

The Relationship Between Emotional Suppression and Fear of Intimacy and the Manifestation of Psychosomatic Symptoms in Individuals With Psychosomatic Symptoms

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Article type:
Original Research

Article history:
Received 04 July 2026
Revised 27 September 2026
Accepted 05 October 2026
Initial Publish 10 October 2026
Published online 01 July 2027

ABSTRACT

The present study investigated the relationship between emotional suppression and fear of intimacy and the manifestation of psychosomatic symptoms in individuals with psychosomatic symptoms. In terms of its purpose, this study was applied research; in terms of the type of data, it was quantitative; and in terms of its nature, it employed a descriptive-correlational design. The statistical population consisted of individuals presenting with psychosomatic symptoms whose symptoms had been confirmed by psychologists at the selected centers. Given that the population size was considered unlimited, 30 participants were selected for each variable, yielding a total sample of 120 participants, using convenience sampling. To measure the study variables, the Emotional Suppression Questionnaire developed by Weinberger (1979), the Fear of Intimacy Scale developed by Descutner and Thelen (1991), and the Psychosomatic Symptoms Questionnaire developed by Lacourt et al. (2013) were used. Data were analyzed using SPSS version 26, Spearman's correlation coefficient, and stepwise regression analysis. The results indicated a significant relationship between emotional suppression and the manifestation of psychosomatic symptoms among individuals with psychosomatic symptoms ($p < .05$). A significant relationship was also found between fear of intimacy and the manifestation of psychosomatic symptoms in these individuals. Moreover, emotional suppression and fear of intimacy significantly predicted the manifestation of psychosomatic symptoms among individuals with psychosomatic symptoms ($p < .05$). In summary, individuals characterized by a constitutionally based behavioral inhibition system may interpret potentially threatening future events as ambiguous stimuli. This process may increase fear and emotional suppression, contribute to the manifestation of avoidant behaviors, and ultimately lead to psychosomatic symptoms in individuals who are prone to such symptoms.

Keywords: emotional suppression, fear of intimacy, psychosomatic symptoms.

How to cite this article:

Latifi, Z., & Asmaee Majd, S. (2027). The Relationship Between Emotional Suppression and Fear of Intimacy and the Manifestation of Psychosomatic Symptoms in Individuals With Psychosomatic Symptoms. *Mental Health and Lifestyle Journal*, 5(4), 1-16. <https://doi.org/10.61838/mhlj.324>

Introduction

Psychosomatic symptoms constitute an important area of concern in clinical and health psychology because they represent the complex interaction between psychological processes, emotional functioning, interpersonal experiences, and physical manifestations. Individuals with psychosomatic problems may report bodily complaints such as pain, gastrointestinal discomfort, fatigue, dizziness, cardiopulmonary sensations, or other somatic experiences for which psychological factors appear to contribute substantially to onset, persistence, or severity. These symptoms are not merely imaginary or intentionally produced;

rather, they reflect genuine physical experiences whose expression can be influenced by affective arousal, stress appraisal, emotional awareness, coping patterns, and interpersonal functioning. Research conducted in both clinical and nonclinical populations has shown that difficulties in identifying, processing, and expressing emotional states are consistently associated with increased somatic complaints and impaired psychological adjustment. For example, emotional awareness deficits have recently been associated with higher levels of somatic symptoms across community and clinical populations, underscoring the relevance of impaired emotional processing to bodily symptom expression (1). Similarly, comparative studies of people with psychosomatic disorders have demonstrated marked differences in emotional climate, ambivalence over emotional expression, psychological coherence, and self-critical tendencies relative to healthy groups (2). Findings from Iranian adult samples have likewise indicated that psychosomatic symptom patterns are closely intertwined with broader psychological difficulties, suggesting that somatic manifestations should be understood within a multidimensional psychological framework rather than as isolated physical complaints (3).

One of the most important psychological processes implicated in psychosomatic functioning is emotional suppression. Emotional suppression refers to the deliberate or habitual inhibition of emotional expression, emotional communication, or the outward manifestation of affective experiences. Although suppression may sometimes function as an adaptive short-term strategy in situations requiring behavioral control, chronic reliance on suppression can increase internal emotional load, reduce opportunities for emotional processing, and interfere with interpersonal regulation. Contemporary evidence indicates that suppressing emotions is associated with psychological and physiological costs, particularly when it becomes a rigid and dominant emotion-regulation strategy. A quantitative review of experimental and correlational studies demonstrated that emotion suppression is associated with alterations in acute physiological responses to stress, highlighting the relevance of suppression to autonomic and stress-related bodily processes (4). Such findings are especially important in the context of psychosomatic symptoms because persistent physiological activation without adequate emotional processing may facilitate the conversion of psychological distress into bodily complaints. Emotional suppression has also been examined in relation to social and relational functioning; among emerging adults, suppression of both positive and negative emotions has been linked to loneliness and romantic relationship satisfaction, with relational factors influencing the psychological consequences of suppression (5). These findings suggest that emotional suppression is not only an intrapersonal regulatory process but also a relational process capable of influencing both psychological well-being and interpersonal connectedness.

The effects of emotional suppression may become particularly pronounced in situations characterized by chronic stress or vulnerability. In women experiencing threatened preterm labor, for example, emotional suppression has been investigated in relation to pregnancy-related anxiety and perceived social support, with social support playing an important mediating role in this association (6). This evidence illustrates how emotional suppression can interact with environmental and interpersonal resources to shape psychological responses during stressful conditions. More broadly, emotion regulation research has shown that the ability to flexibly modulate emotional responses is closely related to mental health, whereas rigid or maladaptive strategies are associated with psychopathological symptoms. A systematic review of emotion regulation, parenting, and psychopathology further demonstrated that emotional regulation processes are embedded

within broader developmental and interpersonal contexts and are strongly associated with psychological adjustment (7). These findings are consistent with the proposition that individuals who habitually inhibit, conceal, or fail to process distressing emotional experiences may become increasingly vulnerable to internal tension and somatic symptom expression.

Within psychosomatic populations, the role of emotion regulation has received substantial empirical support. Emotion regulation strategies have been found to predict depressive and psychosomatic symptoms among adolescents, indicating that how individuals manage their emotions may directly contribute to both psychological and physical symptom patterns (8). In another study, defense styles and emotion regulation significantly predicted somatization symptoms among students, suggesting that maladaptive emotional and defensive processes may contribute to bodily manifestations of psychological distress (9). Likewise, emotion regulation, defense mechanisms, and attachment have been identified as meaningful predictors of psychosomatic symptoms, with gender and distress level influencing some of these relationships (10). More recent intervention evidence has also supported the importance of emotion-focused approaches in people with somatic symptoms; emotion-focused therapy has been shown to improve emotion regulation and coping strategies among women experiencing somatic symptoms, further emphasizing the clinical importance of emotional processing mechanisms in psychosomatic conditions (11). Taken together, these findings indicate that emotional suppression should not be viewed as an isolated cognitive-behavioral habit but as part of a broader pattern of impaired emotional regulation that may increase vulnerability to psychosomatic manifestations.

Closely related to emotional suppression is alexithymia, a construct characterized by difficulty identifying and describing emotions, externally oriented thinking, and limited emotional awareness. Alexithymia has long been associated with psychosomatic complaints because individuals who cannot effectively recognize and verbalize their internal emotional states may be more likely to experience distress through somatic channels. In patients with psychosomatic skin disorders, alexithymia and its components have been significantly related to anxiety and depression, demonstrating the broader affective burden associated with impaired emotional awareness (12). Similarly, alexithymia and emotional expressiveness have been shown to predict somatization symptoms among university students, indicating that emotional processing deficits are relevant not only in clinical samples but also in otherwise functional populations (13). The effectiveness of written emotional disclosure in modifying defense mechanisms among individuals with alexithymia further suggests that facilitating emotional expression may reduce reliance on maladaptive defensive patterns (14). These findings support the assumption that suppression, limited emotional disclosure, and reduced emotional awareness may form an interconnected network of processes through which unprocessed affective experiences contribute to somatic distress.

Defense mechanisms also provide an important theoretical framework for understanding the relationship between emotional suppression and psychosomatic symptoms. Defensive processes are psychological strategies used to reduce internal conflict, anxiety, or distress, often operating outside full conscious awareness. When individuals consistently rely on denial, repression, or other rigid defensive strategies, emotional experiences may remain insufficiently integrated and may consequently emerge through indirect behavioral or bodily channels. Studies have demonstrated meaningful relationships between defense styles and somatization (9), while personality characteristics have also been found to predict different levels of

defensive functioning (15). In addition, emotional disclosure has been associated with changes in defense mechanisms among individuals characterized by emotional-processing difficulties (14). From this perspective, psychosomatic symptoms may partly reflect an indirect expression of psychological tension that has not been adequately recognized, communicated, or cognitively processed.

Another central variable that may contribute to psychosomatic symptomatology is fear of intimacy. Fear of intimacy refers to discomfort, anxiety, avoidance, or inhibition associated with emotional closeness, self-disclosure, vulnerability, and dependency in interpersonal relationships. Individuals with high fear of intimacy may desire closeness while simultaneously perceiving close relationships as threatening, potentially resulting in emotional distancing, restricted disclosure, and reduced access to interpersonal support. Fear of intimacy has been associated with multiple relational and emotional difficulties. Among men, emotional intelligence and fear of intimacy have been shown to influence relationship satisfaction, demonstrating the importance of intimacy-related anxiety for interpersonal functioning (16). In nurses, fear of intimacy, emotional disclosure, and cognitive flexibility have been identified as significant predictors of marital conflict, suggesting that intimacy difficulties are closely intertwined with emotional and relational adaptation (17). Similarly, fear of intimacy has been associated with marital conflict and emotional granularity among women affected by marital infidelity (18), while emotion-focused therapy has been shown to reduce fear of intimacy, hostile attributions, and emotional dysregulation in women with experiences of marital infidelity (19).

Fear of intimacy can develop within the context of adverse relational experiences and insecure attachment patterns. Emotional abuse has been linked to later fear of intimacy through attachment styles and rejection sensitivity, suggesting that relational trauma may alter the perception of closeness and increase vulnerability to interpersonal avoidance (20). Fear of intimacy has also been associated with psychological pain among girls experiencing romantic breakup, where emotional expression appears to be related to psychological suffering through intimacy-related fears (21). In people with and without cancer, differences in attachment styles and fear of intimacy have also been reported, demonstrating that severe health conditions and relational schemas may jointly influence experiences of closeness and vulnerability (22). Moreover, women with social phobia have been shown to differ from healthy women in self-disclosure, intimacy, and emotional processing, reinforcing the notion that interpersonal avoidance and restricted emotional communication are closely connected (23). Such findings suggest that fear of intimacy may reduce opportunities for emotional co-regulation and social support while simultaneously increasing internalization of distress.

The psychological consequences of fear of intimacy may extend beyond relationship satisfaction and social functioning. Intimacy-related fears have also been implicated in emotionally charged and potentially maladaptive interpersonal behavior. For example, research examining power-related emotions and alcohol intoxication found that fear of intimacy contributed to understanding nonconsensual sexual intentions under specific conditions, illustrating how intimacy-related anxiety may interact with affective states and behavioral regulation (24). Although such outcomes differ substantially from psychosomatic symptoms, this evidence underscores the broader role of intimacy-related fear as a clinically relevant construct capable of shaping emotional processing, behavioral responses, and interpersonal functioning. From a psychosomatic perspective, fear of intimacy may be particularly important because individuals who avoid closeness may also be less likely to disclose emotional distress, seek interpersonal support, or process emotionally salient

experiences in relationships. Consequently, emotional tension may remain unresolved and become increasingly expressed through somatic pathways.

The relationship between emotional processing and physical symptoms is further supported by research conducted among populations with chronic pain and other stress-related physical conditions. Emotion regulation has been associated with chronic musculoskeletal pain and with individual differences in responses to ongoing physical discomfort (25). Similarly, research on migraine and stress-related gastric ulcer patients has demonstrated differences in psychological and behavioral characteristics compared with healthy individuals, supporting the broader contribution of psychological processes to stress-related physical conditions (26). Difficulties in emotion regulation have also been associated with worry and metacognitive processes, highlighting how persistent cognitive-affective dysregulation may amplify distress and contribute to maladaptive psychological functioning (27). These findings are consistent with biopsychosocial models in which emotional, cognitive, and physiological systems continuously interact, thereby influencing the emergence and persistence of bodily symptoms.

Interpersonal and personality variables may further intensify this process. Type D personality, characterized by negative affectivity and social inhibition, has been associated with health behaviors and perceived social support among individuals with coronary heart disease, illustrating the health relevance of stable emotional and interpersonal tendencies (28). Social inhibition may reduce emotional disclosure and support-seeking, thereby increasing internalized stress. In psychosomatic contexts, individuals who are simultaneously prone to emotional suppression and fearful of interpersonal closeness may be especially vulnerable because these characteristics can mutually reinforce one another. Emotional suppression may limit the external expression of internal states, while fear of intimacy may inhibit disclosure to close others who could otherwise provide support, validation, and emotional regulation. Over time, this combination may contribute to sustained physiological arousal and increase the likelihood that psychological tension will be experienced in somatic form.

Recent clinical research also suggests that interventions targeting emotional processes may be relevant for people with psychosomatic problems. Compassion-focused therapy and emotion-focused therapy have shown effectiveness in reducing fear of negative evaluation among adolescent girls with psychosomatic problems, indicating that interventions centered on emotional experience, self-compassion, and affective processing may improve clinically relevant psychological outcomes in this population (29). Likewise, emotion-focused therapy has demonstrated beneficial effects on emotion regulation and coping among women with somatic symptoms (11). These intervention findings are important because they imply that psychosomatic symptoms may be modifiable through psychological processes rather than being entirely determined by biological factors. They also reinforce the need to identify specific emotional and interpersonal predictors that can serve as targets for prevention and treatment.

Despite the growing body of evidence regarding emotion regulation, emotional suppression, intimacy difficulties, and somatic symptoms, important gaps remain. Much of the existing literature has examined these constructs separately, focusing either on emotional regulation and psychosomatic complaints or on fear of intimacy in relation to marital, attachment, or interpersonal outcomes. Fewer studies have directly examined emotional suppression and fear of intimacy together as predictors of psychosomatic symptoms in individuals who already present with psychosomatic complaints. This gap is particularly important because

these variables may represent complementary mechanisms. Emotional suppression reflects an intrapersonal tendency to inhibit affective experience and expression, whereas fear of intimacy represents an interpersonal tendency to avoid emotional closeness and vulnerability. When both tendencies are present, the individual may have limited opportunities both to process emotional experiences internally and to regulate them interpersonally. This combined pattern may increase the likelihood of sustained distress and somatic expression. The growing evidence linking emotional-awareness deficits with somatic symptoms (1), emotional suppression with stress physiology (4), and intimacy-related difficulties with impaired psychological and relational functioning (16, 20) provides a strong empirical basis for examining these constructs within a single predictive model.

Therefore, the aim of the present study was to investigate the relationship of emotional suppression and fear of intimacy with the manifestation of psychosomatic symptoms and to determine the predictive contributions of emotional suppression and fear of intimacy to psychosomatic symptoms among individuals with psychosomatic symptoms.

Methods and Materials

Study Design and Participants

In terms of its purpose, the present study was classified as applied research; in terms of the type of data, it was quantitative; and in terms of its nature, it employed a descriptive-correlational design. The statistical population consisted of individuals presenting with psychosomatic symptoms whose symptoms had been confirmed by psychologists at the psychology and psychiatry centers of Dr. Heshmatollah Mousavi. Given that the population size was considered unlimited, 30 individuals were selected per variable, yielding a total sample of 120 participants, using convenience sampling. The inclusion criteria were as follows: participants had to exhibit psychosomatic symptoms, and they had to have attended counseling centers in Rasht during 2023–2024 because of such symptoms. The exclusion criteria included the presence of chronic physical illnesses at the time of the study, incomplete completion of the questionnaires, and the occurrence of an acute symptom or condition during the study.

Data Collection Tools

Weinberger Emotional Suppression Questionnaire (1979): This questionnaire consists of 84 items, 10 subscales, and a brief validity scale. It was designed to assess long-term patterns of functioning rather than short-term symptoms and has been validated for use in both clinical and nonclinical populations. The instrument assesses three major constructs: distress, self-restraint, and defensiveness. The distress construct comprises 29 items and is divided into four dimensions: anxiety, depression, low self-esteem, and low well-being. Self-restraint comprises 30 items and includes four dimensions: suppression of anger and aggression, impulse control, consideration of others, and responsibility. Defensiveness comprises 22 items and is divided into two dimensions: repressive defensiveness and denial of distress. In addition, three items are included to assess the validity of responses. Higher scores on this scale indicate higher levels of emotional suppression (Baudic et al., 2016). The Cronbach's alpha coefficients reported by Weinberger were .91 for distress, .87 for self-restraint, .75 for denial of distress, and .79 for repressive defensiveness (Weinberger, 1971). In another study conducted by Turvey and Salovey (1994) to evaluate the psychometric properties of

questionnaires assessing emotional repression, the results indicated that, among the six instruments examined, the Weinberger Adjustment Inventory was the most psychometrically valid instrument for assessing the repressive coping style. This questionnaire was first used in Iran by Heshmati, Naseri, and Parnia Khoy (2018–2019), who reported a Cronbach's alpha coefficient of .77 for the instrument.

Fear of Intimacy Scale developed by Descutner and Thelen (1991): The Fear of Intimacy Scale was developed by Descutner and Thelen (1991). It consists of 35 items designed to assess fear of intimacy and anxiety related to close interpersonal relationships. The questionnaire is scored on a 5-point Likert scale. Responses to the options “not at all characteristic of me,” “slightly characteristic of me,” “moderately characteristic of me,” “very characteristic of me,” and “extremely characteristic of me” are assigned scores of 1, 2, 3, 4, and 5, respectively. The scoring procedure is based on a 5-point Likert format ranging from complete agreement to complete disagreement. The reported reliability coefficient for the total Fear of Intimacy Scale score was .78. The internal consistency reliability of the scale has also been assessed using Cronbach's alpha, yielding a coefficient of .779 (Hashemi, Badri Gargari, & Esmaeilpour, 2018–2019).

Psychosomatic Symptoms Questionnaire developed by Lacourt et al. (2013): The Psychosomatic Symptoms Questionnaire was developed by Lacourt et al. (2013) to assess psychosomatic symptoms. In Iran, the questionnaire was validated among employees by Heydari et al. (2021). This questionnaire consists of 39 items rated on a 5-point Likert scale and assesses psychosomatic symptoms using items addressing experiences such as dizziness, lightheadedness, and feelings of unreality. Validity concerns the extent to which a measurement instrument actually measures the construct it is intended to measure (Sarmad et al., 2011–2012). In the study by Heydari et al. (2021), the content, face, and criterion validity of the questionnaire were evaluated and found to be satisfactory. Reliability refers to the degree of consistency of an instrument in measuring the construct it is designed to assess; in other words, it indicates the extent to which a measurement instrument produces similar results under comparable conditions (Sarmad et al., 2011–2012). The Cronbach's alpha coefficient calculated for this questionnaire in the study by Heydari et al. (2021) was .95.

Data Analysis

Both descriptive and inferential statistical methods were employed to analyze the data obtained from the study sample. Descriptive statistics included the preparation of frequency distribution tables, frequency percentages, and measures of central tendency and dispersion, such as the mean and variance. In the inferential statistics section, statistical tests appropriate to the nature and structure of the data were used to test the research hypotheses. Initially, the Kolmogorov–Smirnov test was used to assess the normality of the data. Subsequently, statistical procedures including Pearson's correlation coefficient and multiple regression analysis were conducted using SPSS version 26 to examine the relationships among the study variables.

Findings and Results

The study included 120 individuals with psychosomatic symptoms. Regarding age, 38 participants (31.7%) were 18–24 years old, 51 (42.5%) were 25–30 years old, 19 (15.8%) were 31–35 years old, and 12 (10.0%) were older than 35 years. Regarding educational attainment, 21 participants (17.5%) had a high-school

diploma, 51 (42.5%) held a bachelor's degree, 38 (31.7%) held a master's degree, and 10 (8.3%) held a doctoral degree. In terms of gender, 22 participants (18.3%) were male and 98 (81.7%) were female. Thus, the largest age group consisted of participants aged 25–30 years, bachelor's degree holders constituted the largest educational group, and the majority of participants were female.

Table 1. Descriptive Statistics for the Study Variables

Variable	N	Mean	SD
Emotional Suppression	120	375.28	11.50
Fear of Intimacy	120	81.36	9.69
Psychosomatic Symptoms	120	118.95	9.53

As presented in Table 1, the mean score for emotional suppression was 375.28 (SD = 11.50), while the mean score for fear of intimacy was 81.36 (SD = 9.69). The participants had a mean psychosomatic symptom score of 118.95 (SD = 9.53). These descriptive statistics indicate variability in emotional suppression, fear of intimacy, and psychosomatic symptom scores among the participants and provide the basis for examining the associations among the principal study variables.

Prior to testing the study hypotheses, the data were screened to evaluate the statistical assumptions. The internal consistency coefficients of all study instruments were greater than .70, indicating acceptable reliability. Missing responses were handled using median-value replacement, and examination of the data did not indicate problematic outlying observations. The Kolmogorov–Smirnov test was subsequently conducted to assess the normality of the principal study variables. The results were significant for emotional suppression ($Z = 0.159$, $p < .001$), fear of intimacy ($Z = 0.169$, $p < .001$), and psychosomatic symptoms ($Z = 0.075$, $p < .001$), indicating that the distributions significantly deviated from normality. Therefore, Spearman's rank-order correlation coefficient, a nonparametric statistic, was used to examine the bivariate relationships among the study variables.

Table 2. Spearman Correlations Among Emotional Suppression, Fear of Intimacy, and Psychosomatic Symptoms

Variable	1	2	3
1. Emotional Suppression	1.00		
2. Fear of Intimacy	.67**	1.00	
3. Psychosomatic Symptoms	.70**	.27**	1.00

As shown in Table 2, emotional suppression had a strong and statistically significant positive correlation with psychosomatic symptoms ($r_s = .70$, $p < .01$), indicating that higher levels of emotional suppression were associated with greater psychosomatic symptom severity. Fear of intimacy was also positively and significantly correlated with psychosomatic symptoms ($r_s = .27$, $p < .01$), although the magnitude of this relationship was weaker. Furthermore, emotional suppression and fear of intimacy were positively correlated with each other ($r_s = .67$, $p < .01$). Therefore, both study hypotheses concerning the bivariate relationships of emotional suppression and fear of intimacy with psychosomatic symptoms were supported.

Table 3. Multiple Regression Analysis Predicting Psychosomatic Symptoms From Emotional Suppression and Fear of Intimacy

Predictor	B	SE B	β	t	p
Emotional Suppression	0.781	0.068	.942	11.43	< .001
Fear of Intimacy	-0.355	0.081	-.361	-4.38	< .001
Model Statistic	Value				

R	.750
R ²	.562
Adjusted R ²	.554
F(2, 117)	75.02
p	< .001

As presented in Table 3, the regression model including emotional suppression and fear of intimacy was statistically significant, $F(2, 117) = 75.02$, $p < .001$, and accounted for approximately 56.2% of the variance in psychosomatic symptoms ($R^2 = .562$; adjusted $R^2 = .554$). Emotional suppression emerged as the strongest predictor of psychosomatic symptoms ($\beta = .942$, $t = 11.43$, $p < .001$), indicating that greater emotional suppression was associated with higher psychosomatic symptom scores when the effect of fear of intimacy was statistically controlled. Fear of intimacy also made a statistically significant contribution to the regression model ($\beta = -.361$, $t = -4.38$, $p < .001$). Although fear of intimacy showed a positive bivariate correlation with psychosomatic symptoms, its regression coefficient became negative after emotional suppression was simultaneously entered into the model. This pattern reflects the substantial shared variance between emotional suppression and fear of intimacy ($r_s = .67$) and indicates a suppression effect in the multivariable model. Overall, the findings demonstrate that emotional suppression and fear of intimacy jointly contributed significantly to the prediction of psychosomatic symptoms, with emotional suppression accounting for the stronger unique association.

Discussion and Conclusion

The present study investigated the relationships of emotional suppression and fear of intimacy with psychosomatic symptoms among individuals presenting with psychosomatic complaints. The findings demonstrated that emotional suppression was positively and significantly associated with psychosomatic symptoms, such that higher levels of emotional suppression corresponded to greater severity of psychosomatic manifestations. Fear of intimacy was also positively and significantly correlated with psychosomatic symptoms, although this association was weaker than the relationship observed for emotional suppression. In addition, emotional suppression and fear of intimacy were significantly correlated with one another. The regression analysis further showed that the combination of emotional suppression and fear of intimacy significantly predicted psychosomatic symptoms and explained a substantial proportion of their variance. Emotional suppression emerged as the strongest positive predictor in the multivariable model. Although fear of intimacy had a positive bivariate association with psychosomatic symptoms, its standardized regression coefficient became negative after emotional suppression was entered simultaneously into the model. This finding suggests that a substantial proportion of the variance shared between fear of intimacy and psychosomatic symptoms overlaps with emotional suppression and is compatible with a statistical suppression effect rather than indicating that fear of intimacy is intrinsically protective against psychosomatic symptoms.

The significant positive relationship between emotional suppression and psychosomatic symptoms is consistent with a considerable body of literature emphasizing the importance of emotion regulation in somatic distress. Individuals who habitually inhibit emotional expression may experience emotional arousal without adequately processing, labeling, communicating, or resolving the underlying affective state. Over time, this pattern can increase internal psychological tension and physiological activation, thereby creating

conditions under which distress may become manifested through bodily symptoms. The present result is consistent with evidence showing that emotional suppression is associated with altered physiological responses to acute stress, suggesting that suppression can influence autonomic and bodily reactions rather than functioning solely as a cognitive or behavioral strategy (4). This interpretation is particularly relevant for individuals with psychosomatic symptoms, because persistent discrepancies between internal affective arousal and external emotional expression may contribute to prolonged psychophysiological activation.

The present findings also align with studies demonstrating that difficulties in emotion regulation are associated with psychosomatic manifestations. Yıldız and Duy found that emotion regulation strategies significantly predicted both depressive and psychosomatic symptoms, supporting the assumption that maladaptive regulation processes can contribute to the somatic expression of psychological distress (8). Similarly, Ghadiri et al. reported that emotion regulation and defense styles predicted somatization symptoms, highlighting the role of both consciously employed regulatory strategies and more automatic defensive processes in physical symptom expression (9). Badaye et al. likewise identified emotion regulation and defense mechanisms as important predictors of psychosomatic symptoms, with these associations varying according to distress and gender (10). Taken together, these findings support the result of the current study by indicating that psychosomatic symptoms are closely related to how emotional experiences are managed, controlled, or inhibited.

One possible explanation for the relationship between emotional suppression and psychosomatic symptoms concerns the accumulation of unprocessed emotional arousal. Suppression typically occurs after an emotional response has already been generated; therefore, inhibiting outward expression does not necessarily eliminate the underlying physiological activation. Instead, the individual may continue to experience elevated internal arousal while simultaneously attempting to conceal its behavioral manifestations. This discrepancy may increase bodily monitoring, muscle tension, autonomic activation, and sensitivity to internal sensations. Over time, recurrent suppression may contribute to increased awareness of physical discomfort while reducing awareness of the emotional meaning associated with that discomfort. This explanation is compatible with recent evidence showing that deficits in emotional awareness are associated with somatic symptoms in both community and clinical populations (1). Thus, the body may become a principal channel through which poorly differentiated or insufficiently processed affective experiences are experienced and communicated.

The association between emotional suppression and psychosomatic symptoms can also be understood through the related construct of alexithymia. Individuals with difficulty identifying and describing emotions may be more likely to suppress emotional experiences because they lack the cognitive and linguistic resources required for effective emotional processing. Prior studies have documented associations between alexithymia and psychological symptoms among patients with psychosomatic disorders (12), as well as relationships between alexithymia, emotional expressiveness, and somatization in university students (13). These findings suggest that the tendency to somatize may arise not simply from the presence of intense negative emotion, but from the inability to recognize, symbolize, express, and regulate that emotion adaptively. From this perspective, the strong association identified in the present study between emotional suppression and psychosomatic symptoms may reflect a broader deficit in emotional processing.

The significant relationship between fear of intimacy and psychosomatic symptoms also deserves attention. Fear of intimacy reflects discomfort with emotional closeness, self-disclosure, vulnerability, and dependence on others. Individuals with high fear of intimacy may avoid situations that require disclosure of personal concerns or emotional needs. Such avoidance can deprive individuals of interpersonal mechanisms that ordinarily facilitate emotional regulation, including reassurance, validation, empathy, social support, and shared meaning-making. Consequently, emotionally distressing experiences may remain unresolved and become internalized. Previous research has shown that fear of intimacy is meaningfully associated with relational and psychological maladjustment. For example, fear of intimacy has been linked to lower relationship satisfaction and poorer emotional functioning (16). It has also been identified as a predictor of marital conflict along with emotional disclosure and cognitive flexibility (17). These findings support the proposition that fear of intimacy may increase psychological burden by restricting adaptive interpersonal regulation.

The present finding regarding fear of intimacy is also compatible with evidence indicating that intimacy-related fears are connected with attachment insecurity and prior relational adversity. Finzi-Dottan and Abadi showed that emotional abuse was associated with fear of intimacy through attachment styles and rejection sensitivity, suggesting that individuals who perceive closeness as threatening may develop defensive patterns characterized by emotional distancing and avoidance (20). Similarly, fear of intimacy has been associated with emotional dysregulation and hostile interpersonal interpretations among women affected by marital infidelity (19). Shishefar et al. also reported that fear of intimacy mediated the relationship between emotional expression and psychological pain among individuals with experiences of romantic breakup (21). These studies reinforce the view that intimacy-related anxiety may function as an interpersonal barrier to emotional expression and recovery from distress.

The positive correlation between emotional suppression and fear of intimacy found in the present study is theoretically meaningful. Fear of intimacy may encourage individuals to inhibit emotional disclosure because expressing vulnerable feelings can be perceived as increasing the risk of rejection, criticism, loss of control, or dependency. Conversely, habitual emotional suppression may impair the development of intimate relationships because emotional closeness depends partly on the ability to communicate internal experiences openly and reciprocally. Thus, the two variables may reinforce one another in a cyclical pattern. Evidence from research on social phobia similarly indicates that reduced self-disclosure and impaired emotional processing coexist with difficulties in intimacy (23). Karababa also showed that suppression of positive and negative emotions is associated with loneliness and romantic relationship satisfaction, further demonstrating the close connection between emotional inhibition and interpersonal disconnection (5). This interaction may be especially important in psychosomatic populations because simultaneous difficulty with emotional expression and interpersonal closeness can substantially reduce access to both intrapersonal and interpersonal regulation resources.

The multivariable findings provide an additional layer of interpretation. Emotional suppression remained a very strong positive predictor of psychosomatic symptoms after fear of intimacy was statistically controlled, indicating that suppression had a substantial unique association with symptom severity. In contrast, fear of intimacy showed a negative standardized coefficient in the simultaneous regression model despite its positive zero-order correlation with psychosomatic symptoms. This pattern should not be

interpreted as evidence that fear of intimacy reduces psychosomatic symptoms. Rather, it is likely related to the considerable correlation between emotional suppression and fear of intimacy. When highly correlated predictors are included simultaneously, the regression coefficient for one predictor reflects only its unique residual variance after removing variance shared with the other predictor. Under such conditions, coefficient reversal can occur, producing a statistical suppression effect. Therefore, the bivariate finding remains important: greater fear of intimacy was associated with more psychosomatic symptoms, while the multivariable result indicates that much of this association may operate through emotional suppression or through variance shared with it.

This interpretation is supported by research demonstrating the interdependence of emotional and interpersonal processes. Social support has been shown to mediate associations involving anxiety and emotional suppression, suggesting that the interpersonal environment can influence the psychological consequences of emotional inhibition (6). Similarly, attachment and emotion regulation have been shown to contribute jointly to psychosomatic symptoms (10). Fear of intimacy may therefore affect psychosomatic functioning partly through reduced emotional disclosure, diminished support seeking, and increased reliance on suppressive regulation. In this sense, emotional suppression may represent a more proximal mechanism linking interpersonal avoidance to somatic manifestations.

The findings are also consistent with broader research on psychosomatic and stress-related conditions. Differences in psychological functioning have been reported among patients with migraine and stress-related gastric ulcers compared with healthy individuals, supporting the involvement of psychological processes in conditions characterized by prominent physical symptoms (26). Studies of chronic pain have similarly shown relationships between emotion regulation and pain-related functioning (25). Moreover, Type D personality, characterized partly by social inhibition and negative affectivity, has been associated with health behavior and perceived social support in individuals with coronary heart disease (28). Together, these findings suggest that emotional inhibition and interpersonal withdrawal may be relevant across a broad range of health-related conditions involving persistent bodily distress.

The present results also have clinical implications because emotional suppression is potentially modifiable. Evidence indicates that emotion-focused interventions can improve emotion regulation and coping strategies among individuals with somatic symptoms (11). Similarly, emotion-focused and compassion-based therapies have demonstrated benefits for psychological outcomes among adolescents with psychosomatic problems (29). Written emotional disclosure has also been shown to affect defensive functioning among individuals with alexithymia (14). These findings suggest that interventions designed to increase emotional awareness, improve differentiation of affective states, facilitate safe emotional expression, and reduce rigid suppression may be particularly relevant for individuals with psychosomatic symptoms.

In addition, therapeutic work with fear of intimacy may be valuable because improving the capacity for closeness and disclosure can increase access to social support and interpersonal emotion regulation. Fear of intimacy has been shown to be responsive to emotion-focused interventions in relationally distressed populations (19). Because the current findings suggest that fear of intimacy and emotional suppression are substantially interconnected, interventions that address only one of these domains may be less effective than approaches that simultaneously target emotional expression and interpersonal safety. Treatment may

therefore benefit from integrating emotion-regulation training with interventions addressing attachment insecurity, rejection sensitivity, vulnerability, trust, and self-disclosure.

The findings of the present study should be interpreted in light of several limitations. First, the cross-sectional correlational design does not permit causal conclusions regarding whether emotional suppression and fear of intimacy contribute to psychosomatic symptoms or whether persistent psychosomatic distress itself increases emotional inhibition and interpersonal avoidance. Second, convenience sampling limits the representativeness of the sample and may reduce the generalizability of the findings to other clinical or community populations. Third, the study relied on self-report questionnaires, making the results potentially vulnerable to response bias, social desirability, recall limitations, and shared-method variance. Fourth, the sample included a substantially larger proportion of women than men, which may have affected the observed relationships. Finally, although emotional suppression and fear of intimacy explained a considerable proportion of variance in psychosomatic symptoms, other relevant factors, including anxiety, depression, attachment style, perceived stress, alexithymia, personality characteristics, and social support, were not included in the predictive model.

Future studies should employ longitudinal designs to clarify the temporal direction of the relationships among emotional suppression, fear of intimacy, and psychosomatic symptoms. Research with larger and more diverse samples is also recommended, particularly studies with more balanced gender distributions and participants from different age groups, clinical settings, and sociocultural backgrounds. Future investigations could test mediation and moderation models to determine whether emotional suppression mediates the association between fear of intimacy and psychosomatic symptoms or whether variables such as attachment insecurity, rejection sensitivity, perceived social support, alexithymia, and psychological distress alter the strength of these relationships. Using multimethod assessment approaches, including clinical interviews, physiological indicators, behavioral measures, and reports from significant others, would also help reduce dependence on self-report data. Experimental and intervention studies could further determine whether reducing emotional suppression or fear of intimacy leads to measurable reductions in psychosomatic symptom severity.

In clinical practice, assessment of individuals presenting with recurrent or persistent psychosomatic symptoms should include systematic evaluation of emotional regulation patterns and interpersonal functioning in addition to physical symptom assessment. Clinicians may benefit from identifying whether patients habitually suppress emotions, experience difficulty naming or communicating feelings, avoid emotional closeness, or perceive interpersonal vulnerability as threatening. Psychological interventions can focus on developing emotional awareness, differentiating and labeling affective states, increasing tolerance of emotional activation, reducing rigid suppression, and strengthening adaptive emotional expression. Interventions may also address gradual and safe self-disclosure, trust, interpersonal boundaries, and tolerance of intimacy. Integrating these components into psychosomatic treatment may help patients develop more adaptive channels for processing psychological distress and may reduce reliance on bodily expression as a primary manifestation of unresolved emotional tension.

Acknowledgments

The authors express their deep gratitude to all participants who contributed to this study.

Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

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