



## Anxiety, Depression and Stress between Psychosomatics and Normal Adults

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### ORIGINAL ARTICLE



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### ABSTRACT

*With the objective to examine the influence of psychosomatic disorder on stress, anxiety and depression, 120 psychosomatic were compared with 120 normal. It was hypothesized that psychosomatic and normal would differ significantly from one another in terms of (i) stress, (ii) anxiety and (iii) depression. Stress, anxiety and depression were measured using SPSSI, Sinha's MAI and Jamuar's MDI. Besides these, a PDS was used to seek the necessary information about the respondents. The obtained data were analysed using t-test. The results uphold the hypotheses. It was found that psychosomatic excelled over normal in terms of stress, anxiety and depression. Thus, it was concluded that psychosomatic disorders are function of stress, anxiety and depression.*

### KEY WORDS

*Anxiety, Depression, Stress, Adults.*

### INTRODUCTION

Mental health has emerged as one of the most pressing concerns in contemporary society, with anxiety, depression, and stress affecting individuals across various demographics. Among the many populations vulnerable to these psychological disturbances, psychosomatic patients represent a unique group. The term "psychosomatic" refers to conditions wherein psychological factors significantly influence physiological functioning, often leading to real physical symptoms without identifiable organic pathology. This phenomenon underscores the intrinsic connection between mind and body, where emotional disturbances manifest as physical ailments. In contrast, individuals without such psychosomatic tendencies

often referred to as “normal” or non-psychosomatic individuals may still experience anxiety, depression, and stress but do not typically translate these mental struggles into physical symptoms. The comparative analysis of these two groups offers vital insights into the nuanced interplay between mental and physical health.

Psychosomatic disorders are physical illnesses or conditions caused or exacerbated by mental factors. Although the body may exhibit real symptoms, medical testing often fails to detect a definitive physical cause. Common psychosomatic complaints include chronic fatigue, gastrointestinal problems, headaches, chest pain, and musculoskeletal issues. Unlike malingering or factitious disorders, where symptoms are intentionally fabricated, psychosomatic symptoms are genuine and often involuntary, rooted in psychological distress. Conditions such as irritable bowel syndrome (IBS), fibromyalgia, and tension headaches are often cited as examples of psychosomatic manifestations. These disorders arise when unresolved psychological issues, such as anxiety, depression, or chronic stress, affect the autonomic nervous system, endocrine responses, or immune system functioning. Over time, this can lead to real, persistent physical symptoms. Therefore, psychosomatic disorders are considered a legitimate area of concern in both psychological and medical domains.

In contrast, normal individuals in this context, those who do not develop physical symptoms in response to psychological stress may still experience anxiety, depression, and stress, but in ways that do not manifest physically or impair them physiologically. These individuals may have better coping mechanisms, higher resilience, or simply different personality and biological makeups that prevent psychological distress from escalating into somatic complaints. That said, the absence of psychosomatic symptoms does not equate to optimal mental health. Stress, anxiety, and depression still take a toll on emotional well-being and cognitive functioning. However, the primary distinction lies in the mode of expression: while psychosomatic patients translate their mental pain into bodily symptoms, non-psychosomatic individuals may express their distress through emotional breakdowns, behavioral issues, or cognitive impairments.

Anxiety is a core feature in many psychosomatic disorders. The persistent worry, fear, and hyperarousal associated with anxiety can stimulate autonomic nervous system responses such as increased heart rate, muscle tension, and gastrointestinal discomfort all of which are frequently reported by psychosomatic patients. This anxiety is often chronic and may be linked to underlying personality traits such as neuroticism or past traumatic experiences. In psychosomatic patients, anxiety tends to be internalized and may remain unexpressed until it finds a physical outlet. Normal individuals also experience anxiety; however, they often process and articulate it more directly. They may report feeling nervous or fearful but are less likely to experience severe bodily symptoms in the absence of an organic cause. They might engage in therapeutic or lifestyle strategies to manage anxiety, such as exercise, mindfulness, or seeking social support, thereby reducing the risk of somatization.

Depression is another critical dimension to examine in this context. In psychosomatic individuals, depression often coexists with anxiety and is a significant factor in the development of somatic symptoms. Feelings of helplessness, hopelessness, and low self-worth are internalized to such an extent that they compromise the immune and autonomic systems, leading to fatigue, chronic pain, and other physical issues. These individuals may not even report feeling “sad” in the typical sense; instead, they might focus on their physical symptoms, inadvertently obscuring the underlying depression. Normal individuals suffering from depression may articulate emotional symptoms more clearly sadness, lack of interest, guilt, or suicidal thoughts. They may recognize their condition as psychological in origin and seek psychiatric help or counseling. Thus, while both groups experience depressive symptoms, psychosomatic individuals often experience it through a more physicalized, masked form, which can complicate diagnosis and treatment.

Stress is arguably the most ubiquitous mental health challenge and a significant catalyst for both psychosomatic and non-psychosomatic distress. In psychosomatic individuals, chronic stress is often the tipping point that leads to the development of physical symptoms. The body remains in a prolonged state of

fight-or-flight response, resulting in elevated cortisol levels, muscle tension, digestive issues, and compromised immune function. Over time, this leads to the emergence of somatic symptoms that may become chronic and debilitating. In contrast, normal individuals might experience similar physiological responses to stress but often recover quickly once the stressor is removed or resolved. Their coping mechanisms, whether cognitive, behavioral, or emotional, allow them to process stress without it converting into long-term physical illness. However, in cases of prolonged or intense stress, even non-psychosomatic individuals can experience stress-related physical issues such as high blood pressure, ulcers, or sleep disturbances — though typically not to the extent or complexity observed in psychosomatic cases.

From a psychodynamic perspective, psychosomatic symptoms are often viewed as a defense mechanism against repressed emotional conflicts. The physical symptoms serve as a symbolic expression of unconscious distress, thereby deflecting emotional pain into a more socially acceptable or manageable physical form. Freud and his successors, such as Franz Alexander, emphasized the role of unconscious conflict in generating psychosomatic illness. On the other hand, cognitive-behavioral models suggest that maladaptive thoughts and beliefs play a central role in the development of both psychosomatic and non-psychosomatic mental health issues. Psychosomatic individuals may harbor irrational beliefs about health, misinterpret normal bodily sensations as signs of severe illness, or have a heightened sensitivity to physical discomfort, thereby creating a vicious cycle of anxiety and symptom amplification.

Understanding the differences in how psychosomatic and normal individuals experience anxiety, depression, and stress has important clinical implications. For psychosomatic patients, an integrated treatment approach that includes cognitive-behavioral therapy (CBT), stress management techniques, and possibly pharmacotherapy is essential. Addressing the underlying emotional causes of their physical symptoms is crucial for long-term relief. For non-psychosomatic individuals, preventive mental health care, lifestyle changes, and early intervention can significantly mitigate the effects of stress, anxiety, and depression. Public health strategies should focus on promoting awareness, reducing stigma, and enhancing emotional literacy so that individuals can seek help before psychological distress escalates into more serious mental or physical health problems.

The comparison between psychosomatic and normal individuals in terms of anxiety, depression, and stress underscores the intricate relationship between mind and body. While both groups experience emotional turmoil, the mode of expression, severity, and impact on physical health differ significantly. Recognizing these distinctions is vital for developing effective therapeutic interventions and health policies that cater to diverse psychological needs. As our understanding of the psychosomatic interface deepens, a more holistic approach to mental health that acknowledges the unity of psychological and physical well-being becomes not only possible but necessary.

## Review of Literature

Lipowski<sup>4</sup> (1988) Lipowski explored the concept of psychosomatic disorders and emphasized that individuals with psychosomatic conditions tend to express psychological conflict through physical symptoms. He found that anxiety and depression are frequently underlying contributors to such conditions. Unlike normal individuals, these patients often deny emotional problems and focus solely on physical symptoms, complicating diagnosis and treatment. Kellner<sup>3</sup> (1990) Kellner's study compared psychosomatic patients with psychiatric and normal patients. He reported higher levels of somatization, anxiety, and hypochondriacal fears among psychosomatic individuals. In contrast, normal individuals with anxiety or depression usually do not present physical symptoms to the same extent, suggesting differences in symptom expression styles. Pilowsky<sup>7</sup> (1994) Pilowsky introduced the concept of "abnormal illness behavior" and found that psychosomatic patients tend to misinterpret bodily sensations and exhibit excessive concern over health, driven by anxiety and stress. This behavior contrasts with that of normal individuals who typically have better insight into the psychological origin of their distress. Taylor, Bagby, & Parker<sup>10</sup> (1997) their work on alexithymia—a trait often seen in psychosomatic

patients—demonstrated that these individuals struggle to identify and express emotions. This emotional deficit was linked to increased somatic complaints, in contrast to normal individuals who were more emotionally articulate and less likely to somatize psychological stress. Barsky, Goodson, Lane, & Cleary<sup>1</sup> (1988) Barsky et al. investigated hypochondriasis and found a strong link with anxiety and depressive symptoms among psychosomatic patients. Their study indicated that such individuals often perceive minor bodily sensations as evidence of serious illness, unlike the normal population who demonstrate more rational health beliefs. Sifneos<sup>9</sup> (1996) Sifneos continued his pioneering work on alexithymia and noted that individuals with psychosomatic conditions often show poor stress management and emotional regulation skills. These deficits contribute to chronic anxiety and depressive symptoms, which become somatized into physical ailments—less common in normal individuals. Wise & Mann<sup>11</sup> (1994) this research compared levels of stress and coping strategies between psychosomatic and non-psychosomatic individuals. The study found that psychosomatic patients had significantly higher perceived stress and were more likely to use emotion-focused and avoidant coping strategies, unlike the problem-solving approaches used by normal individuals. Looper & Kirmayer<sup>5</sup> (2002) their review emphasized the role of psychological trauma and early life stress in the development of somatic symptom disorders. They argued that psychosomatic patients often have histories of unresolved psychological issues that manifest as bodily symptoms, whereas normal individuals may have healthier emotional processing mechanisms. Nakao & Barsky<sup>6</sup> (2007) Nakao and Barsky conducted a meta-analysis showing that psychosomatic patients frequently present with undiagnosed psychiatric comorbidities, especially anxiety and depression. They concluded that normal individuals, although prone to emotional distress, seldom translate their emotions into multiple, unexplained physical symptoms. Henningsen, Zimmermann, & Sattel<sup>2</sup> (2003) their study on somatoform disorders revealed that psychosomatic individuals have a heightened focus on bodily sensations and often interpret them catastrophically. Anxiety and depression in this group are thus amplified by this focus, unlike in the normal population where such symptoms are more cognitively managed. Rief & Broadbent<sup>8</sup> (2007) these researchers investigated illness perceptions and found that psychosomatic individuals often possess maladaptive beliefs about health and illness, strongly influenced by stress and emotional trauma. Their findings highlight that while anxiety and depression exist across populations, psychosomatic individuals uniquely express these through somatic symptoms. The foregoing references indicate that variables have not been conducted in context of psychosomatics of Patna (Bihar). Hence, the study.

## Objective

The objective was to make a comparison between psychosomatic and normal adults in terms of their level of stress, anxiety and depression.

## Hypotheses

1. Psychosomatic respondents will differ significantly from their normal counterparts in terms of level of stress.
2. The psychosomatic respondents will differ significantly from normal counterparts in terms of level of anxiety.
3. The psychosomatic respondents will differ significantly from normal counterparts in terms of depression.

## Sample

The sample consisted of 120 psychosomatic respondents equally (N=30) belonging to bronchial asthma, essential hypertension, peptic ulcer and ischemic heart diseases besides 120 normal subjects equally (N=30) belonging to each group having no complaint of psychosomatic nature. The 120 respondents having psychosomatic complaints constituted the experimental group and 120 normal subjects constituted the control group. The patients of the four psychosomatic disorders were the outdoor and indoor patients from different medical colleges located in Patna town. The normal subjects were selected from the relatives and attendants of those patients.

**Research Design**

Causal comparative ex-post-facto research design was used.

**Tools Used**

- (i) A Personal Data Sheet was used to get other necessary information relating to the respondents.
- (ii) SPSSI was used to measure level of stress of the respondents.
- (iii) Manifest Depression Inventory by Anita Jamuar was used to measure the degree of depression on the respondents.
- (iv) Manifest Anxiety Scale by Sinha was used to measure the anxiety of the respondents.

**Results and Interpretations**

**Table 01:** t-ratio showing the comparison between the normal subjects and the psychosomatic patients in terms of stress

Respondents	N	Mean	SD	t-matrix	df	P
(a) Normal	30	61.65	2.90			
(b) Bronchial Asthama	30	69.45	2.70	$t_{ab} = 10.83$	58	<.01
(c) Hypertension	30	70.90	2.49	$t_{ac} = 13.21$	58	<.01
(d) Peptic Ulcer	30	70.85	2.86	$t_{ad} = 12.34$	58	<.01
(e) IHD	30	71.48	2.59	$t_{ae} = 13.84$	58	<.01

The results contained in table 01 showed that the normal subjects differed significantly from the four psychosomatic groups of the patients under reference. Thus, hypothesis no (1) stating that psychosomatic patients would differ significantly from their normal counterparts in terms of level of stress is retained. The respondents belonging to bronchial asthama ( $t_{ab} = 10.83$ ,  $df = 58$ ,  $p < .01$ ), hypertension ( $t_{ac} = 13.21$ ,  $df = 58$ ,  $p < .01$ ), peptic ulcer ( $t_{ad} = 12.34$ ,  $df = 58$ ,  $p < .01$ ), and IHD ( $t_{ae} = 13.84$ ,  $df = 58$ ,  $p < .01$ ) excelled in terms of stress as compared to their normal counterparts. Thus, higher degree of stress is also an etiological factor responsible for the development of psychosomatic disorders. Psychosomatic patients with bronchial asthma, hypertension, peptic ulcer, and ischemic heart disease (IHD) are more prone to stressful behavior because chronic physical conditions heighten emotional tension, anxiety, and physiological arousal. Continuous worry about health, lifestyle restrictions, and fear of relapse further intensify psychological stress, whereas normal individuals maintain better emotional stability and stress tolerance.

**Table 02:** t-ratio showing the comparison between the normal subjects and the psychosomatic patients in terms of anxiety

Respondents	N	Mean	SD	t-matrix	df	P
a. Normal	30	70.40	2.65			
b. Bronchial Asthma	30	78.50	2.54	$t_{ab} = 12.27$	58	<.01
c. Hypertension	30	79.25	2.49	$t_{ac} = 13.41$	58	<.01
d. Peptic Ulcer	30	78.46	2.81	$t_{ad} = 11.51$	58	<.01
e. Ischmic Heart Disease	30	80.29	2.69	$t_{ae} = 14.33$	58	<.01

The results of table 02 confirmed the second hypothesis. The normal subjects differed significantly from bronchial asthmatic patients ( $t_{ab} = 12.27$ ,  $df = 58$ ,  $P < .01$ ), hypertensive patients ( $t_{ac} = 13.41$ ,  $df = 58$ ,  $P < .01$ ),

peptic ulcer patients ( $t_{ad} = 11.51$ ,  $df = 58$ ,  $p < .01$ ) and Ischmic Heart Disease patients ( $t_{ae} = 14.33$ ,  $df = 18$ ,  $P < .01$ ). Thus, hypothesis no. (2) was retained. It was hypothesised that psychosomatic patients would differ significantly from normal counterparts in terms of level of anxiety, was retained. Psychosomatic patients suffering from bronchial asthma, hypertension, peptic ulcer, and ischemic heart disease (IHD) are more prone to acute anxiety because their chronic physical ailments heighten physiological arousal and emotional tension. Constant worry about health, fear of complications, and sensitivity to stressors intensify anxiety responses, unlike normal individuals who possess better emotional regulation and physical resilience.

**Table 03:** t-ratios showing the comparison between the normal subjects and the psychosomatic patients in terms of depression

Respondents	N	Mean	SD	t matrix	df	P
a. Normal	30	20.42	2.84	$t_{ab} = 10.25$	58	<.01
b. Bronchial Asthma	30	27.90	2.79	$t_{ac} = 10.73$	58	<.01
c. Hypertensive	30	28.36	2.89	$t_{ad} = 11.03$	58	<.01
d. Peptic Ulcer	30	27.91	2.76	$t_{ae} = 10.99$	58	<.01
e. Ischmic Heart Disease	30	28.44	2.81			

The results recorded in table 03 showed that the normal subjects differed significantly from the psychosomatic patients in terms of depression. The normal differed significantly from the bronchial asthma patient ( $t_{ab} = 10.25$ ,  $df = 58$ ,  $p < .01$ ), hypertension patient ( $t_{ac} = 10.73$ ,  $df = 58$ ,  $p < .01$ ), peptic ulcer patients ( $t_{ad} = 11.03$ ,  $df = 58$ ,  $p < .01$ ) and from the Ischmic Heart Disease patients ( $t_{ae} = 10.99$ ,  $df = 58$ ,  $p < .01$ ) in terms of depression. Thus, the third hypothesis was completely retained in respect of depression. Higher degree of depression in psychosomatic patients might be interpreted on the ground of more stress and frustration caused due to disease from which the person is suffering leading to have more depression in them than normal counterpart. Psychosomatic patients with bronchial asthma, hypertension, peptic ulcer, and ischemic heart disease (IHD) manifest higher levels of depression because chronic illness leads to prolonged physical discomfort, emotional helplessness, and social withdrawal. Persistent health concerns, lifestyle limitations, and fear of worsening conditions contribute to feelings of hopelessness and sadness, unlike normal individuals who experience greater physical well-being and psychological stability.

## CONCLUSIONS

1. Stress is one of the prominent factor for the growth and development of psychosomatic disorders (bronchial asthma, essential hypertension, peptic ulcer and IHD.)
2. Anxiety is one of the prominent factor for the growth and development of psychosomatic disorders (bronchial asthma, essential hypertension, peptic ulcer and IHD.)
3. Depression is prominent factor for the growth and development of psychosomatic disorders (bronchial asthma, essential hypertension, peptic ulcer and IHD.)

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