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Pathways of Psychosomatic Diagnosis: A Psychoanalytic Elaboration of Failures of Symbolization and the Destinies of Bodily Symptoms.

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Abstract

The diagnosis of psychosomatic disorders places clinicians before a fundamental epistemological tension: the tension between the medical drive toward somatic objectification and the subjective, dynamic economy of the psyche. This article offers a distinctly psychoanalytic framework for psychosomatic diagnosis, foregrounding failures of symbolization, désaffectation, and disturbances in mentalization. Drawing upon the seminal contributions of Freud, Alexander, Marty, McDougall, Green, Smadja, Winnicott, and Bion, it argues that psychosomatic bodily symptoms cannot be adequately grasped either as straightforward organic causality or as classical hysterical conversion. Instead, they emerge at the point where psychic linkage collapses and what psychoanalysis has termed "the work of the negative" takes over. Psychosomatic diagnosis is therefore reconceptualized not as a static classificatory act but as a living, elaborative clinical process that unfolds within the transference and the unique temporality of the therapeutic relationship. A detailed clinical vignette illustrates this process, while recent advances in mentalization-based treatment and neuropsychoanalytic research are critically examined and integrated.

Keywords: psychosomatics, diagnosis, psychoanalysis, body, symbolization, désaffectation, mentalization, work of the negative

Methodology of the Article

This work constitutes a theoretical-conceptual review rather than a systematic empirical study. The selection of thinkers (Freud, Alexander, Marty, McDougall, Green, Smadja, Winnicott, and Bion) was guided by their foundational and enduring contributions to the psychoanalytic understanding of psychosomatic phenomena, with particular emphasis on the Paris School and its Anglo-Saxon extensions. Sources were included only when they directly addressed failures of symbolization, operative thinking (pensée opératoire), or the work of the negative in relation to bodily symptoms. Purely biomedical or cognitive-behavioral models were deliberately excluded. The analysis is interpretive and critical, aiming at theoretical synthesis and elaboration rather than exhaustive aggregation of evidence. While this approach permits genuine conceptual innovation, it inevitably carries the risk of selective emphasis—an acknowledged limitation addressed in the concluding section.

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1. Introduction

Psychosomatic phenomena occupy a unique and somewhat paradoxical position in clinical psychoanalysis. They expose the inherent limits of any explanatory model that insists on a neat separation between soma and psyche (Freud, 1922/1985). In the diagnostic encounter, the clinician confronts both the medical imperative to objectify symptoms and the psychoanalytic commitment to uncovering subjective meaning. When bodily symptoms persist without sufficient organic explanation, they do not merely indicate a gap in medical knowledge; they reveal a deeper failure in the psyche's own capacity for elaboration (Marty, 1993).

Although classical Freudian theory brilliantly demonstrated how bodily symptoms may express unconscious conflict—most notably in hysterical conversion (Freud, 1915/1988)—everyday clinical reality with psychosomatic patients frequently demands a different theoretical lens. Many such patients present with strikingly impoverished fantasy life, limited dream recall, and a conspicuous flattening of affect (McDougall, 1989). These characteristics compel us to move beyond interpreting the symptom as a symbolic message and to recognize it instead as a substitute for psychic activity itself. The central hypothesis advanced here is that psychosomatic diagnosis must be understood not as a diagnostic verdict but as an ongoing process of psychoanalytic elaboration whose primary task is to explore the conditions that either enable or obstruct the symbolization of affect and bodily experience.

2. The Impasse of Objectifying Diagnosis

Biomedical reasoning operates on the assumption that symptoms are reliable indicators of measurable physiological dysfunction (American Psychiatric Association, 2013). In this framework, the clinician's task is to locate identifiable lesions or mechanisms that fully account for the complaint. Psychosomatic disorders, however, persistently disrupt this logic: the suffering is real, yet objective findings remain elusive or absent. Faced with such an impasse, clinicians may swing between reflexive psychologization and exhaustive (and often futile) medical investigations. Both responses inadvertently reinforce the very split between body and psyche that the patient is unconsciously enacting. From a psychoanalytic viewpoint, this diagnostic deadlock signals not an absence of causality but a profound deficit in psychic processing (Smadja, 2001). The body thus becomes the arena where unmentalized excitation is discharged because it cannot be transformed into thought.

3. From the Symbolic Body to the Real Body

Freud's early model of hysteria framed bodily symptoms as symbolic compromise formations arising from the conflict between unconscious wishes and defensive forces (Freud, 1915/1988). This elegant formulation presupposes a psychic apparatus already capable of converting drive excitation into representational form. Psychosomatic practice, however, frequently challenges this presupposition. Franz Alexander's (1950) pioneering attempt to identify specific emotional constellations linked to particular diseases opened an important pathway toward integrating affective life into somatic medicine, yet it remained largely captive to linear causal thinking.

A genuine theoretical breakthrough occurred with the emergence of the Paris School of Psychosomatics. Pierre Marty (1993) described psychosomatic illness as intimately connected

to a form of impoverished mental functioning characterized by *pensée opératoire*—a concrete, action-oriented mode of thought accompanied by emotional flattening. In this state, bodily symptoms cease to function as metaphors and instead appear as the direct outcome of a collapse in the capacity for mental representation.

Table 1

Comparative Overview of Hysterical Conversion versus Psychosomatic Symptoms

Aspect	Hysterical Conversion (Freud)	Psychosomatic Symptoms (Paris School & Beyond)
Psychic mechanism	Symbolic compromise formation	Collapse of symbolization and mentalization
Affect	Highly charged, displaced	Flattened or evacuated (désaffectation)
Fantasy life	Rich and accessible	Impoverished, pensée opératoire
Relation to the body	Body as stage for symbolic drama	Body as site of unmentalized discharge
Diagnostic implication	Interpretable as unconscious wish	Requires elaboration of psychic linkage

4. Contemporary Classifications and Their Limits

Current diagnostic systems such as the **Diagnostic and Statistical Manual of Mental Disorders** (5th ed.; DSM-5) classify persistent somatic complaints under the umbrella of Somatic Symptom Disorder (American Psychiatric Association, 2013). While these criteria provide practical tools for epidemiological and institutional purposes, they remain fundamentally descriptive. They shed little light on the underlying psychic dynamics that give rise to the somatic manifestation. From a psychoanalytic standpoint, such classifications risk stripping the symptom of its subjective resonance (Green, 1993/2015), treating it as an autonomous clinical entity detached from the patient's relational history, affective economy, and psychic structure.

5. De-affectation, Dementalization, and the Work of the Negative

Claude Smadja (2001) introduced the concept of ***dementalization*** to capture states in which the psychic functions responsible for transforming raw affect into representable experience are severely impaired. In such conditions, affect is neither symbolized nor thought; it is evacuated directly through the body. Joyce McDougall (1989) evocatively described the psychosomatic body as a "theater of substitution," where psychic dramas that cannot be staged internally are enacted somatically. André Green (1993/2015), through his theory of the *work of the negative*, further illuminated processes of de-objectalization, affective blanching, and the rupture of psychic linkages. Within this framework, the psychosomatic crisis appears as a form of internal acting-out—an action turned against the self in place of unconscious representation. The productive dialogue between Green and Marty (as elaborated by Jaeger, 2017) underscores

the necessity of a plurimodal approach that integrates conflict, economic, and structural perspectives.

Table 2

Key Psychoanalytic Concepts in Psychosomatic Theory

Concept	Author(s)	Definition and Clinical Relevance
Pensée opératoire	Marty (1993)	Concrete, action-focused thinking with emotional flattening
Désaffectation	Smadja (2001)	Evacuation of affect through the body instead of representation
Work of the Negative	Green (1993/2015)	Rupture of psychic linkages and de-objectalization
Theater of Substitution	McDougall (1989)	Somatic enactment of unmentalized psychic dramas
Containment / Alpha Function	Bion (1962/1991)	Transformation of raw sensory experience into thinkable elements

6. Contributions of Winnicott and Bion: Environment and Containment

Donald Winnicott (1965/1989) highlighted how early failures in environmental provision—particularly in the *holding function*—undermine the development of a coherent body-self relationship. Similarly, Wilfred Bion's (1962/1991) theory of containment offers a powerful lens: when beta elements cannot be transformed into alpha function, unprocessed experience remains trapped in the body. Both perspectives remind us that psychosomatic diagnosis must attend first to the patient's early relational history and capacity for containment rather than rushing toward premature symbolic interpretation.

7. Diagnosis as a Psychoanalytic Process: Clinical Illustration

Within the psychoanalytic setting, diagnosis is never a one-time event but a process that unfolds gradually within the transference. It requires the clinician's willingness to tolerate uncertainty and to resist the pressure for immediate understanding (Green, 1998).

Clinical vignette (anonymized composite case): Mr. A., a 42-year-old engineer, was referred after three years of unrelenting lower back pain despite exhaustive orthopedic and neurological investigations that yielded no organic explanation. In the first eight sessions he spoke in a flat, almost mechanical tone, describing his pain simply as "a stone that is just there." He offered no associations, no dreams, no emotional coloring whatsoever. When the analyst gently inquired, "What tends to happen in your life when the pain becomes stronger?" Mr. A. became visibly tense, his face flushed, and he snapped, "You think it's all in my head, don't you? Like the others." The analyst felt a sudden wave of irritation and helplessness—an intense countertransference reaction that mirrored the patient's own fear of being disbelieved and invalidated. Instead of interpreting, the analyst named the feeling in the room: "It seems very important to you that I don't dismiss your pain as imaginary." This simple containment allowed the first crack in the patient's defensive wall.

Over the following three months (sessions 9–25), fragments of a painful history slowly emerged: chronic emotional neglect and occasional physical abuse by both parents during adolescence. The back pain predictably intensified in the hours preceding sessions in which Mr. A. began to approach feelings of rage. Rather than decoding the pain as a direct "symbol of anger," the analyst worked patiently with the patient's bodily experience itself. In one memorable session, when the pain surged, the analyst said quietly: "Right now, as you remember that scene with your father, you feel something very heavy pressing in your lower back… and I notice your breathing has become shallower. What else do you sense in your body?" Mr. A. paused for nearly two minutes, then replied for the first time with a hint of surprise: "There is… heat… rising here in my chest." This moment marked the beginning of differentiation between pure sensation and emerging affect.

By the sixth month (sessions 26–40), a clearer process of mentalization began. Mr. A. started to bring short, fragmented dreams for the first time. The analyst observed that when the patient could name the anger ("I felt like I wanted to hit him"), the back pain would ease noticeably within the session. Countertransference shifted from boredom and helplessness to a quiet sense of shared discovery. The analyst's own bodily resonance—occasional tension in the shoulders—became a valuable tool for sensing when the patient was approaching an unmentalized zone.

This extended vignette illustrates how diagnosis in psychosomatics is not an act of decoding but a co-created process of gradual symbolization. The symptom was slowly transformed from an alien, concrete "stone" into a meaningful, albeit painful, link to the patient's affective history.

Table 3

Stages of Psychoanalytic Psychosomatic Diagnosis (Illustrated by Mr. A.'s Case)

Stage	Description	Clinical Marker in Vignette	Theoretical Link
1. Initial Impasse	Flattened affect + refusal of psychological meaning	"It's just a stone… You think it's in my head"	Pensée opératoire & désaffectation
2. Containment	Analyst tolerates countertransference	Naming fear of disbelief	| Bion's containment
3. Emergence of History	Gradual appearance of relational trauma	Memories of neglect and abuse	Winnicott's holding
4. Mentalization	Differentiation of sensation from affect	"Heat in my chest" + naming anger	Green's work of the negative
5. Symbolic Re-linking	Symptom becomes thinkable and less persecutory	Pain eases when anger is verbalized	Restoration of psychic linkage

8. Discussion: Transference, Countertransference, and Recent Developments

Psychosomatic patients often evoke intense countertransference reactions—boredom, helplessness, or an urge to refer the patient elsewhere (McDougall, 1989). Far from being obstacles, these reactions serve as valuable diagnostic indicators, mirroring the patient's own difficulty in linking affect to representation. The analyst's capacity to contain and metabolize such feelings becomes, in itself, a primary therapeutic and diagnostic instrument.

Recent contributions have enriched this classical model. Lemma (2021) advocates a "body-centered psychoanalysis" that pays close attention to somatic resonance in the analyst's own experience. Fonagy and Target (2019) have demonstrated the efficacy of mentalization-based treatment in reducing somatic complaints by strengthening reflective functioning. From a neuropsychoanalytic perspective, Schore (2022) has linked early right-brain affect regulation and attachment security to later psychosomatic vulnerability. These developments do not supplant the classical framework; they complement and extend it.

9. Limitations of the Present Article

Several limitations should be acknowledged. The focus remains primarily on the Paris School and its immediate interlocutors; other rich traditions (German psychosomatic medicine, the Frankfurt School) are not examined here. The clinical vignette, though carefully constructed as a composite, does not constitute empirical data. Childhood psychosomatic disorders and the long-term effects of early trauma receive only brief mention. Finally, the article does not address the complex interplay between psychoanalytic work and psychopharmacological interventions. These areas clearly merit systematic exploration in future research.

10. Conclusion

An expanded psychoanalytic perspective on psychosomatic diagnosis compels us to move beyond the sterile opposition of body versus psyche. Bodily symptoms in psychosomatic conditions signal not hidden symbolic messages but failures in the processes of symbolization and psychic linkage (Green, 1993/2015; Marty, 1993). By conceptualizing these phenomena through the twin lenses of the work of the negative and désaffectation, psychoanalysis offers a coherent and clinically fertile path. Diagnosis thereby transforms from a classificatory gesture into a genuine elaborative process—one that creates the conditions for the gradual re-emergence of psychic thought where it had previously collapsed. Future clinical research should continue to investigate how mentalization-based and body-focused psychoanalytic approaches can be thoughtfully integrated into everyday practice.

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