). The patients would also increase their utilization of healthcare services and likely to develop of comorbidities like depressive and anxiety disorders (Hsu et al., 2025).

Researches proved that Chinese patients were more likely to express their psychological frustration, interpersonal conflicts or life traumas through somatic symptoms (Yin, Wardenaar, Xu, Tian, & Schoevers, 2020). In Chinese society, emotional distress is often expressed through physical symptoms, a tendency that may be further reinforced by widespread difficulties in identifying and articulating emotions(Chio & Zaroff, 2015). At the same time, persistent stigma surrounding mental health can discourage individuals from seeking psychological care, leading many to present their symptoms in general medical settings instead(Shi, Shen, Wang, & Hall, 2020). Moreover, deeply rooted biomedical and traditional Chinese medicine beliefs may lead patients to interpret physical discomfort as evidence of underlying organic disease or disrupted qi, thereby encouraging repeated auxiliary examinations and contributing to prolonged cycles of somatic medical consultations(Yang, Zhou, Zhou, & at al.,2019).Qualitative evidence further confirms that Chinese patients with somatization symptoms often adopt a biomedical understanding of their symptoms and initially seek care from non-psychiatric departments. In a qualitative study of 10 Chinese patients, participants initially attributed their discomfort to physical problems and sought treatment across multiple medical specialties before eventually turning to psychological services(Shu, Ma, & Zhao, 2023).The research shows that patients with physical discomfort from multiple medical conditions tend to rely on non-professional sources rather than formal mental health services(Fang et al., 2019). At the same time, many patients seem to prefer a multi-pronged approach to seeking medical treatment. A large number of patients with physical symptoms in China will move between different departments, visiting both Western medicine and traditional Chinese medicine practitioners, hoping to achieve a complete cure for their diseases(Ma et al., 2023).

Generally speaking, much of the existing literature about SSD is quantitative research and from etic perspectives of the general population toward people with SSD. Studies on emic perceptions of patients about their understanding of the cause and treatment of SSD, the influence of their social interaction, and daily life about the discomfort symptoms from their own point of view are still scarce (Löwe et al., 2022). Previous studies on SSD have mostly focused on adolescents or the elderly, with relatively little attention paid to the young-and-middle-aged population. A previous study reveals that the presence of SSD is associated with a significant decrement in role functioning even among persons with no co-occurring physical or mental disorder; nevertheless, the common comorbidity with either physical or mental disorders increases the level of role impairment (Gureje et al., 2025). This fact provided strong reason for SSD to get clinical attention.

Middle-aged and young people are the backbone of society, and whether their functions are impaired is extremely important for both families and society. Therefore, this study adopted a qualitative approach based on Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of Young and Middle-Aged SSD Patients in China (age from 18–45). This study aims to fill the gap in localized qualitative research on SSD, clarify the unique illness experience of Chinese SSD patients, narrow the doctor-patient cognitive gap, and provide targeted theoretical references for culturally adaptive psychosomatic intervention and clinical health education.

Methods

Participants

8 participants were recruited between September 2024 and February 2025 from East Hospital of Tongji University, Shanghai, China. All participants fulfilled the following criteria: aged between 18-45 years old; no evidence of organic disease had been detected by physicians in previous examinations; two attending psychiatrists assessed that the patient meets the DSM-5 diagnostic criteria for SSD, with or without comorbid depressive disorder, panic disorder, and generalized anxiety disorder. **Meanwhile**, Patients with organic mental disorders, substance dependence, schizophrenia, bipolar disorder, and eating disorders were excluded. The participants’ demographic characteristics are listed in Table 1.

[Insert Table 1]

Ethical Standards

The research proposal received ethical approval from Shanghai Pudong New Area Mental Health Center and departments of the hospital (No. PDJW-KY-2025-010). Each participant was informed of the purpose of the research and a consent form was signed. Interviews were conducted when patients felt able and willing to share their feelings and thoughts about their post traumatic growth experiences. Confidentiality was ensuring by using numbers instead of names (e.g., P1, P2) and removing identifying information from the transcripts.

Data Collection

Semi-structured interviews were performed with every participant in a private interview room. The interviews were conducted by three researchers who had conducted qualitative research for at least 1 year. The interviews were audio-recorded with the participants' permission and then transcribed verbatim. Field notes including the participants' demographic data, the main content of the interviews and the self-reflections of the researchers were also made before, during and after the interviews. Each interview was conducted until the participants' experiences were well-explained and no new information was available. The following semi-structured interview guide was used during the interviews:

1. Could you tell me where you feel unwell? (When did these discomforts start? Under what circumstances do these discomforts usually occur? Under what circumstances do they subside? How do you explain the causes of these discomforts?)
2. Could you talk about your medical experiences in dealing with these discomforts? How did the doctors in these departments explain your condition?
3. Which of the treatments you have received do you think have been helpful to you? (Have you learned anything during this illness?)
4. Besides seeking medical treatment at hospitals, what other measures have you taken to cope with these discomforts?
5. What is the most distressing problem for you right now? (The condition itself? The attitudes of people around you? Other issues?) What impacts have these problems had on you? (Your work, family, interpersonal relationships?)
6. What do the people around you (family, friends) think of your discomforts? What do they believe is the cause of your problems? (How do you feel when others do not understand you?)
7. How do you plan to deal with your discomforts next?

Data analysis

The transcribed interviews were analyzed following Smith et al.'s guidelines (Smith JA, 2009). The transcripts were read several times, and the left-hand margin was used to annotate what was interesting or significant about what the respondent said. The second step was initial noting, in which the semantic content and language use were examined in a very exploratory manner. The process of initial coding included descriptive, linguistic, and conceptual comments. The third step was developing emergent themes. The main task in this process was to reduce the volume of detail while maintaining complexity in terms of mapping the interrelationships, connections, and patterns among the exploratory notes. The fourth step consisted of further reducing the data by establishing connections between the preliminary themes and clustering them appropriately. Finally, a table was produced that showed each higher-order

theme and the subthemes that composed them. After the analysis of each interview separately, connections among the superordinate themes across the interviews were identified. Several strategies were used to ensure trustworthiness and credibility. Two coauthors analyzed the transcripts independently by bracketing their preconceived ideas and strictly following the adapted method from Smith et al. described above. The findings were then compared and discussed by two authors until consensus on themes, theme clusters, and superordinate themes was achieved. After completing the analysis, we chose three analytic texts to return to the participants and asked them to evaluate whether the text analysis was in line with their real life experiences.

Findings

From our analysis, four superordinate themes emerged as the Struggling with Symptoms, each with several subthemes. The finalized thematic map is shown in Figure 1. They are discussed in detail below.

[Insert Figure 1]

Theme1 Embodied processing of distress and enduring somatic imprinting

This theme emerges from participants' in-depth accounts of the internal perceptual experiences accompanying recurrent episodes of somatic symptoms. It centers on individuals' subjective perceptions and lived feelings regarding the relationships among their emotions, physical bodies and selfhood amid physical distress. Participants could identify pent-up negative inner feelings yet lacked effective strategies to regulate or manage them, leaving these emotions to manifest solely through diverse physical discomforts. Prolonged physical pain with no identifiable organic basis creates a sense of separation between the self and the body. The body no longer feels integrated into one's whole identity; consciousness passively endures relentless physical torment, accompanied by intense feelings of alienation and detachment. Recurrent physical distress gradually consolidates into automatic bodily responses activated without conscious effort. When stressors emerge, physical suffering surfaces involuntarily, forming entrenched somatic memories.

Subtheme1 Embodied externalisation of unregulated negative emotions

A comprehensive synthesis of symptomatic episodes reported by all participants revealed no distinct situational precipitants. Nonetheless, every episode unfolded following an identical sequential pathway: awareness of fear, heightened subjective fear perception, failure of intentional conscious emotion regulation, and subsequent embodied transformation into somatic symptoms. This progression suggests that negative affective states fail to be processed and attenuated within conscious cognitive systems; instead, unregulated distress is somatically externalised as uncomfortable bodily and visceral sensations. Thanatophobia, the persistent dread of mortality, was identified as the primary driver of progressive symptom aggravation. The debilitating affective distress arising from unmanaged fear trapped participants in an inescapable cycle of persistent somatic discomfort.

Excerpts from Participant 1 and Participant 6 illustrate this pattern:

"At first I couldn't fall asleep, and the more I feared being awake, the more insomnia plagued me. I had no idea whether I would be jolted awake by a coughing fit or a racing heart in the middle of the night. By the wee hours, I started experiencing palpitations and my whole body trembled." (P1)

"I believe my condition originates from fear, above all the fear of death. The greater my dread, the more severe my symptoms become. For instance, during my subway trips between Pudong and Puxi, the train traverses an underwater tunnel beneath the Huangpu River. Intrusive catastrophic thoughts emerge that the tunnel might collapse. Despite deliberate efforts to suppress these ruminations, such catastrophic cognitions involuntarily dominate my mind, leaving me overwhelmed by the conviction that a fatal catastrophe will occur." (P6)

Subtheme2 Mind-body alienation: conscious self as bystander of physical suffering

Some interviewees frequently use the pronoun "it" to refer to their bodies during episodes. Chronic, unrelieved physical suffering severs the connection between body and mind, turning the body into an external object beyond one's control. The conscious self strives to gain mastery over physical symptoms, yet the harder it tries to exert control, the more powerful "it" becomes, leaving the conscious self to passively watch the unceasing physical discomfort unfold. Take Participant P4 as an example:

"I don't know what triggers it; it just strikes out of nowhere. I lose all control over my nerves and thoughts. It grows increasingly severe, like a domino effect, amplifying every single emotion and symptom of mine bit by bit. Then I become completely immobile, frozen in place. My mind goes blank during those spells, incapable of processing a single thought." P4

Participant P8, who has a shorter course of illness, likens panic attacks to an ever-looming dark cloud:

"Panic attacks are like a dark cloud hanging constantly over my head. It follows me wherever I go, and I can never shake it off." P8

Subtheme3 Physical symptoms internalised as automatic somatic memories

Chronic anxiety and mental exhaustion separate symptoms from their original triggers, solidifying them into habitual physical responses beyond conscious control. The threshold for tolerating distress keeps lowering, and triggers such as public spaces, social engagements, and environmental shifts can randomly set off these automatic physical manifestations. Take Participant 1 and Participant 4 as examples:

"This really happens to me. Whenever I'm facing something urgent or under stress, I feel an urge to cough, followed by shortness of breath. Persistent coughing leads to gasping, and then my hands and feet go numb—that's the whole sequence." (P1)

"This condition is just like riding a bicycle; once you learn it, you never forget it. People who've never had an episode might never experience it in their lives, but after I had one attack, then another, it turned into an ingrained pattern. I don't know how to fully reset my nervous system back to normal." (P4)

Theme2 An unsafe living world co-existing with Symptoms

The sense of loss of control stemming from potential sudden symptom flare-ups undermines individuals' inherent sense of stability and security in daily life. Their range of accessible activities shrinks, with home and hospital described as the only safe spaces; all other environments feel unsafe and unmanageable to navigate alone. The agonizing experience of flare-ups makes them doubt the continuity of their lives, leaving them unable to envision the future. Fixation on symptoms consumes most of their daily time, resulting in impaired multi-dimensional social functioning.

Subtheme1 Shrinking of safe living spaces

Nearly all interviewees stated that their range of activities has been restricted since the onset of their illness. They judge whether a space is safe solely based on the risk of physical discomfort episodes. Going out, travelling far, unfamiliar venues and crowded environments are all perceived as dangerous spaces likely to trigger physical symptoms. To avoid the embarrassment and helplessness brought on by sudden symptom flare-ups, individuals voluntarily narrow their scope of free movement. Home and hospitals are regarded as the only two controllable and safe areas, while all other places are labelled unsafe. Take Participant 4 and Participant 8 as examples:

"Going outside is a hurdle for me. The only places where I feel safe are my home and the hospital. My mood calms down and stabilizes only in these two spots." (P4)

"I can't seem to find any safe places apart from home and the hospital. I don't feel at ease around anyone right now except my father, and I have to ask him to accompany me whenever I go out." (P8)

Subtheme2: Questioning the continuity of one's life

Symptom attacks thrust them from a predictable, routine life into an unknown and uncontrollable existence. The agony endured during flare-ups makes patients doubt the continuity of their own lives, compelling them to repeatedly check whether their bodies remain healthy. Take Participants P1 and P3 as examples:

"I feel absolutely terrible with these cardiopulmonary symptoms! I'm in so much agony, thinking I'm dying and won't make it. The Oriental Hospital is close to my home, and I've been there countless times." (P1)

"My view is that just because heart disease doesn't show up on today's tests doesn't mean it won't develop tomorrow. You have to monitor its dynamic changes at all times. ... When panic hits, your first thought is the last hospital exam that confirmed I was perfectly fine." (P3)

Subtheme3 Pre-existing interpersonal relationship dilemmas

Chronic exhaustion caused by recurrent somatic symptoms, coupled with the fear of experiencing unassisted symptom attacks in public settings, leads patients to actively avoid social interaction. Since their physical symptoms lack organic pathological evidence, patients are frequently confronted with doubt and misunderstanding from others, resulting in profound estrangement and loneliness across familial, friendship, and social domains. Five participants reported that their family members failed to recognize the severity of their condition and expressed dissatisfaction with their impaired social functioning. Meanwhile, illness-induced guilt and shame further undermined their marital intimacy. As P8 described: *"My family thinks I am overreacting and making trouble out of nothing. I have changed jobs multiple times, earn less than before, and constantly complain of physical discomfort, yet no abnormalities have been identified after extensive hospital examinations, which leaves them feeling exasperated. I feel deep guilt toward my wife and have even considered divorcing her. Even if my wife does not mind my condition, my parents-in-law will surely disapprove."* (P8)

Participant 4 endured panic attacks and persistent fear of death in isolation. Family members' persistent incomprehension further discouraged him from sharing his inner struggles and symptomatic experiences with others.

"My parents insist that my dizziness stems from cervical problems. They cannot understand my real condition no matter how I explain it, so I choose to stay silent. They accuse me of being lazy and lying in bed all day, but I rest merely to relieve my physical discomfort, not out of idleness." (P4)

Widespread misunderstanding from others constitutes a major source of patients' emotional distress. "Just cheer up" has become the most common yet ineffective advice patients receive in daily life. Fear of being stereotyped as abnormal or mentally ill prevents participants from disclosing their condition to colleagues and friends, which partially explains their reluctance to accept formal psychiatric diagnostic labels.

P1: *"Once people learn that your condition is related to mental health, they tend to assume that it is intractable. Knowing that you have received treatment at a psychiatric hospital will make them label you as 'mentally ill' and believe that you will suffer from this condition permanently."* (P1)

P6: *"Others' judgmental attitudes distress me greatly. Increased life stress easily triggers my symptoms. Tasks that appear simple to others can be extremely difficult for me to accomplish, yet people fail to understand my struggles and mistakenly believe that I am deliberately refusing to cooperate or make things difficult for others."* (P6)

Subtheme 4 Impairment of multi-dimensional social functioning

Persistent and lingering physical distress completely undermines individuals' originally stable social roles. In daily life, they lose the ability to travel alone, handle errands, and take care of themselves independently. Although P5 and P8 are already parents, their fear of symptom flare-ups reduces them to dependent children unable to fend for themselves.

"When I'm extremely anxious, I dare not go to the hospital alone because I've had panic attacks here before. My dad always accompanies me when I come for treatment." (P5)

"I only feel at ease when I'm with my dad, and I can't go outside without him by my side. Sometimes I feel ashamed that I still have to rely on my father even at my age. I hope I can become independent soon, but I just can't manage it right now." (P8)

Occupationally, they struggle to complete work tasks and hold down steady jobs; four participants transferred to different positions or resigned due to their illnesses, as recounted by P1 and P2:

"I used to work an office job, but I constantly felt irritable and overwhelmed by the heavy workload assigned by my supervisor. I lost confidence in my ability to get things right, and the more I worried, the more mistakes I made. After discussing it with my family, I quit my job... I spend most of each day fighting these physical symptoms. I'm neither happy nor bored, just trapped." (P1)

"My mind is constantly fixated on my physical discomfort and how to deal with it—how could I possibly focus on work?" (P2)

Socially, they are unable to take part in gatherings, outings and other social activities. Their capacity to fulfill multiple social roles fades one after another, leaving them unable to live up to their social identities and further intensifying their sense of loss of control and unease about life.

As P6 articulated :*"I can't go out for fun. Lots of people invite me out, and my wife suggests we go somewhere to relax on weekends, but I absolutely hate going out on Saturdays and Sundays. I have no desire to leave home at all; staying quietly indoors is the only thing that feels safe to me." (P6)*

Theme 3: Tracing symptom origins and the lived journey of help-seeking

All eight interviewees began seeking medical treatment due to physical discomfort. The duration of their symptoms ranged from six months to seven years (six participants had suffered symptoms for over three years, and two for less than three years). Almost all patients had consulted multiple departments in various general hospitals. Repeated CT scans, magnetic resonance imaging (MRI) and blood tests revealed no organic lesions. They often described their experience with symptoms using words such as inexplicable, irregular and out of control. The symptoms defied explanation by daily life experience yet lingered constantly. The desire to figure out the root causes of their symptoms and find scientific coping methods constituted the core reason why every interviewee kept seeking medical advice repeatedly.

Subtheme 1: Ingrained physical-centered health beliefs

The fundamental question of what was wrong with their bodies stemmed from their adherence to the biomedical disease model, which drove the participants to raise all kinds of doubts and thus travel between different hospitals and departments for a long time. Their various hypotheses were continuously disproved through repeated examinations and verifications. Statistics showed that before

visiting the psychiatric department, Interviewees P1 and P4 had consulted more than ten tertiary hospitals in Shanghai; in their own words, they had visited nearly every department of those hospitals. P8, whose illness had only lasted six months, had received treatment in at least four departments by the time of the interview. Traditional Chinese Medicine, Gastroenterology and Cardiology were the most frequently visited departments. They hoped that non-psychiatric departments in general hospitals could provide convincing explanations for their physical symptoms, as stated by P2:*"I've visited numerous departments and undergone gastroscopy, colonoscopy and gynecological examinations. I just want to figure out exactly what's wrong with me. I trust the results of scientific examinations a lot. If there's something wrong with my body, getting tested puts my mind at ease."* (P2)

P1 has a seven-year medical history and has consulted internal medicine doctors many times, yet he still insists on seeking biomedical evidence for his symptoms: *"I've had two chest CT scans in three months and visited the ENT department twice in one week. I was hospitalized last week and had seven vials of blood drawn; all test results came back normal. But sometimes I still wonder if the doctors missed something, if there's an underlying issue that hasn't been detected yet."* (P1)

To prove that their symptoms stem from biomedical causes, these patients spare no expense on all kinds of medical tests. P4, who has suffered from symptoms for over seven years, is a frequent visitor to major hospitals across Shanghai, spending more than 50,000 yuan on medical care each year.

"I've been unwell for such a long time that I've memorized the addresses of nearly all hospitals in Shanghai. I've been to most of them countless times." (P4)

P3 also holds medical tests in extremely high regard. As he recounted: *"My doctor told me the hospital had just acquired the latest PET-CT scanner. A full-body scan costs over ten thousand yuan and isn't covered by medical insurance, but I didn't hesitate at all and paid right away to get the scan."* (P3)

Subtheme2 Retrospective reflection on psychosocial triggers underlying symptoms

Frequent consultations across various clinical departments and biomedical examinations fail to yield objective evidence accounting for their physical symptoms or effective relief measures. The physical symptoms persistently recur like a learned habit or an unwelcome visitor, leaving interviewees confused and perplexed about the true nature of their ailments. Referrals to psychological departments or mental health institutions also prompt some patients to reflect on the origins of their symptoms. Their illness narratives reveal a clear correlation between the onset or exacerbation of symptoms and stressful life events they have experienced as well as their distinct personality traits.

[Insert Table 2]

Subtheme3 Ambivalent emotions toward referral for psychiatric consultation

Some patients expressed acceptance of being referred to the psychiatric-psychological department and held high expectations for psychiatric diagnosis and treatment. For instance, Participant 1 regarded the

referral to the psychiatric department as the most helpful measure in her treatment-seeking journey.

"After seeing so many doctors with little benefit, I think the greatest help came from the traditional Chinese medicine practitioner who told me that I ought to visit the psychiatric and psychological departments." (P1)

After years of treatment, Participant 6 placed high hopes on psychiatric care: *"This (visiting the psychiatric department) should be my last resort. I have struggled for three years with no improvement, and I am on the verge of breaking down..."(P6)*

Participants P2 and P7 expressed distrust toward referrals to the psychiatric-psychological department, and felt confused or indescribably ashamed about psychiatrists' explanations for somatization.

"Everyone gets anxious, but does it have anything to do with physical discomfort? Physical discomfort is just physical discomfort; what does it have to do with psychology?" (P2)

"The gastroenterologist suggested I see the psychology department. I just came over since I had nothing else to do. Otherwise, I wouldn't have come. I don't think it's a mental illness. It's clearly physical discomfort. When internal medicine can't find anything wrong, they just pass the buck to you (psychiatry department)...." (P7)

Fearing misunderstanding from others or disease-related stigma, they tended to explain their symptoms using non-psychiatric diagnoses.

"I probably wouldn't tell them it's an anxiety-related panic attack. I might say I'm having an asthma attack, because I think they wouldn't know what that (panic attack) is. Most people know a little about asthma. They know asthma is dangerous and serious, but they would think anxiety is nothing – everyone gets anxious sometimes." (P1)

Subtheme4 Navigating multiple treatment approaches amid inner contradictions

Although all patients acknowledged the correlation between psychosocial factors and their symptoms, some participants (P2, P3, P7) still harbored doubts about psychiatrists' explanations for their symptoms. Other patients, even though they accepted psychiatrists' interpretations of their symptoms, remained wary of psychiatric medication treatment, fearing dependence and addiction. Take P2 and P3 as examples:

"I didn't dare take sleeping pills because people say they cause dependence. I also didn't dare take the mood-regulating medication. I'm very worried about taking medicine, after reading the side-effect descriptions." P2

P3 repeatedly used the term "take" to express fear of addiction to psychiatric medications: *"I didn't take a single pill Dr. Ma prescribed for me. I read about the drug side-effects and I'm not sure if I can tolerate them. I take psychiatric substances very seriously. It's better to stay away from such things. I won't take them."P3*

All patients, even those referred to the psychiatry department, whether they accepted or declined psychiatric interventions, kept going from one major hospital to another across Shanghai to seek treatment from various departments, especially traditional Chinese medicine treatment. Nearly all participants mentioned trying traditional Chinese-medicine health-preserving approaches "including herbal medicine, qigong, acupuncture, massage, cupping, practicing the Five-Animal Frolics, and taking folk remedies". Hoping to regain health through physical conditioning was the wish of most research subjects, yet the expected therapeutic effects were not achieved.

"I was afraid of taking Western medicine and feared its various side-effects. Later I went to a traditional Chinese medicine hospital to get herbal prescriptions. I took them for about a month, but I felt there was little effect." P2

No reasonable explanations or symptom-control measures can be found through somatic medicine. There exists stigma toward psychiatry as well as concerns over adverse drug reactions. Nevertheless, most patients still insist that pharmacotherapy should be the first-line treatment. Only three patients have tried psychotherapy, and they also hold skeptical attitudes toward it.

"I have been receiving psychological counseling for two months, twice a week. My psychologist told me that I should go running every day. I know the measures he suggested are beneficial, yet I am unable to put them into practice." (P6)

Theme4: Self-growth within the lived experience of symptom co-existence

After tracing the origins of their symptoms and trying multiple treatments, some interviewees (P1, P3, P5) gradually achieved growth amid their struggles with physical and psychological symptoms. Such growth is reflected in aspects including "inner self-awareness, behavioural regulation in daily life, adjustment of interpersonal relationships, and re-evaluation of life values".

Subtheme1: Emergence of a reflexive self through struggles with symptoms

The study found that some patients (long-history participants P1, P5, etc.) experienced repeated conflicts between their conscious self and physical symptoms. Amid repeated setbacks and moments of relief from fighting symptoms, they gradually learned to coexist peacefully with symptoms by reviewing and reflecting on their personal traits and lifestyles. Take P1 and P5 as examples:

"I used to be extremely impulsive and argumentative. Even small things would trigger huge emotional swings, and I got angry easily. While I cannot change overnight, I now stop to think: 'Is winning an argument more important than my life?' I have become more laid-back." P1

"My way of thinking from childhood was like a building constructed crookedly. I felt out of place with the world and would fall apart at the slightest setback. Now I have a much better attitude toward life than I did before I fell ill, and I am far less irritable..... I used to be overly self-centered. I only thought about myself, always expecting others to change instead of changing myself." (P5)

Subtheme2: Rebuilding a sense of self-mastery amid disordered daily life

In the early stage of illness, the goal is to completely eradicate symptoms, and daily life revolves around combating physical suffering. As symptoms recur repeatedly, some research participants gradually let go of the obsession with a complete cure, come to accept the normalization of symptoms, and develop coping strategies amid their disrupted everyday lives. For instance, Participant P1's interaction with symptoms resembles a cat chasing its own tail. Within this endless, fruitless cycle, P1 gradually learned to engage with symptoms and slowly regained a sense of mastery over the body.

"Sometimes when it strikes suddenly and I feel terrible, I tell myself: 'It's fine, it's just a panic attack. It's all fake, all in your head; your nerves are just misfiring.' I talk to myself now, which I never used to do. I used to be so scared I would call 120." (P1)

After P5 and P6 gave up resisting their symptoms, they also gradually experienced positive turns:

"I don't care anymore. If I'm going to die, so be it. I stopped paying attention to the symptoms, threw myself into work, looked after my kids, and lived in the moment. Slowly I stopped fixating on them, and they got better, faded away little by little." (P5)

"Someone told me I could set it aside when I'm busy and reflect on it when I have free time. Doing that really does reduce my worries a bit." (P6)

Subtheme3 Rebuild relationships with others amid interpersonal dilemmas

Unexplainable symptoms, physical suffering, and impaired social functioning often leave clients trapped in loneliness, longing to be understood and supported. Amid their hardships, they actively seek supportive interpersonal resources, with family members frequently serving as the primary source of support. Participants P3 and P8 used to have highly estranged relationships with their parents, yet the onset of symptoms fostered connection between the two generations.

"My mother used to resist talking to me, but now she is willing to listen because she knows I am going through this issue." (P3)

"This illness has brought me closer to my family. My father and I barely communicated before; we only talked when something needed to be dealt with. Now my father and I are more like friends, and we have grown much closer." (P8)

After P5 fell ill, care and affection from her family repaired her early-life attachment trauma:

"My mother passed away long ago, and my grandmother raised me. After I got sick, I spent a long time with her. I discovered many shining qualities in her that I had never noticed before. As for my father, he is rigorous and tends to bottle up his feelings. Our time together during this period helped me understand him better, and I no longer hold resentment toward him." (P5)

Six respondents stated that they frequently searched online for information about relevant illnesses or joined peer support groups for "anxiety, depression, obsessive-compulsive disorder, and so on" to seek peer support. Three participants reported that exchanging experiences of anxiety with peers had a detrimental effect on them, as described by P6 and P7:

"I joined several groups during previous counselling sessions and communicated with people going through similar struggles. I found that the deeper we talked, the worse I felt, because I would project their symptoms onto myself." (P6)

"I once joined an anxiety peer group where mental-health-related content was posted non-stop. Some group members shared their treatment experiences, which I tried but found unsuitable. There was an overwhelming flood of information that left me agitated, so I simply quit the group." (P7)

Subtheme4 Reshaping the Meaning of Life While Coexisting with Symptoms

By reflecting on the origins of their symptoms and their respective coping journeys, P3 and P5 re-organised their thinking concerning existential issues such as life and death, and gradually found inner support in the face of death-related fears.

"My child is still very young. What will become of him if I die? I've come to terms with it. Illness is bound to happen, and there is nothing I can do to control it. I might as well be kinder to my child every single day, and treat my family and child as if each day were the last day of my life. ... I never used to think about why people live or how people die. After falling ill, my mindset has changed. Everyone has their hardships, and we are all going to die. You cannot keep dwelling on your physical discomforts every day. You should create something for others and offer others some help, and in this way you will find meaning in life."(P5)

After experiencing wealth and illness in life, P3 also began to reflect on the meaning of life:

"There was a period when I made a lot of money, which made me get a little too high-spirited. I went overboard, being overly free and indulgent. This life experience prompted me to reflect: I can't live such a meaningless life anymore. I want to do something meaningful, become stronger, and help more people." (P3)

Discussion

Four master themes emerged from the interviews, each with associated subordinate themes.

3.1 The first theme emerging from the data describes participants' embodied processing of distress and enduring somatic imprinting. Five patients who had experienced panic attacks reported a disruption in the connection between the mind and the body. During symptom episodes, the conscious self assumed the position of a spectator and was unable to exert regulation. This finding is consistent with reports from previous research showing that a common characteristic of somatic symptom disorder is the patients' troubled relationship to their body: they experience their body as dysfunctional and have

difficulty acknowledging and understanding body signals (Kalisvaart, van Broeckhuysen-Kloth, Busschbach, & Geenen, 2022). Death-related anxiety is an important triggering factor for the initial onset of patients' symptoms. Six participants mentioned that the first onset of symptoms occurred following the death or cancer diagnosis of a significant person in their lives. However, after repeated episodes, patients become more susceptible to external stimuli; the experience of an attack is like a learned skill, which can be triggered by even slight stress or environmental changes. It can reveal the function of somatic symptoms, namely acting as an automatic response pattern for patients to cope with stress, where patients express emotions through symptoms instead. One meta-analysis confirmed that alexithymia was found to be higher in patients with SSD (Smakowski et al., 2024).

A prior study has confirmed that individuals with high-sensitivity personality traits are more likely to report physical health complaints (Cavicchioli et al., 2026). Highly Sensitive Person (HSP) refers to individuals who possess the trait of "sensory processing sensitivity" (SPS) composed of features such as deep processing of sensory information, high emotional reactivity, easy overstimulation, and sensitivity to subtle detail. Participants in this study also exhibited personality traits similar to those of HSP, such as being short-tempered, argumentative, and over-thinking. This suggests that in clinical practice, we should comprehensively collect medical histories, explore emotional issues, discuss social and family factors as well as personality traits, investigate symptom- and illness-related beliefs, and understand patients' illness narratives. Sorting through patients' stories helps facilitate their emotional catharsis and cognitive adjustment.

3.2 Theme 2 focuses on the impact of symptoms on patients' lived experience. Participants reported profound insecurity, including fears of unsafe environments and impending death, which impaired their social functioning and substantially reduced their quality of life. According to cognitive neuroscience, when an individual is in an emotionally-activated state, rational thinking ceases to function and social engagement becomes difficult. This suggests that facilitating patients' emotion recognition and expression to free them from emotional blockages can serve as an entry point for psychological intervention in patients with SSD. One study has revealed that emotional awareness and expression therapy have positive long-term effects for somatic symptom disorder (Hallberg, Maroti, Lumley, & Johansson, 2025).

3.3 Somatic symptom disorders are prevalent worldwide, but their expression, help-seeking patterns, and management are strongly shaped by cultural context. One review (Eid et al., 2025) found that the common symptoms of the patients with SSD in Arabic culture included muscle, back, and abdominal pain, often accompanied by depression and anxiety. The symptoms reported by patients in this study included stomach discomfort, cardiac discomfort, dyspnea, sleep disorders, dizziness, and others. A study from eastern India reported that Only 10% believed their symptoms were psychiatric in origin, with most attributing them to medical conditions or stress—and this led to indirect healthcare pathways, as 90% sought help from non-psychiatric providers, causing delays in appropriate care (Abhijita, Balasubramanian, Padhy, & Mishra, 2026). In this study, patients with SSD had findings similar to those of the above-mentioned studies; they also firmly believed in explanations for their physical illnesses and

frequently visited general hospitals to seek non-psychiatric medical treatment. The difference was that patients in this study also sought various folk therapies (fortune-tellers, feng shui consultations, exorcism rituals) as well as traditional Chinese medicine treatments.

All the participants were persuaded by non-psychiatrists to seek psychiatric care. They had some reflection on the pathogenic role of psycho-psychological factors yet remained skeptical. They also held entrenched beliefs about psychiatric medications, such as “they are addictive and have severe side effects”, which prevented them from adhering to regular medication despite having visited the psychiatric department. While receiving psychiatric diagnosis and treatment, most participants still frequently underwent examinations and consultations in non-psychiatric departments of general hospitals. One notable observation was that only three participants received brief psychotherapy, and all participants stated that they did not believe psychological counseling or therapy could alleviate their symptoms. Nevertheless, amid their repeated medical visits, they had a strong desire to be heard. Taking Participant 1 as an example, she had kept consulting a traditional Chinese medicine practitioner for several years, drawn by the doctor’s patience and good-humored manner, which made her feel understood and supported.

This may be related to the fact that most psychotherapy services in China are self-funded, psychotherapy resources in outpatient departments of formal hospitals are in short supply, and private counseling clinics charge high fees. It may also stem from the public’s stigma against mental illnesses, which discourages them from proactively seeking psychiatric diagnosis and treatment as well as psychotherapy. (Naskar, Grover, Sharma, & Padhy, 2020). Reducing SSD-related stigma can modify patients’ illness behaviors and prevent disease chronicity. (von dem Knesebeck, Lehmann, Löwe, & Makowski, 2018). Public-oriented science communication for SSDs still has a long way to go.

The final theme focuses on the growth of SSD patients. Among the eight participants, P1 and P6 demonstrated partial growth, such as reflecting on and adjusting their behavioral patterns and finding a certain degree of room to coexist with their symptoms. P5 showed multifaceted growth; for instance, the participant was able to develop a reflexive self-awareness, form new understandings of the self, the meaning of life and death, and gradually gain a sense of control over symptoms.

An analysis of the factors behind P5’s growth can be summarized as follows: acceptance and attentive-listening from the family, the acquisition of abundant new insights after embracing Buddhism, and the supportive strength from his son, a significant figure in his life. This also suggests that systemic family therapy may offer a new perspective for intervening in patients with somatic-symptom disorders. For instance, the onset of patients’ illness is frequently linked to the death or serious illness of a key family member. Secondly, patients’ sense of shame surrounding their condition often prevents them from authentically voicing their feelings, and functional impairments brought on by the illness further intensify their feelings of guilt toward family members. These emotions also need to be processed and expressed within the family system.

Clinical implication

Integrating previous studies (Nair, Kwan, Ng, & Teo, 2021) (Croicu, Chwastiak, & Katon, 2014) and the findings of this study, the clinical implications of case-based interventions for patients with somatic disorders are as follows for general practitioners and psychiatrists: **First**, clinicians should collect the medical histories of patients with SSD to explore their emotional difficulties, familial factors, personality traits, and illness-related beliefs, identify available supportive resources, and summarize effective strategies and relevant treatments applied in previous similar clinical cases. **Second**, clinicians should provide feedback on physical examination results and avoid excessive medical investigations. They should express empathy for patients' disappointment, validate their suffering and symptoms from the patient's perspective, and facilitate the recognition and expression of patients' inner emotions. **Third**, clinicians should help patients reframe the meaning of their symptoms by establishing connections between symptoms and stress or lifestyle factors, and by explaining the anxiety-disease transition pathway (Emotional state-Physiological reactions-Symptoms) and the vicious cycle of somatic symptom responses. Through psychoeducation, patients can learn symptom-management strategies, such as maintaining a symptom diary and engaging in inner dialogue with their symptoms. Clinicians should encourage patients and their family members to participate in evidence-based psychotherapies, including cognitive behavioral therapy (CBT). For patients whose symptom episodes are associated with family factors, family therapy is recommended to mobilize family and social support resources.

Limitation

This study has three limitations. First, purposive sampling was adopted in accordance with the homogeneity principle, and all participants were patients receiving treatment in psychiatric departments. Somatization-symptom patients who have not received psychiatric interventions may have different healthcare-seeking experiences and treatment choices, which therefore limits the scope of this research topic. Second, the findings of this qualitative study are not generalizable. Its primary purpose is to help readers understand patients' experiences of struggling against symptoms. Larger-sample studies are required for further verification if generalizable conclusions are to be drawn. Third, from a methodological perspective, the frequencies of recurring themes were summarized during the analysis of interview data. As a result, important and valuable minor themes or information that failed to reach a certain proportion threshold might inevitably be overlooked or lost and thus not presented in the results.

Declarations

Fundings

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Data availability

The qualitative datasets generated and/or analyzed during the current study are not publicly available due to the sensitive nature of the interview materials and the risk of deductive identification of participants. De-identified excerpts and supporting materials may be made available from the corresponding author on reasonable request, subject to approval by the institutional ethics committee and completion of an appropriate data use agreement.

Ethics approval and consent to participate

This study was approved by the Ethics Review Committee of Shanghai Pudong New Area Mental Health Center and departments of the hospital (No. PDJW-KY-2025-010) and was conducted in accordance with the Declaration of Helsinki. Written informed consent was obtained from all participants prior to data collection. Participation was voluntary, and participants could withdraw at any time without any consequences. All interview data were de-identified and stored securely with access restricted to the research team.

Consent for publication

Written informed consent for publication was obtained from all participants, including consent from legal guardians for minors. All potentially identifying information was removed, and any quoted excerpts were anonymized to protect participants' privacy

Competing interests

The authors declare no competing interests.

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Tables

Tables 1 and 2 are available in the supplementary files section.

Figures

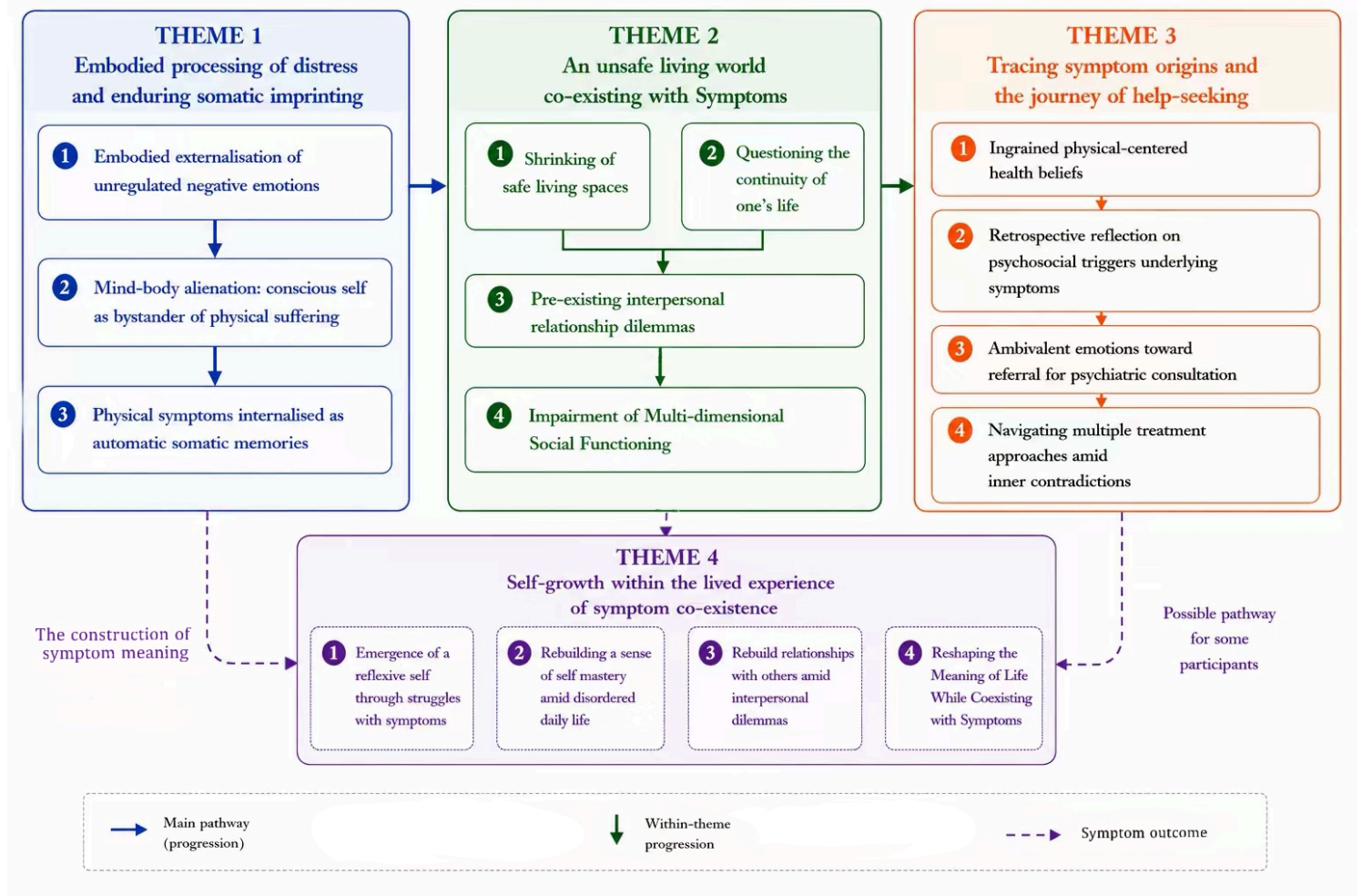


Figure 1

Legend not included with this version.

Supplementary Files

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