

A Psychoanalytic Account of Psychosomatic Disorders: An Analytic Review of the Relationship Between Unconscious Processes, the Body, and Lifestyle

Abstract

Psychosomatic disorders are complex conditions in which somatic symptoms are closely associated with psychological, emotional, and social processes. Psychoanalytic perspectives have traditionally emphasized unconscious processes, psychological conflict, defensive functioning, emotional experience, bodily states, and the subjective meaning of symptoms. Contemporary developments, however, have challenged models that assume a direct transformation of psychological conflict into physical symptoms. A broader perspective is therefore needed to understand the interaction between psychological processes, bodily experience, and everyday life.

The reviewed literature suggests that unconscious processes should not be viewed as direct causes of somatic symptoms. Rather, they may influence bodily experience and health-related behavior through psychological conflict, defensive processes, emotional regulation, relational experiences, and self-experience. Bodily experience is also shaped by attention to symptoms, interpretations of bodily states, and emotional responses, which may affect coping and health-related behaviors. Lifestyle factors, including sleep, nutrition, physical activity, work, interpersonal relationships, self-care, and responses to stress and illness, should not be considered merely consequences of psychosomatic disturbance. They may also contribute to the reciprocal relationship between psychological and bodily processes. Accordingly, this article proposes an interactive framework in which unconscious processes, emotion, bodily experience, and lifestyle are interconnected dimensions of everyday functioning. A psychoanalytic perspective can provide a complementary framework for understanding the subjective meaning of symptoms, unconscious processes, bodily experience, and the ways illness becomes embedded in everyday life.

Keywords: Psychosomatic disorders; Psychoanalysis; Unconscious processes; Bodily experience; Emotion; Lifestyle; Health psychology

1. Introduction

Psychosomatic disorders and conditions associated with somatic symptoms lie at the intersection of mind and body and have long been challenging issues in medicine, psychology, and psychiatry. The human body cannot be regarded as independent of psychological experience; at the same time, not all somatic symptoms can be reduced to psychological processes. The experience of illness develops within a context in which biological, emotional, cognitive, behavioral, interpersonal, and social factors interact with one another [1, 2, 3]. Despite advances in biomedical medicine and the expansion of diagnostic methods, the mind–body relationship remains an important issue because, in some cases, the severity and persistence of somatic symptoms cannot be fully explained by pathophysiological findings alone. Under such circumstances, the ways in which individuals experience and interpret their symptoms, as well as their emotions, stress, social relationships, health-related behaviors, and lifestyle, become particularly important [1, 4]. Accordingly, psychosomatic medicine has moved beyond a simple model of psychological effects on the body toward a multidimensional approach that considers the interaction of biological, psychological, and social factors. One of the fundamental challenges in this field is to avoid a dichotomous understanding of biological and psychological explanations. Reducing illness to physical damage or dysfunction may overlook the individual's psychological and social experience, whereas directly attributing somatic symptoms to psychological conflicts may oversimplify the relationship between mind and body. The experience of illness is shaped by interactions across multiple levels, and the involvement of psychological processes does not imply that somatic symptoms are unreal or imagined [3, 2, 5]. This development is also reflected in contemporary diagnostic systems. In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the category of somatic symptom and related disorders replaced the older category of somatoform disorders, and the diagnostic emphasis shifted from the mere medical inexplicability of symptoms toward excessive thoughts, feelings, and behaviors associated with somatic symptoms [6, 7]. This change indicates that the presence of a physical illness or a medical explanation for a symptom does not necessarily exclude the role of psychological factors in the experience, perception, and consequences of illness. Nevertheless, somatic symptom disorder, functional neurological disorder, chronic pain, and medically unexplained symptoms should not be treated as interchangeable conditions or assumed to share a single explanatory mechanism. The significance of this issue becomes more apparent when somatic symptoms persistently affect everyday functioning, social relationships, employment, and quality of life. Individuals with somatic symptom disorder may also exhibit higher levels of depression, anxiety, health anxiety, and alexithymia; however, evidence regarding the causal and predictive roles of these factors remains inconsistent [8]. Such associations do not, in themselves, establish a specifically psychoanalytic mechanism. Therefore, rather than seeking a single psychological cause, it is necessary to consider the interaction of psychological, bodily, and environmental factors. The psychoanalytic perspective offers a particular way of understanding psychosomatic experience. Psychoanalysis draws attention to processes that may not be accessible to conscious awareness through concepts such as unconscious processes, conflict, anxiety, defense mechanisms, relational history, and the meaning of experience [9, 10]. The study of hysteria and conversion symptoms was also among the earliest areas in which the relationship between psychological experience and the body was explored, allowing physical symptoms to be considered not only in terms of their bodily manifestations but also within the broader organization of the individual's psychological life [11]. However, contemporary psychoanalytic approaches cannot be reduced to the assumption that every physical illness represents the direct expression of a specific unconscious conflict. Developments in this field have led to greater attention to emotional experience, alexithymia, interpersonal relationships, and the mind–body relationship alongside unconscious conflicts [10, 12, 13]. These concepts provide an interpretive perspective on bodily experience but should not, in themselves, be regarded as evidence of established causal mechanisms. From this perspective, the aim of a psychoanalytic approach is not to replace biological or medical explanations but to contribute to an understanding of the meaning of symptoms, the individual's relationship with the body, emotional experience, unconscious processes, and personal history. Lifestyle represents an important domain through which this perspective can be connected to health psychology. Lifestyle is not limited to behaviors such as diet, sleep, and physical activity; rather, it encompasses relatively stable patterns of behavioral and social functioning associated with health and illness [1, 14]. Patterns of self-care, the individual's relationship with the body, responses to needs and life stressors, emotion regulation, and everyday behavioral patterns may be relevant to the experience of illness and adaptation to it, alongside physical and social factors. The relationship between psychosomatic conditions and lifestyle can be understood as bidirectional. Illness may alter sleep, physical activity, relationships, and health-related behaviors, while chronic stress, behavioral patterns, and difficulties with self-care may also influence the experience of and adaptation to illness [2, 14]. These

relationships should not be interpreted as evidence of a single causal pathway. Accordingly, examining lifestyle in relation to psychosomatic experience may help clarify the connections among bodily experience, psychological processes, and everyday life. The present article aims to provide a narrative review of psychoanalytic accounts of psychosomatic experience, with a particular focus on the relationship among unconscious processes, the body, emotion, and lifestyle. The central question is how far psychoanalytic concepts contribute to understanding the subjective meaning and relational context of psychosomatic experience, while recognizing the limits of these concepts in establishing symptom mechanisms or causal relationships. By reviewing the historical development of the psychosomatic concept and psychoanalytic perspectives on somatic symptoms, the article examines how bodily experience and psychological processes have been conceptualized in relation to everyday life. Within this framework, lifestyle is considered in relation to emotional, relational, behavioral, and bodily patterns without assuming that these relationships constitute an established causal model. The article seeks to develop a conceptual understanding of the contribution and limitations of the psychoanalytic perspective in relation to psychosomatic experience and health psychology.

2. The Concept and Historical Development of Psychosomatic Disorders

The term *psychosomatic* is derived from two Greek words referring to the “psyche” and the “body” and, in its broadest sense, denotes the relationship between psychological and bodily processes. However, its scientific meaning has changed throughout history. From its emergence, the psychosomatic concept has occupied the boundaries between medicine, psychology, psychiatry, and the philosophy of mind, reflecting changing perspectives on the relationship between mind and body [15].

In its early formulations, the term *psychosomatic* was primarily used to refer to the role of psychological factors in the development or exacerbation of physical symptoms. Although this perspective contributed to the establishment of the field, simplistic interpretations could reinforce a dichotomy between physical and psychological illness. In contrast, contemporary psychosomatic medicine emphasizes the interaction of biological, psychological, and social factors in health, illness, illness behavior, and its consequences [1, 2]. From this perspective, bodily, emotional, cognitive, behavioral, and social processes are considered in relation to one another. Questions concerning the relationship between mind and body long predate the emergence of the term *psychosomatic*. In ancient medical traditions, including the Hippocratic tradition, illness was considered in relation to living conditions, the environment, diet, and the individual's overall state. With developments in Western philosophy and medicine, particularly the increasing influence of mind-body dualism, these domains gradually came to be regarded as more distinct. The development of modern medicine, with its emphasis on anatomy, physiology, and pathology, greatly expanded knowledge of the body as a biological system. Although this development played a crucial role in medical advancement, some interpretations placed the patient's subjective and social experience in a secondary position [15, 13]. In response to reductionist interpretations of illness, increasing attention was given to the role of psychological factors in physical symptoms. The study of hysteria represented an important historical context for this development. In the work of Breuer and Freud, certain physical symptoms were examined in relation to emotional experiences and psychological conflicts, allowing the body to be considered in relation to the individual's psychological life [11]. The term *psychosomatic* also began to appear in medical literature. It is commonly associated with Johann Christian August Heinroth in the early nineteenth century, although historical research has identified evidence of earlier uses, including its appearance in a medical dissertation in Montpellier in 1784 [16, 17]. The history of psychosomatic medicine is therefore better understood as a broader historical development in conceptions of the relationship between mind and body rather than as the achievement of a single individual or a specific date. The psychosomatic concept gradually moved away from dualistic and narrowly causal models. Some early theories attempted to establish specific relationships between particular psychological characteristics or conflicts and particular diseases. However, the relationship between psychological processes and illness cannot be adequately represented by a simple one-to-one association, and biological, psychological, and social factors may interact in different ways [3, 2]. Research on stress and its physiological mechanisms further contributed to this perspective. McEwen [18], through the concept of allostatic load, examined the physiological consequences of repeated and prolonged adaptation to psychological and environmental stressors. Chrousos [19] likewise emphasized the role of stress-regulatory systems in linking psychological states with bodily processes. These contributions provide physiological perspectives on stress-related processes but do not, by themselves, establish a specifically psychoanalytic explanation of psychosomatic symptoms. During the second half of the twentieth century, psychosomatic medicine expanded its focus beyond the etiology of illness to include illness behavior, quality of life, health-related behaviors, and lifestyle [1]. Engel's [20] biopsychosocial model represented an important attempt to move beyond biological reductionism by considering interactions among

biological, psychological, and social levels. Although this model has substantially influenced psychosomatic medicine and health psychology, its philosophical foundations and the challenges involved in operationalizing it have also been subject to criticism [5]. Alongside these broader developments different approaches to understanding psychosomatic phenomena have emerged. The biomedical approach focuses primarily on bodily mechanisms of illness, whereas the psychophysiological approach examines relationships between psychological states and physiological changes. Cognitive-behavioral approaches emphasize symptom perception and interpretation, health-related beliefs, and behavioral responses. The biopsychosocial model considers interactions among multiple levels of illness, while the psychoanalytic approach focuses on unconscious processes, conflict, emotion, defense mechanisms, relationships, and the meaning of bodily experience [1, 13, 10]. These approaches differ in their explanatory emphasis and should not be assumed to provide equivalent forms of evidence for the same mechanisms. The differences between these approaches do not necessarily imply that they are fundamentally incompatible. Each may illuminate a different dimension of illness experience. The contribution of the psychoanalytic perspective lies primarily in its interpretive attention to symptom meaning, the individual's relationship with the body, emotional experience, unconscious processes, and personal history [13, 10]. These concepts may complement biological and behavioral explanations, but their interpretive value should be distinguished from evidence establishing the mechanisms of symptom onset or persistence. The conceptual development of psychosomatic medicine is also reflected in contemporary diagnostic systems. In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the category of somatic symptom and related disorders replaced the older category of somatoform disorders, and the medical inexplicability of symptoms was no longer a necessary criterion for the diagnosis of somatic symptom disorder [6, 7]. This change reflects a shift toward greater attention to how individuals experience, interpret, and respond to their symptoms rather than relying solely on whether a physical cause can be identified. However, somatic symptom disorder, functional neurological disorder, chronic pain, and medically unexplained symptoms remain distinct concepts and should not be treated as interchangeable manifestations of a single explanatory process. The historical development of psychosomatic medicine reflects a transition from relatively simple accounts of psychological effects on the body toward a multilevel understanding of illness. Within this framework, illness is not adequately understood solely as a bodily process or solely as the consequence of psychological conflict. Rather, its experience may involve interactions among bodily processes, psychological experience, behavior, and the social environment. Psychoanalysis contributes to this discussion through concepts concerning unconscious processes, conflict, emotion, and symptom meaning. Its contribution is primarily interpretive, while claims about causal mechanisms require appropriate empirical evidence. This distinction provides the conceptual basis for examining psychoanalytic perspectives on psychosomatic experience and lifestyle without presuming that unconscious processes constitute an established causal pathway.

3. A Psychoanalytic Account of Psychosomatic Disorders and Unconscious Processes

The entry of psychoanalysis into the study of psychosomatic disorders is closely associated with early investigations of hysteria and Freud's attempts to understand bodily symptoms for which no corresponding structural pathology could be identified. In the late nineteenth century, patients presented with symptoms such as paralysis, numbness, sensory disturbances, and pain. Breuer and Freud's studies of hysteria suggested that some bodily symptoms could be explored in relation to emotional experiences, memories, and conflicts that were not necessarily accessible to conscious awareness [11, 21]. This perspective positioned bodily symptoms not only as physical experiences but also as potential subjects of inquiry into personal history and the meanings attributed to experience. The relationship between psychological and bodily processes was also central to Freud's early work. His *Project for a Scientific Psychology* reflected an attempt to conceptualize this relationship, although the project was never published in its final form [22]. As psychoanalytic theory developed, concepts such as the unconscious, repression, conflict, and defense became central to its account of psychological life. From Freud's perspective, wishes, impulses, and experiences that conflict with moral demands, external reality, or an individual's self-concept may be excluded from conscious awareness while continuing to influence psychological functioning [9]. Within this framework, unconscious conflict refers to the coexistence of opposing wishes or forces that remain active without necessarily being consciously recognized. In classical psychoanalytic theory, a neurotic symptom could be understood as a compromise between a wish and a defense, simultaneously expressing aspects of an impulse and protecting the individual from confronting it directly [23]. Applied to psychosomatic phenomena, this formulation raises the possibility that bodily experience may be involved in the expression or organization of psychological conflict. It does not, however, establish that every bodily symptom reflects a specific unconscious conflict. The interpretive value of this

perspective lies in examining possible relationships among bodily experience, emotion, personal history, and the meanings individuals attribute to illness and their bodies. One historically important concept in this context is conversion. In his studies of hysteria, Freud used this concept to explain how psychological conflict might become associated with bodily symptoms [24, 11]. Within this formulation, an experience or impulse that cannot be expressed directly and consciously may be associated with a bodily symptom. However, conversion in its classical sense must be distinguished from the broader category of psychosomatic disorders. Not every physical disorder associated with psychological factors constitutes a conversion disorder, and conversion cannot provide a comprehensive explanation for all psychosomatic conditions [6, 1]. Contemporary psychosomatic medicine therefore requires a perspective that moves beyond a simple psychogenic explanation. The presence of a bodily symptom or physical illness does not, in itself, demonstrate the existence of unconscious conflict. Biological, psychological, and social factors may contribute simultaneously to vulnerability, symptom experience, persistence, and the consequences of illness [1, 2]. Conversion is consequently best understood as an important historical concept in psychoanalytic thinking about the body, rather than as a general model explaining all psychosomatic disorders. Post-Freudian approaches broadened this account by shifting attention from a direct conflict-symptom relationship toward personality development, early relationships, emotion-regulation capacities, and the ability to represent and symbolize internal experiences [10, 25]. In Winnicott's theory, psychological development is closely connected to bodily experience and the early environment. The gradual integration of psychological and bodily experience is understood as important to the development of a sense of continuity of being [26, 27]. From this perspective, the body is not merely a site where psychological processes become manifest; it is also part of the context in which the self and the individual's experience of the world develop. Within the French psychosomatic tradition, attention also shifted toward the psychological processing of emotion and the capacity to organize internal experience. Marty and McDougall emphasized that, under some conditions, emotional experiences may not be fully organized in psychological and symbolic forms, with bodily experience consequently assuming greater prominence [28, 25]. This perspective shifts the question from whether a particular unconscious conflict exists to how individuals experience, differentiate, interpret, and express their internal states. These theoretical formulations offer interpretive possibilities, but they should not be taken as establishing a single mechanism for the development of bodily symptoms. The concept of alexithymia became particularly important in this context. Alexithymia refers to characteristics such as difficulty identifying and describing feelings, limited imaginative capacity, and externally oriented thinking [29, 30]. It does not imply an absence of emotion; rather, it concerns difficulties in recognizing, differentiating, and expressing emotional experience. Research has identified an association between alexithymia and bodily symptoms and somatization, although this association does not establish a simple causal relationship or demonstrate a specifically psychoanalytic mechanism [4, 31]. The relevance of alexithymia lies in the possibility that differences in emotional awareness and representation may be associated with how individuals experience and report bodily symptoms. Repression and defense mechanisms provide another set of concepts for understanding the organization of psychological experience. Repression refers to the exclusion of certain contents from conscious awareness, without necessarily implying their complete elimination or the absence of any subsequent influence on psychological life [9]. Defense mechanisms are processes through which individuals manage anxiety and difficult experiences; they are not necessarily pathological. Individual differences may partly concern the flexibility and appropriateness of these processes across circumstances [32, 33]. In relation to psychosomatic experience, the potential relevance of defenses lies in their possible relationship to emotional experience and regulation, rather than in a direct correspondence between a particular defense and a specific physical illness. Anxiety is another important concept in accounts of the relationship between psychological and bodily processes. Freud conceptualized anxiety as a warning signal within the psychological apparatus that may be activated in response to threat or conflict [23]. Anxiety has both psychological and bodily dimensions and may be accompanied by increased heart rate, sweating, muscular tension, and changes in respiration. Research on stress has also shown that the activation of physiological stress systems can affect bodily processes [18, 19]. Such findings support consideration of interactions between psychological experience and physiological processes, but they do not establish that a specific unconscious conflict causes a particular illness. A psychoanalytic inquiry into anxiety may therefore focus on how individuals recognize, experience, and manage it: whether they can describe their emotional states, represent them mentally, and communicate them to others. Some individuals may describe their emotions relatively clearly, whereas others may rely more heavily on bodily sensations when communicating distress. These possibilities may help frame an exploration of lived experience, but they should not be assumed to characterize every individual with a psychosomatic disorder. The concept of symbolization

extends this theoretical perspective. Symbolization enables individuals to organize internal experiences through language, imagery, fantasy, and other forms of representation, making them available for reflection and communication [34]. Some psychosomatic theories propose that limitations in this capacity may be associated with a reduced ability to represent emotional experiences psychologically, allowing bodily experience to assume greater prominence [25]. Within this formulation, the body should not be treated simply as a translator of a hidden unconscious message; bodily experience is itself part of how individuals experience and relate to the world. This account differs from a simplified interpretation of conversion. Whereas the classical model emphasizes the possible expression of psychological conflict through a bodily symptom, some post-Freudian approaches focus more on how emotional experiences are organized and represented. A bodily symptom may have personal significance, but its meaning should not be assumed to be fixed, universal, or predetermined. It may instead be explored in relation to the individual's history, relationships, emotions, and life circumstances [25, 10]. Bodily symptoms can thus be examined in the context of personal experiences, relationships, emotions, defenses, and subjective meanings without denying their physical reality. This distinction is important in contemporary psychosomatic medicine because bodily experiences remain real even when the mechanisms underlying their emergence or exacerbation are not fully understood [7]. A psychoanalytic approach should therefore not reduce symptoms to merely psychological signs; its potential contribution is to explore how individuals experience and make sense of them. This emphasis on meaning-making also has relevance to interpretative phenomenological analysis (IPA). IPA aims to explore how individuals make sense of illness, their bodies, and their lives, and how researchers interpret this process of meaning-making [35]. It does not, by itself, establish the presence of unconscious content beyond what participants report. Research involving individuals with psychosomatic disorders can therefore explore how they describe pain, fatigue, discomfort, anxiety, anger, fear, and their relationships with their bodies, while situating these accounts within their broader life narratives. Psychoanalytic concepts may inform interpretation, but they should not predetermine what participants' accounts are taken to mean. Illness experience may also become intertwined with everyday life. In response to symptoms, individuals may restrict daily activities, change sleep and rest patterns, reduce physical activity, attend more closely to bodily sensations, or seek medical care repeatedly. Bodily experience may therefore interact with everyday patterns of living. Conversely, living conditions, stress, relationships, and health-related behaviors may also affect psychological and bodily experience [2]. Lifestyle should consequently not be regarded merely as an outcome of unconscious processes; rather, lifestyle, bodily experience, emotion, and environmental conditions may influence one another. Psychoanalytic approaches to psychosomatic disorders extend beyond explanations of symptom etiology to provide concepts for exploring psychological organization and the meaning of bodily experience. The unconscious, conflict, repression, defense, anxiety, alexithymia, and symbolization can serve as conceptual tools for examining how illness is experienced. Their relevance and explanatory status, however, should not be presumed to be identical, nor should their presence be assumed in every individual with a psychosomatic disorder. In the present qualitative study, these concepts are therefore best used as sensitizing and interpretive frameworks rather than as predetermined explanations of illness. The development of psychoanalytic perspectives from Freud to later approaches illustrates a shift away from reducing the relationship between psychological and bodily processes to a linear conflict-symptom relationship. Early studies of hysteria introduced the concept of conversion, while subsequent approaches broadened attention to early relationships, emotional processing, alexithymia, symbolization, and the personal meaning of bodily experience [11, 26, 28, 25, 31]. These perspectives offer a framework for exploring how individuals understand and experience bodily symptoms in the context of their lives. Their principal contribution in this review is interpretive; they do not, on their own, establish the mechanisms or causes of specific physical illnesses.

4. Emotion, the Body, and the Regulation of Psychological Experience

The relationship between psychological and bodily processes has been a central concern in the development of psychoanalytic theory. Freud and Breuer's early studies of hysteria suggested that certain bodily experiences could not be fully understood without considering an individual's psychological life [11]. In Freud's theory, the concept of the drive occupies a position at the boundary between the bodily and the psychological, as stimuli arising from the organism's internal state enter subjective experience through a psychical representative [36]. From this perspective, the body is not merely an object of the mind but also a source of psychological experience. This perspective was developed further in post-Freudian theories, particularly in Winnicott's work. His concept of the psyche-soma emphasizes the importance of the gradual integration of psychological and bodily experience in healthy development [26]. Early experiences of touch, holding, feeding, and movement occur within a relational context and contribute to the development of a sense of continuity of being and the self [27,

37]. Psychological and bodily experience are therefore not treated as entirely separate domains that begin to interact only later in development; rather, they are closely intertwined from the outset. This integration also draws attention to the body as lived and experienced, rather than solely as a biological structure. Although medicine examines the body in physiological terms, individuals also perceive, interpret, and attribute meaning to their bodies. Pain, fatigue, palpitations, muscular tension, and gastrointestinal discomfort have physiological dimensions, but they are also experienced in relation to emotions and personal meanings. The concept of body image similarly highlights the psychological representation of the body and its relationship to early experiences, interpersonal relationships, and social conditions [38]. Accordingly, the body may become associated with experiences of security, strength, shame, vulnerability, or threat. These considerations become particularly relevant when bodily symptoms affect an individual's sense of self and relationship with the world. Illness may restrict independence, perceived control, daily activities, and social roles, thereby changing how individuals experience their bodies and identities. Persistent symptoms may lead a person who previously experienced the body as reliable to perceive it as unpredictable or threatening. Understanding illness therefore involves not only identifying the symptoms but also examining their personal significance and their effects on the individual's experience of the body, self, and world. The phenomenological perspective similarly distinguishes the body as a biological object from the body as lived experience. People engage with the world through their bodies, and changes in bodily condition may affect how they inhabit their environment, participate in relationships, work, and carry out everyday activities [39]. This perspective is relevant to qualitative research on psychosomatic disorders because it allows illness to be explored as an experience embedded in personal life rather than merely as a collection of separate symptoms. Emotion is another important dimension of the relationship between psychological and bodily experience. Emotional experiences are accompanied by physiological, cognitive, and behavioral changes. Changes in heart rate, respiration, muscular tension, and autonomic nervous system activity may form part of experiences such as fear, anxiety, anger, and sadness [40, 41]. Emotion is therefore experienced not only psychologically but also through bodily sensations and responses. Individuals nevertheless differ in their ability to identify, interpret, and express emotional experiences. Some can readily recognize and verbalize their feelings, whereas others may describe pressure, palpitations, pain, gastrointestinal discomfort, or muscular tension without clearly identifying the associated emotional state. Alexithymia is relevant to this distinction and refers to difficulties in identifying and describing feelings and a tendency toward externally oriented thinking [29, 42, 43]. Research has reported an association between alexithymia and bodily symptoms, although the strength and direction of this relationship have varied across studies [4, 44]. This association should not, by itself, be taken as evidence of a specifically psychoanalytic mechanism. Difficulty processing emotion does not necessarily indicate an absence of emotion. An individual may experience feelings while having difficulty recognizing, labeling, or representing them verbally. From a psychoanalytic perspective, this issue can be considered in relation to symbolization and the organization of internal experience. McDougall [25] proposed that, under certain conditions, emotional experiences may not be sufficiently processed at psychological and symbolic levels, potentially giving bodily experience greater prominence. This remains a theoretical interpretation rather than a basis for assuming that every bodily symptom results from difficulty expressing emotion. Such difficulties are better considered as one possible aspect of the complex relationship between psychological and bodily processes. A related distinction concerns psychoanalytic repression and the suppression of emotional expression in contemporary psychology. Repression refers to an unconscious process through which psychological contents become inaccessible to conscious awareness [45]. By contrast, expressive suppression refers to efforts to limit the outward expression of emotion and does not necessarily eliminate the internal emotional experience itself [46]. Empirical findings have also indicated that reduced outward expression may coexist with persistent or increased physiological responses [47]. Thus, an outward appearance of calm does not necessarily indicate that emotional or physiological arousal has subsided. Emotion regulation is broader than expressive suppression and refers to processes through which individuals manage the intensity, duration, direction, and expression of emotions [46, 48]. Although emotion regulation serves an adaptive function, rigid reliance on strategies such as avoidance, rumination, worry, or suppression may be associated with adverse longer-term consequences [49]. In somatic symptom disorders, difficulties in some emotion-regulation processes, including emotional identification, clarity, and the selection of regulatory strategies, have also been reported, although the findings are not entirely consistent [50]. These observations suggest possible relationships between emotional processes and symptom experience without establishing a single explanation for psychosomatic disorders. The interaction among emotion, bodily processes, attention, and symptom interpretation provides one way of understanding these relationships. An intense emotional state may accompany increased physiological arousal, while greater

attention to bodily changes may make sensations more salient. If these sensations are interpreted as signs of danger or illness, concern and anxiety may increase and may further influence bodily arousal. Symptom experience may consequently intensify through reciprocal interactions among emotional states, bodily processes, attention, and interpretation [51]. This account does not imply that symptoms are fabricated or unreal; rather, it recognizes that the experience and interpretation of real bodily symptoms may be influenced by emotional and cognitive processes. Further questions concern why an individual responds to emotions in particular ways, which emotional experiences are difficult to tolerate, and how personal history and early relationships may relate to these patterns. A symptom should not be treated simply as evidence of a psychological cause of illness. It may have biological mechanisms while also acquiring personal significance within the individual's life history and relationships. Psychoanalytic approaches emphasize the potential relevance of conflicts, relationships, and the organization of subjective experience to understanding this significance [23, 25, 13]. Their contribution is therefore to explore the lived meaning of symptoms alongside, rather than in place of, explanations of bodily processes. Emotional and bodily experiences may also be related to patterns of everyday living. Emotions can be associated with sleep, activity, rest, eating, work, social participation, and self-care. For example, avoidance, overwork, physical inactivity, or irregular sleep may function as ways of responding to tension in some circumstances. Conversely, occupational pressure, sleep deprivation, insufficient rest, and restricted activity may also affect emotional regulation and bodily experience. These relationships are best understood as reciprocal rather than as a one-directional sequence in which emotional or unconscious processes determine lifestyle. Lifestyle should therefore not be understood merely as a list of health-related behaviors. Similar behaviors may have different meanings in different individuals' lives. Irregular sleep, for instance, may be associated with occupational stress for one person and with avoidance or difficulty maintaining boundaries between work and rest for another. A psychoanalytic exploration of lifestyle can examine how individuals experience their bodies, emotions, selves, and relationships in everyday life and how these experiences relate to their behavioral patterns, without presuming a particular unconscious explanation in advance. The literature discussed in this section identifies emotion as an important dimension of the relationship between psychological processes, bodily experience, and everyday life. Alexithymia, difficulties in emotional processing and regulation, expressive suppression, and attention to and interpretation of bodily symptoms may each illuminate aspects of this relationship, but none alone provides a comprehensive explanation of psychosomatic disorders. Psychoanalytic concepts, including defenses, unconscious conflict, relational history, and the development of the self, offer an interpretive perspective, while the findings discussed here also point to the relevance of biological, cognitive, emotional, and social factors. Considering the lived body, emotional experience, symptom meaning, and everyday patterns of living together may therefore help frame an exploration of how individuals experience illness and understand its place in their lives. Table 1 summarizes the principal concepts and explanatory processes discussed in this section, highlighting their proposed mechanisms, evidential basis, and interpretive limitations.

Table 1. Emotion, bodily experience, and the regulation of psychological experience

Concept or perspective	Main focus	Relevance to psychosomatic experience	Key limitation
Drive theory	The relationship between bodily stimuli and psychological experience	Highlights the connection between bodily processes and subjective experience	Does not establish that bodily symptoms are caused by unconscious processes
Psyche-soma integration	The development of psychological and bodily integration within early relationships	Emphasizes the intertwined development of bodily and psychological experience	Provides a theoretical perspective rather than a complete explanation of psychosomatic disorders
Lived body and body image	The subjective experience, representation, and personal meaning of the body	Helps explain how illness may	Focuses on lived experience and meaning rather than

		affect identity, independence, relationships, and everyday activities	establishing physiological mechanisms
Emotional and physiological responses	Bodily changes accompanying emotional experiences	Highlights the coexistence of emotional states and physiological responses	The presence of physiological arousal does not, by itself, identify the cause of a symptom
Alexithymia	Difficulties identifying and describing feelings and an externally oriented thinking style	May help illuminate associations between emotional awareness and bodily symptoms	Associations vary across studies and do not establish a specifically psychoanalytic mechanism
Symbolization and emotional processing	The psychological representation and processing of emotional experience	Offers a psychoanalytic interpretation of circumstances in which bodily experience becomes prominent	Should not be used to assume that every bodily symptom reflects unprocessed emotion
Repression and expressive suppression	Unconscious inaccessibility of psychological contents versus the limitation of outward emotional expression	Distinguishes psychoanalytic repression from a contemporary emotion-regulation construct	The concepts are not interchangeable, and reduced expression does not necessarily mean reduced physiological arousal
Emotion regulation [46,	Processes involved in managing emotional intensity, duration, and expression	May illuminate some emotional processes associated with somatic symptoms	Findings are not entirely consistent and do not provide a single explanation for psychosomatic disorders
Attention and symptom interpretation	Reciprocal relationships among emotion, bodily sensations, attention, and interpretations of symptoms	Helps explain how symptom salience and concern may intensify through interacting processes	Does not imply that symptoms are fabricated or establish one universal causal pathway
Psychoanalytic and relational interpretation	The potential significance of personal history, relationships, conflicts, and subjective experience	Helps explore the lived meaning of symptoms within an individual's life	Interpretive value should be distinguished from evidence that unconscious conflict causes illness
Lifestyle and everyday experience	Relationships among emotional states, sleep, activity, rest, work, relationships, and self-care	Highlights the reciprocal relationship between	Lifestyle patterns should not automatically be attributed to unconscious motives or

		everyday patterns and bodily and emotional experience	treated as a one-way cause of symptoms
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5. Psychosomatic Disorders, Lifestyle, and the Unconscious–Body–Everyday Life Nexus

Lifestyle is a multidimensional concept in health research and cannot be reduced to individual choices concerning diet or physical activity. Sleep, nutrition, physical activity, substance use, self-care, social relationships, work, leisure, and ways of coping with life stressors, together with social, economic, and cultural conditions, are important dimensions of lifestyle organization [52, 53]. The relationship between lifestyle and health is reciprocal: everyday behaviors may affect psychological and physical well-being, while illness and bodily symptoms may, in turn, alter patterns of daily living. This relationship becomes more complex in psychosomatic disorders. Persistent pain, fatigue, gastrointestinal discomfort, sleep disturbance, and other bodily symptoms may lead individuals to modify their physical activity, sleep, social relationships, occupational functioning, and self-care. Lifestyle may therefore be both a context associated with the persistence or exacerbation of bodily experiences and a consequence of living with illness. For example, occupational stress may be associated with psychological strain and bodily symptoms, while persistent symptoms may subsequently affect occupational functioning and daily routines. This reciprocal perspective is consistent with the biopsychosocial model, which conceptualizes illness in terms of interactions among biological, psychological, and social factors [20]. Studying lifestyle among individuals with psychosomatic disorders requires more than classifying behaviors as healthy or unhealthy. It also involves examining how everyday life is organized in relation to the body, illness, emotions, relationships, and psychological stressors. Behaviors such as physical activity, nutrition, sleep, healthcare utilization, treatment adherence, and preventive care may serve different functions and carry different meanings for different individuals. For example, frequent medical consultations may represent appropriate healthcare for one person, whereas for another they may occur in the context of persistent concern about bodily symptoms. The meaning of a behavior is therefore relevant alongside the behavior itself [54]. Self-care should likewise be considered within this broader context. It encompasses actions individuals undertake to maintain health, manage symptoms, cope with illness, and preserve everyday functioning, and may be associated with beliefs, motivation, social resources, and perceptions of illness [55]. Attention to the body may facilitate appropriate care, but in some circumstances it may also involve excessive symptom monitoring or heightened health-related concern. The distinction between caring for the body and becoming excessively preoccupied with it is therefore important. From a psychoanalytic perspective, bodily care may also be explored in relation to self-worth, security, and trust in the body. These are interpretive possibilities, however, rather than established causal associations. Interpersonal relationships are another component of lifestyle and illness experience. Social support, relationship quality, and interpersonal conflict may affect psychological and physical health, while illness may also alter relationships [56, 57]. Individuals with persistent symptoms may withdraw from social activities, become more dependent on others, or rely more heavily on family members and other close contacts. Conversely, conflict, loneliness, and relational stress may contribute to psychological strain. From a psychoanalytic perspective, relationships may also be relevant to the development of security, self-worth, identity, and ways of negotiating dependency. The meaning of illness can therefore be explored within the individual's relational context. This does not justify attributing illness to a presumed need for attention or support; rather, it highlights the importance of considering relationships when examining illness experience. Work and everyday activities are also affected by illness. Persistent symptoms may reduce energy, concentration, occupational attendance, and productivity, while reduced work capacity may affect feelings of competence, identity, and independence. In some disorders associated with somatic symptoms, perceived symptom severity does not necessarily correspond directly to the degree of functional limitation. Symptom interpretation, anxiety, illness-related beliefs, and coping patterns may also be relevant to everyday functioning [7]. Illness may consequently affect not only the experience of symptoms but also the organization of daily activities and the individual's sense of self. Sleep, nutrition, and physical activity are similarly embedded in the relationship between bodily experience and everyday life. Sleep disturbance may be associated with fatigue, mood difficulties, impaired emotion regulation, and increased sensitivity to bodily symptoms, while pain and physical discomfort may, in turn, disrupt sleep [58]. Although regular physical activity is generally associated with positive physical and psychological outcomes, fear of exacerbating symptoms may lead some individuals to avoid activity. Such avoidance may provide a short-term sense of safety

but, under some circumstances, may be associated with reduced physical fitness and greater functional limitation. Eating behavior is also shaped by factors beyond conscious individual decisions, including family habits, emotional states, social circumstances, and the organization of daily life. Examining these behaviors therefore involves considering the meanings individuals attribute to sleep, food, and physical activity and how these behaviors relate to their experience of the body and illness. Stress and coping are further aspects of this relationship. Persistent stress may involve activation of physiological systems associated with the stress response and, when prolonged, may affect physical and psychological functioning [18]. Individuals differ in how they respond to stress, including whether they seek support, engage in problem solving, avoid difficult situations, or suppress emotional expression. Within coping theory, appraisal is also important because the same event may carry different meanings for different people [59]. An illness may be experienced as a threat to the future, a temporary limitation, or part of personal identity. Responses to illness may therefore relate not only to symptom severity but also to the meanings attributed to illness, available psychological and social resources, and the organization of subjective experience. These considerations suggest that lifestyle is better understood as an interconnected pattern of everyday activities than as a collection of isolated behaviors. Occupational pressure, sleep, fatigue, physical activity, mood, and perceived competence may influence one another. Such interactions illustrate how lifestyle may both reflect illness experience and be associated with the persistence or modification of patterns related to that experience. They do not, however, establish a single causal sequence applicable to all individuals. Psychoanalytic perspectives provide an additional interpretive lens for examining these patterns. Everyday behaviors are not necessarily the products of entirely conscious and rational choices; they may also be explored in relation to defensive patterns, emotion regulation, internalized relationships, past experiences, and the organization of the self. From this perspective, studying lifestyle involves more than documenting behaviors: it also concerns how individuals organize their everyday lives and the meanings they attribute to their ways of living. Unconscious processes may be considered one interpretive dimension of experience, rather than a demonstrated upstream cause of bodily symptoms. They may be explored in relation to defenses, relational patterns, responses to emotion and anxiety, and the individual's relationship with the self and body. Contemporary psychoanalytic perspectives have likewise moved beyond the simple notion of psychological conflict being converted into a bodily symptom, emphasizing the integration of psyche and soma, symbolization, emotion regulation, and bodily experience [25, 26]. These concepts provide ways of interpreting experience but do not, by themselves, establish the mechanisms underlying specific disorders. Emotional experience may also be relevant to the relationship among psychological processes, bodily sensations, and lifestyle. Difficulties in identifying, tolerating, or regulating emotions may be associated with the salience of bodily experience. Research on alexithymia has reported associations between difficulties in identifying and describing emotions and bodily symptoms, although the relationship is complex and multifactorial [42, 43, 4]. An individual may describe palpitations, gastric heaviness, pain, or fatigue in detail while having difficulty identifying or expressing the emotions associated with these sensations. Such accounts can be explored as part of the individual's lived experience without assuming that bodily symptoms necessarily result from difficulties in emotional expression. Bodily experience is also closely connected to everyday decisions. Individuals may adjust activity and rest, decide whether to attend work or remain at home, change social participation, or seek medical care in response to their physical condition. These decisions may gradually affect daily routines and lifestyle. The relationship is nevertheless neither linear nor unidirectional: living conditions, sleep, activity, relationships, and self-care may also influence emotional and bodily states [18, 7]. Lifestyle is therefore best considered within a reciprocal relationship among bodily experience, psychological processes, and environmental circumstances. On this basis, an integrative conceptual framework can be used to explore psychosomatic disorders in relation to unconscious processes, emotion, bodily experience, relationships, and everyday life. Within this framework, unconscious processes are not assumed to produce symptoms directly or mechanically. Instead, psychoanalytic concepts such as defenses, relational patterns, and the organization of the self can inform the interpretation of how individuals experience their bodies and respond to emotion and anxiety. Emotional processes, including emotional identification, regulation, and alexithymia, provide another area for consideration. Bodily sensations, their perception and interpretation, and the behaviors associated with them can then be examined in relation to these experiences and to the individual's circumstances. Bodily experience may be associated with coping and self-care behaviors, including changes in activity, rest, healthcare use, sleep, and eating patterns. Over time, these behaviors may become part of the organization of everyday life. At the same time, lifestyle and environmental circumstances may influence emotional and physiological experience. The framework thus emphasizes reciprocal relationships rather than a fixed sequence from unconscious processes to emotion, bodily symptoms, and

behavior. This framework is a theoretical and interpretive proposal, not an empirically established causal model. Its purpose is to conceptualize psychosomatic disorders without reducing them to a simple opposition between psychological and physical explanations. The presence of psychological factors does not negate the physical reality of symptoms. Bodily experience is real, while the perception, interpretation, and meaning attributed to it may also be shaped by psychological and social contexts [20, 7]. The nature and extent of these relationships, including the contribution of unconscious processes, cannot be established by the conceptual framework alone. Lifestyle can therefore be considered part of the individual's psychological–bodily context rather than merely an external or independent variable. Everyday behaviors may reflect the effects of illness and may also be associated with patterns that affect how illness is experienced over time. The same symptom may have different meanings and consequences for different individuals because it occupies a different place in their personal narratives, relationships, identities, and life circumstances. This perspective is relevant to qualitative research, particularly interpretative phenomenological analysis (IPA). The aim is not simply to determine levels of alexithymia, sleep quality, or physical activity, but to explore how individuals experience bodily changes, interpret symptoms, describe their emotions, and understand changes in their relationships with themselves and others. It also involves examining how illness affects work, sleep, nutrition, activity, and daily routines. Lifestyle is thus one of the contexts in which psychological and bodily experience becomes apparent in everyday life. The framework brings together psychoanalytic perspectives, health psychology, and IPA while retaining their distinct roles. Psychoanalysis offers concepts for interpreting unconscious processes, defenses, emotions, and relationships with the body; health psychology draws attention to behavior, living conditions, and health-related processes; and IPA provides an approach to exploring how individuals experience and make sense of these aspects of their lives. Together, these perspectives can inform an examination of how bodily experience, emotional life, relationships, and lifestyle are interconnected in the lived experience of individuals with psychosomatic disorders.

6. Conclusion

A psychoanalytic account of psychosomatic disorders represents one of the early theoretical attempts to understand the relationship between psychological processes and bodily experience. However, it has also faced theoretical and empirical criticisms. Whereas some classical formulations conceptualized bodily symptoms as expressions of unconscious conflict, contemporary approaches generally understand psychosomatic disorders and problems associated with somatic symptoms in terms of interactions among biological, psychological, and social factors [20, 7]. The contemporary value of psychoanalysis therefore lies not solely in its ability to explain the causes of illness, but also in its potential to illuminate symptom meaning, bodily experience, emotions, relationships, and personal history. One contribution of psychoanalysis is its emphasis on the meaning of symptoms within an individual's psychological life. Whereas biomedical approaches primarily investigate the physiological processes underlying disease, psychoanalysis also considers how symptoms are experienced and incorporated into personal history and psychological organization [23, 25]. This perspective may be relevant when examining the effects of illness on identity, relationships, and everyday life, including circumstances in which medical findings alone do not fully capture the individual's subjective experience. However, the personal significance of a symptom should not be taken as evidence that it has a particular unconscious cause. Psychoanalysis also emphasizes that aspects of psychological life may not be directly accessible to conscious awareness [9]. This perspective can inform the exploration of recurring emotional and relational patterns, but it is important to distinguish the interpretive use of unconscious processes from the empirical demonstration of a specific unconscious cause for a bodily symptom. Similarly, psychoanalytic accounts of the relationship between psychological and bodily experience have developed from early theories of drives toward later formulations emphasizing their integration. Winnicott's concept of the psyche–soma relationship is one example of this development [60, 26]. Attention to early relationships and developmental history may also provide a context for exploring how individuals experience illness in later life [27]. Despite these contributions, psychoanalytic accounts have important limitations. Some classical concepts, including unconscious conflict, repression, and symbolization, are difficult to translate directly into measurable variables, particularly when their definitions do not specify how they can be independently assessed. The presence of a bodily symptom alone therefore cannot establish the existence of a particular unconscious conflict. Without adequate supporting evidence, interpretations of this kind risk attributing meanings to an individual's experience that have not been independently established. A related limitation is the risk of psychologizing physical illness. Presuming that bodily symptoms arise from psychological factors may divert attention from relevant biological processes and medical assessment. The possibility that psychological factors influence the experience or persistence of symptoms does not mean that symptoms are imaginary or fabricated. Bodily symptoms are real

even when psychological factors may also be relevant to their experience [7]. An adequate account must therefore acknowledge physical symptoms while examining psychological and social dimensions without reducing one to the other. The heterogeneity of psychosomatic phenomena also limits the application of any single explanatory model. The term *psychosomatic disorders* has been used in different ways and does not denote a uniform diagnostic category. Somatic symptom disorder, functional neurological disorder, chronic pain, and medically unexplained symptoms should not be treated as interchangeable. A psychoanalytic formulation developed in relation to one type of experience cannot automatically be generalized to all conditions associated with bodily symptoms [7]. Compared with psychoanalysis, contemporary empirical approaches provide more direct ways to investigate specific relationships among psychological processes, bodily states, and behavior. The biopsychosocial model emphasizes interactions among biological, psychological, and social factors [20], while cognitive and behavioral models examine processes such as attention to bodily sensations, symptom interpretation, illness-related beliefs, and coping behaviors [7]. Research on emotion regulation also investigates associations between the identification, experience, and regulation of emotions and psychological and physical health [46, 48]. These approaches address questions that differ from the primarily interpretive questions posed by psychoanalysis, and their evidence should not be treated as interchangeable. Alexithymia illustrates the relationship between psychosomatic theory and empirical research. Initially introduced in the context of research on psychosomatic patients, the construct was subsequently examined using psychometric instruments [29, 42, 43]. Reviews have reported an association between alexithymia and somatic symptoms, but this association does not establish a simple causal relationship or confirm a specifically psychoanalytic mechanism [4]. Similarly, research on stress and its prolonged physiological effects provides a basis for investigating relationships between stress and bodily functioning [18]. Psychoanalysis may complement these approaches by examining how individuals experience and interpret stress, emotions, bodily sensations, and relationships, but it does not independently establish the mechanisms investigated by empirical models. Psychoanalysis is therefore best considered a complementary interpretive approach rather than a replacement for biomedical, cognitive-behavioral, or psychophysiological accounts. Empirical approaches investigate physiological, cognitive, emotional, and behavioral processes, whereas psychoanalysis can contribute questions concerning personal meaning, psychological organization, developmental history, relationships, and the lived experience of the body. This distinction preserves the potential interpretive value of psychoanalysis without treating psychological conflict as a definitive explanation for physical symptoms. This distinction is also relevant to lifestyle. Lifestyle includes the organization of work, rest, relationships, self-care, sleep, nutrition, physical activity, and responses to everyday pressures, rather than isolated health-related behaviors alone [53]. Illness may alter these patterns through activity restriction, changes in sleep and daily routines, increased attention to bodily symptoms, or reduced social participation. Conversely, living conditions and everyday pressures may be associated with stress, emotional experience, and bodily symptoms. The relationship between illness and lifestyle is therefore reciprocal, although the direction and strength of particular relationships cannot be assumed in advance. An important question for qualitative research concerns how individuals experience these interconnections in everyday life. Research on somatic symptoms, stress, alexithymia, and health-related behaviors can examine particular constructs and their associations, but measurements of individual variables do not, by themselves, explain how illness is experienced within a person's broader life. In particular, they may not fully capture how bodily symptoms affect an individual's sense of self, relationships, daily activities, and understanding of the future. The lived experience of illness is therefore an important focus. The emergence of persistent symptoms may change the relationship between individuals and their bodies: bodily sensations that were previously taken for granted may become more prominent, while some individuals may monitor their bodies more closely or avoid attending to bodily experiences. The significance of these responses needs to be explored in context rather than inferred from symptom presence alone. Symptoms may also acquire different meanings for different individuals. A symptom may be experienced in relation to vulnerability, independence, or future possibilities, depending on the person's circumstances and life history. Psychoanalytic concepts may help researchers consider these meanings in relation to emotions, relationships, and psychological organization. However, an interpretation should not impose a hidden meaning on every symptom. It should remain grounded in participants' accounts and distinguish their expressed experiences from the researcher's interpretation. Interpretative phenomenological analysis (IPA) provides a relevant approach to examining how individuals make sense of significant experiences in their lives [35]. In research on psychosomatic disorders, it can support an exploration of how participants describe their bodies, symptoms, emotions, relationships, and everyday activities, and how they understand changes associated with illness. Psychoanalytic concepts can serve as sensitizing and interpretive resources

within this process, but they should not replace participants' accounts or be treated as predetermined explanations of their experiences. Within this qualitative context, lifestyle can be examined as part of lived experience rather than merely as a set of behaviors to be counted. Research may explore how illness is associated with changes in sleep, nutrition, physical activity, work, rest, relationships, and self-care, and how individuals understand these changes within their life circumstances. The emphasis is on the meanings and relationships that emerge from participants' accounts, rather than on assuming a uniform pattern across individuals with psychosomatic disorders. Psychoanalysis may contribute to understanding the subjective and relational dimensions of psychosomatic illness, while contemporary empirical approaches remain important for investigating biological, cognitive, emotional, and behavioral mechanisms. Its interpretive contribution should be distinguished from claims about disease mechanisms or causal pathways, which require appropriate empirical evidence. This position recognizes both the limitations of psychoanalytic explanations and their potential relevance to the meaning of illness within an individual's life history and relationships. The present review thus provides a conceptual basis for exploring how individuals with psychosomatic disorders experience and make sense of their bodies, illness, emotions, relationships, and lifestyles. The focus is not simply on identifying factors associated with psychosomatic disorders, but on examining how these experiences are understood and organized within everyday life. IPA can support this exploration by attending to participants' lived experiences and meaning-making [35], while psychoanalytic concepts may inform interpretation of emotional, defensive, and relational dimensions without overriding participants' own accounts. In conclusion, understanding psychosomatic disorders requires moving beyond a strict psychological-physical dichotomy. Illness is experienced within the context of an individual's body, emotions, relationships, behaviors, and social circumstances. Lifestyle is consequently relevant not only as a collection of health-related behaviors but also as part of the individual's everyday experience of the body and the world. A dialogue between psychoanalysis, IPA, and health psychology may help illuminate these different dimensions while preserving the distinction between interpretive understanding and empirically established explanations.