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АКТУАЛЬНІ ПИТАННЯ ПСИХОЛОГІЇ

THE PSYCHOSOMATIC PARADIGM: INTEGRATIVE PATHWAYS IN PSYCHOLOGICAL COUNSELLING, CLINICAL PSYCHOLOGY AND PSYCHOTHERAPY

ПСИХОСОМАТИЧНА ПАРАДИГМА: ІНТЕГРАЦІЯ У ВИМІРАХ ПСИХОЛОГІЧНОГО КОНСУЛЬТУВАННЯ, КЛІНІЧНОЇ ПСИХОЛОГІЇ ТА ПСИХОТЕРАПІЇ

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This article considers the psychosomatic paradigm an integration framework in psychological counselling and psychotherapy. Based on psychoanalytic legacies, the model developed into a multidimensional theory that respects the convergence of biological, psychological, social, and ecological systems. This is a transformation of the reductionist towards systemic and meaning-driven practices in the clinic. Central concepts by Franz Alexander, George Engel, and the Chicago School are revisited, demonstrating the progression of developments in the transition from the initial psychodynamic formulations to Engel's biopsychosocial model. Concepts of alexithymia and allostatic load further refine the specifications of the effects of emotional processing and chronic stress on somatic health. The Pesseschkian' psychosomatic curve, developed by Arno Remmers, accounts for the progression of symptoms from the disruption of affect to the development of symptoms at the vegetative and organic levels. This diagnostic and therapy-providing model invites clinicians to examine symptom stories in metaphor and embodiment. Recent research underscores the role of epistemic trust and mentalisation in treatment outcomes. Efficiently developed, these capacities promote emotional control, insight into the patient, and treatment adherence. Therapeutic response at the beginning of therapy, dictated by the patient's beliefs, also foretokens the improvement in the longer term. Strategies applied include Well-Being Therapy, somatically oriented techniques, and clinometric measures like the Diagnostic Criteria of Psychosomatic Research. They facilitate differential, holistically oriented treatment and the contextualisation of symptoms. Its significance in the public health and lifestyle medical sectors is in recognising disease and therapy's structural and social determinants. Ultimately, the paradigm is a humane, collaborative, and person-oriented approach to care.
Key words: *psychosomatic paradigm, biopsychosocial model, epistemic trust, mentalisation, therapeutic alliance, allostatic load, symbolic symptoms.*

У статті розглядається психосоматична парадигма як інтегративна модель у психологічному консультуванні та психотерапії. Витоки цієї моделі лежать у психоаналітичній традиції, однак із часом вона трансформувалась у багатовимірний підхід, що враховує взаємодію біологічних, психологічних, соціальних та екологічних чинників. Такий зсув від редукціонізму до системного та смислового бачення є ключовим для сучасної клінічної практики. У центрі уваги – праці Франца Александера, Джорджа Енгеля та Чиказької школи, які заклали основу для розуміння несвідомих процесів у соматичній симптоматиці. Подальші концепції, як-от алекситимія та алостатичне навантаження, розширили психосоматичне бачення шляхом включення емоційної регуляції та хронічного стресу. Концепція «психосоматичної дуги», що заснована на ідеях Н. Песешкяна та описана Арно Реммерсом пояснює розвиток симптомів від емоційного розладу до вегетативних та органічних порушень. Ця модель слугує як діагностичним, так і терапевтичним орієнтиром, спонукаючи до роботи з символічним змістом симптомів. Дослідження підтверджують важливість епістемічної довіри та менталізації як чинників терапевтичних змін. Їх розвиток пов'язаний зі зменшенням дистресу та покращенням адаптації. Ранній терапевтичний ефект також виявляється прогностично значущим і залежить від уявлень пацієнта про хворобу. Серед клінічних стратегій – Терапія Благополуччя, тілесно-орієнтовані методи, макро- і мікроаналіз симптомів, а також клініметричні інструменти. Вони забезпечують персоналізований і цілісний підхід. Психосоматична парадигма виходить за межі медицини, охоплюючи публічне здоров'я та соціальні детермінанти, пропонуючи гуманний, міждисциплінарний вектор розвитку психотерапевтичної допомоги.
Ключові слова: *психосоматична парадигма, біопсихосоціальна модель, епістемічна довіра, менталізація, терапевтичний альянс, алостатичне навантаження, символізація симптому.*

Problem statement. The discipline of psychosomatic medicine in the last century has transformed dramatically, evolving from a psychoanalytic tradition of exploration to a highly developed interdisciplinary approach that shapes current psychological counselling and psychotherapy. At its essence, the psychosomatic paradigm is concerned with how emotional and psychological processes affect – but are inextricably contained within – physiological systems, producing a continuum of functional and organic disturbances.

By Franz Alexander and the Chicago School, early models launched the development of psychosomatic theory, the theory that unconscious intrapsychic strife might become expressed in the body as "organ neuroses". Later critiques by Carlsson and Jern [3] challenged the models' implicit linearity of causality in favour of systems and a dialectical approach to disease causation more in line with the dynamic interchange of biological, psychic, and social determinants of health.

The biopsychosocial approach, influentially launched by George Engel [5], is a milestone reconceptualisation of health and sickness. It remains a cornerstone epistemological framework in psychosomatic research and treatment. Subsequent developments in the theory of personality and affect research, the alexithymia construct of Taylor, Bagby, and Parker [19], more precisely targeted emotional awareness and processing deficits in psychosomatic exploration. This model diverted attention away from conflict per se, in the direction of the cognitive-affective processes that condition the somatisation of suffering.

In the past decades, the paradigm evolved further by incorporating knowledge from affective neuroscience, psychoneuroimmunology, and network medicine. McEwen's [11] work on the concept of allostatic load led to a physiological explanation of the accumulation of the burden of stress, while Sivik and Schoenfeld [18] and Lázár [10] elaborated pluralistic models like the psychosomatology and the network paradigm. These views highlight the need to conceptualise disease as a result of multilevel interaction in personal, relational, cultural, and environmental systems.

At the same time, psychosomatic theory regained salience in Lifestyle Medicine, and in a series of publications, Fava, Cosci, and others [4; 6; 7] presented the argument in support of a reconceptualisation of the role of the patient as active health producer. This perspective relocates the patient not as a passive recipient of treatment but as a co-creator of health – involving self-regulation, collaborative decision-making, and modulation of lifestyle, mood, and psychosocial context.

Therapeutically, the psychosomatic approach requires a tuned-in, relational style to detect somatic symptoms' symbolic, defensive, and communicatory aspects. Writers like Remmers [15] and Mentzos [12] promote an interpretative framework that supports the metaphorical discourse of the body and intertwines this with body-oriented techniques, mentalisational strategies, and the development of epistemic trust [16]. These innovations meet empirical support in studies of early therapeutic reaction [20], reflective functioning [9], and the role of the therapeutic alliance [13; 21].

This paper presents a conceptual synthesis and comprehensive review of the psychosomatic paradigm, following the historical lineage, theoretical development, and practical use of psychological counselling and psychotherapy. Emphasis is given to clinical presentation, therapeutic techniques, and the epistemic and relational conditions under which one heals. In doing so, the paper contends that the psychosomatic approach is not a specialised adjunct to general mental health care but a foundational orientation – one that needs to be revisited in both clinical education and practice.

Analysis of Recent Studies and Publications. Recent empirical research has also supported the priority of the psychosomatic therapy processes. In particular, research by Riedl et al. [16] illustrates that increased epistemic trust and mentalising ability are strong predictors of the effectiveness of therapy in psychosomatic rehabilitation. Those who formed increased trust in their therapists and improved their capacities of mentalising experienced significant decreases in psychological disturbance, underlining the role of the safety of the relationship and self-awareness as mediators in treatment outcomes.

In addition, von der Warth et al. [20] highlight the prognostic significance of the earliest treatment response, indicating that initial benefits correlate with sustained improvements. Significantly, this is not only a consequence of symptom severity but of the patients' beliefs concerning their disease and its treatment, including expectations, control, and understandability of the condition. These findings highlight the necessity of psychosomatic interventions that centre on the earliest uptake, clarification of beliefs, and building trust in the working alliance.

Purpose of the article. The central aim of this article is to critically assess the theoretical underpinnings, clinical uses, and interpersonal processes of the psychosomatic paradigm in psychological counselling and psychotherapy. Informed by contemporary interdisciplinary studies and clinical data, the article sheds light on how psychosomatic models provide a multidimensional, integrative account of symptomatology above and beyond the conventional mind-body dualisms.

Presentation of the primary material. The developmental theory of psychosomatics bears witness to paradigm changes in conceptualising the human condition. Based on the initial psychoanalytic theory, the psychosomatic method developed considerably in the last century in the conceptual and methodological directions. Today, it is an integrative framework that links psychodynamic theory, systems theory, neuroscience, behavioural medicine, and socio-cultural health models.

The classical psychosomatic paradigm emerged from the works of Franz Alexander and the Chicago School in the early 20th century. Alexander theorised that unconscious emotional conflicts could manifest in specific organ systems, a phenomenon he described as "organ neuroses." This psychodynamic approach was revolutionary in connecting internal psychic processes to somatic illness. However, as the field matured, the limitations of linear, monocausal explanations became increasingly evident.

Carlsson and Jern [3] were amongst the earliest to question the insufficiency of this linear causality, proposing a systems-based, dialectical approach in its place. They contended that the aetiology of the

disease is not explicable in terms of solitary psychological or somatic causes but is more effectively conceptualised as a dynamic interaction of social, psychological, and biological systems. This systems-based orientation paved the way for a more inclusive and context-specific view of psychosomatic functioning.

One of the defining points in the history of psychosomatic medicine was George Engel's [5] advent of biopsychosocial theory, which questioned the Western biomedically oriented mind-body dualism of the time. Engel suggested that both health and disease result from the interaction of biological, psychological, and social factors, presenting a comprehensive and person-centred system of clinical history and treatment planning. It continues to be a foundation of modern psychosomatic and holistic medicine.

As the theory of psychosomatics developed, it incorporated new developments in emotion and personality theory. Taylor, Bagby, and Parker [19] proposed the alexithymia construct as a development of the theory of psycho-somatics. Alexithymia is the lack of awareness and verbal facility concerning emotion, which is hypothesised to cause sustained physiological activation and susceptibility to somatic disease. This theoretical change involving the transition from the concept of unconscious conflict to the deficit in emotional processing was a paradigm change in both psycho-somatic research and clinical practice.

In recent years, the development of psychoneuroimmunology and affective neuroscience provided empirical support to the mind-body link. McEwen's [11] theory of allostatic load illustrates the physiological cost of chronic psychological stress, showing how psychosocial adversity causes dysregulation at the systems and disease levels. These results are consonant with the integrative perspective of Sivik and Schoenfeld [18], who define psychosomatology as a multidisciplinary exploration of the bidirectional interactions of neuroendocrine, immunological, societal, and psychological systems.

Lázár [10] develops this integrative vision further by adding the network paradigm, where the psychosomatic is seen in a larger web of biopsychosocial and cultural determinants. This framework transits attention away from standalone clinical syndromes towards systems of meaning, physiology, and context and their intersections. This view of network medicine sees it as a strategic method of searching for connections across the domains of biology and experientiality to achieve a more nuanced clinical work.

The practical effects of these theoretical developments have been set out by Fava, Guidi, and Sonino, who advocate a holistically oriented model of psychosomatic care. This model stresses a movement from disease-specific treatment towards personal, patient-focused strategies that utilise psychosocial resources and promote collaborative health planning. In the same vein, Fava, Cosci, and Sonino [7] outline how psychosomatic work needs to include the assessment of chronic stress, maladaptive coping, alexithymia, and demoralisation. They advocate the need to widen diagnostic criteria and, in this regard, outline Well-Being Therapy as a new psychotherapeutic approach that seeks to increase emotional resilience and quality of life.

Putting these views together shows how psychosomatic theory has evolved from a conflict-based to a pluralistic, interdisciplinary approach. It embraces a variety of explanatory models – ranging from unconscious processes and emotional dysregulation to sociocultural determinants and neurobiological mechanisms – and always yields a holistic conception of health and illness. This emergent paradigm is theoretically sound and clinically applicable, facilitating nuanced assessment and multifaceted treatment in psychological counselling and psychotherapy.

In order to present a concise integration of the theoretical foundations and clinical considerations addressed in this article, the following tables detail the core elements of the psychosomatic paradigm, its development, and its utilisation in psychotherapeutic settings. Table 1 provides a conceptual contrast between the conventional biomedical models and the integrative psychosomatic approach, and Table 2 summarises the relational and treatment factors delineated as essential to effective psychosomatic treatment. These models serve to inform clinicians, educators, and researchers in the translation of advanced interdisciplinary theory to organised clinical practice.

In clinical environments, psychosomatic presentations account for many patient encounters, especially in primary care, psychiatry, cardiology, and gastroenterology. Such patients present persisting somatic symptoms – chronic fatigue, gastrointestinal anomalies, cardiovascular symptoms, dermatological disorders, or pain syndromes – that no organic pathology can account for. Although the symptoms seem medically unexplained, the psychosomatic construct reconceives them as not illusory or secondary to psychiatric conditions but as integrative, intricate expressions of psychological, biological, and social interaction [1; 2].

From a psychosomatic perspective, somatic symptoms are typically expressions of psychic conflict, dysregulation of emotional processing, or inappropriate coping with stress [19]. Note, however, that these symptoms also have the potential to serve the defence, symbolic, or communicative roles inscribed in the patient's biography and sociogenic context [4]. It is,, therefore,, crucial to distinguish these presentations as distinct from factitious disorders, malingering, or primary medical illness while keeping the subjective experience of the patient real and valid. The therapist's task is to achieve a delicate attunement and then weigh validation against gentle exploration of psychological factors.

Cosci and Fava [6] have pushed the psychosomatic approach forward by incorporating it into Lifestyle Medicine, and the philosophy of the health producer patient these two writers reconsider the role of

Table 1

Conceptual Distinctions: Biomedical vs Psychosomatic Models of Health and Illness

Dimension	Biomedical Model	Psychosomatic Paradigm
Ontology of Disease	Disease as isolated pathology in specific organs	Illness as a product of bio-psycho-social interactions
Causality	Linear, reductionist (e.g., pathogen → disease)	Multifactorial, systemic, contextual
Patient Role	Passive recipient of treatment	Active health producer and collaborator
Symptom Interpretation	Objective, somatic-only	Symbolic, communicative, emotionally meaningful
Therapeutic Focus	Pharmacological/surgical intervention	Integrative: psychological, lifestyle, relational, and body-oriented
Key Theoretical Figures	Virchow, Pasteur	Alexander, Engel, McEwen, Fava, Remmers
Assessment Tools	Biomedical diagnostics	Clinimetric models, macro/microanalysis, narrative interviews
Core Values	Objectivity, standardisation	Contextuality, meaning, relational attunement

Table 2

Critical Success Factors in Psychosomatic Counselling and Psychotherapy

Therapeutic Factor	Definition	Key Literature	Clinical Implication
Epistemic Trust	Patient's capacity to accept therapeutic input as trustworthy and relevant	Riedl et al. (2023), Fonagy et al. (2015)	Foundational to alliance-building and symptom re-signification
Mentalisation	Ability to reflect on one's own and others' mental states	Riedl, Rothmund et al. (2023); Laskoski et al. (2021)	Enhances affect regulation and self-awareness
Early Response	Positive clinical shift within the first 2 weeks of treatment	von der Warth et al. (2025)	Predictive of long-term outcome; influenced by treatment expectations
Therapeutic Alliance	Empathic, validating, collaborative therapist-patient relationship	Panou & Baourda (2025); Remmers (2022)	Facilitates openness to symptom exploration and behaviour change
Symbolic Language	Use of metaphors, idioms, and cultural imagery in symptom narratives	Mentzos (2010); Peseschkian (1994)	Unlocks emotional meaning and patient insight
Lifestyle Integration	Embedding psychosocial and behavioural change within daily life structures	Fava (2023); Cosci (2023)	Promotes long-term health production and personal agency

the patient As active partners in the self-management and decision-making processes and not mere recipients of cars. This challenges the reductionist character of the biomedical approach, calling it to adopt a more encompassing method covering narrative, context, and personal agency.

Fava [6] shows how psychosomatics broadens lifestyle medicine beyond diet and exercise advice. It includes psychological variables such as euthymia, social determinants of health, and even environmental factors like living conditions, work, and interpersonal relations. Thus, patients' symptoms are not interpreted as mere personal events but as somatic reactions to systemic factors, consistent with Engel's biopsychosocial theory [5] and McEwen's [11] theory of allostatic load.

The psychosomatic perspective informs a nuanced clinical assessment process. Clinimetric tools, such as the Diagnostic Criteria for Psychosomatic Research [7], are essential in identifying syndromes like health anxiety, hypochondriasis, illness denial, and demoralisation, which often underlie maladaptive illness behaviours and hinder medical adherence. Macroanalysis and microanalysis [8] allow clinicians to cluster symptoms into functional areas, assess their hierarchy, and guide targeted interventions. These tools align with a broader commitment to personalised medicine, recognising the individual variability of illness trajectories and psychosocial stress responses.

In addition, the model facilitates staging treatment strategies for illness, examining the severity of symptoms, longitudinal change, and resilience factors. Charlson Comorbidity Index and Patient-Reported Outcome Measures (PROMs), which have been created using clinometric rigour, facilitate the thorough assessment of objective indicators of disease and the subjective experience of illness [4].

The quality of the therapeutic alliance, founded on collaborative decision-making, narrative search, and patient empowerment, undergirds the efficacy of psychosomatic treatment [6]. Engel saw the clinical interview as the best and most adaptable instrument at physicians' disposal – not just to collect diagnostic information but also to construct meaning in partnership with the patient [4]. This ethic of participation is a counterpoint to the industrialisation of medicine, where consultations are transformed into transactions and patients into consumers.

In Fava's account, the patient becomes a "health producer" through reflexive work on lifestyle, emotional

health, and social environment. This reframing has a wide-ranging effect on treatment compliance, management of chronic conditions, and general health. For example, in hypercholesterolemia or type 2 diabetes, a pharmacological approach based on passivity tends not to trigger effective behavioural change. However, the psychosomatic approach promotes active engagement through motivational awareness, continuous relations, and mutual goal-setting.

Consistent with Cosci's [4] contention, lifestyle interventions must have a robust theoretical underpinning – or risk being superficial and powerless in their advice. In a reductionist biomedical paradigm, practitioners might view lifestyle counselling as a tick-box exercise, whereas the psychosomatic approach demands situating behaviour in affective, social, and cognitive frameworks.

For example, Well-Being Therapy (WBT), created by Fava, combines cognitive-behavioural techniques with lifestyle change and euthymia-directed psychotherapy. This multi-element treatment has already been demonstrated effective in lowering depression relapses and shows potential for more extensive uses in psychosomatic treatment. Likewise, adding stress management, mindfulness, and patient education in collaborative decision models has shown value in cardiovascular outcomes, as presented in Albus [1] and Apple et al. [2].

Psychosomatic presentations do not occur in a vacuum; they are deeply embedded in social realities. Poverty, discrimination, environmental exposures, and trauma are potent determinants of somatic symptom expression. The network model [10] of psychosomatic medicine attempts to synthesise these dimensions, providing a framework for understanding the interdependence of psychological, physiological, and ecological systems.

As Fava asserts, real progress in patient health requires collaboration among clinicians, economists, educators, and patients. Medical education and practice must evolve to prioritise relational depth over procedural efficiency, and clinicians must resist the pharmaceuticalisation of distress. In this view, psychosomatic medicine is not merely a specialisation – it is a philosophical foundation for humane, effective, and sustainable health care.

One of the most persistent challenges in psychosomatic therapy is establishing a robust and healing therapeutic alliance, especially with patients who present with somatic complaints lacking clear biomedical explanations. Such patients tend to feel misunderstood, dismissed, or pathologised by clinicians who base their assessment solely on objective medical outcomes [15]. Therapeutic efficacy hinges upon the ability to accept the body's language as a metaphor, interpreting symptoms as meaningful communications of emotional and existentially lived distress.

Remmers [15] proposes the "psychosomatic arc," a dynamic progression of following a patient's symptomatology through affective experience, dysregulation of the vegetative, and possible organic manifestation. Identifying this arc allows clinicians to see how conflict is not worked through and affect is not integrated along a continuum, where initial symptoms could be difficulty sleeping or indigestion, which leads to chronic functional or organic conditions unless treated.

To promote treatment movement along this trajectory, the therapist will need to address symptom stories as communicative and symbolic acts, using metaphors, figurative speech, and culturally saturated patterns of words to create resonance and validation. Such a hermeneutic activity is foundational to establishing epistemic trust, which has become recognised as a success factor of prime importance in psychosomatic psychotherapy [16].

Table 3 below is intended to supplement the previously presented conceptual and relational frameworks. This table presents the "Stages of the Psychosomatic Arc" developed by Remmers [15] and situated in more general psychosomatic literature. It presents a systematised visual representation of how somatic symptoms might progress through affective, functional, and organic stages – and how therapeutic processes might align.

The theory of epistemic trust, or the patient's willingness to learn from another human being in a social context, has come to be more and more recognised as being crucial in enabling the progress of treatment [16]. In the context of the rehabilitation of somatoform disorders, epistemic trust, mistrust, and credulity are predictive of the outcomes of the patients. Optimal

Table 3

Stages of the Psychosomatic Arc: Symptom Evolution and Therapeutic Focus

Stage	Symptom Expression	Underlying Process	Therapeutic Focus	Key References
1. Affective Disturbance	Mood swings, anxiety, irritability, sleep disruption	Unprocessed emotional conflict or stress	Emotional validation, mentalisation, building epistemic trust	Remmers (2022); Cosci (2023)
2. Vegetative Dysregulation	Headaches, palpitations, GI discomfort, fatigue	Dysregulation of autonomic nervous system, stress hormones	Body–mind integration, relaxation techniques, psychosomatic dialogue	McEwen (1998); Wortman et al. (2022)
3. Functional Somatic Syndrome	Chronic pain, fibromyalgia, IBS, tension-type headaches	Persistent somatisation, impaired coping	Psychoeducation, symbolic interpretation, self-regulation training	Fava et al. (2016, 2017); Mentzos (2010)
4. Organic Manifestation	Hypertension, ulcerative colitis, cardiovascular disease	Long-term allostatic overload, immune and metabolic compromise	Multidisciplinary care, lifestyle medicine, resilience enhancement	Lázár (2020); Fava (2023); Albus (2022)

responders in inpatient somatoform programs exhibit high improvements in trust and decreases in mistrust and credulity [16], showing that a secure relational context not only heals distress but facilitates more fundamental changes in self-knowledge and emotion regulation.

Equally, mentalising, or the ability to think about one's own and others' mental lives, has also become associated with outcome in therapy. In both treatment having a structured format [9] and in rehabilitation settings [17], improvements in mentalising strongly relate to change in anxiety, depression, somatisation, and social functioning. These results reinforce the need to promote a reflective function and awareness of the self as primary treatment goals.

Longitudinal evidence [20] indicates that a positive response at the beginning of psychosomatic rehabilitation is a robust prognosticator of the ultimate treatment outcome. Significantly, it is informed not only by symptom severity but also by the illness and treatment beliefs of the patient, including their expectations, fears, and cognitive appraisals of the rehabilitation process itself. Thus, for example, beliefs concerning the controllability and comprehensibility of the illness and the credibility of the treatment were found to have a significant bearing on outcomes. Such findings underpin the clinical imperative of eliciting and negotiating systems of belief at the commencement of therapy, as consonant with person-centred engagement protocols.

Panou and Baourda [13] concur using qualitative research on person-centred psychotherapy in treating psychosomatic patients. They establish empathy, validation, and unconditional positive regard as the therapy's necessary active ingredients, enabling the patients to interpret the body's symptoms. Such elements were ameliorating and transformed, enabling more in-depth self-understanding and reframing the body-mind relationship.

Wortman et al. [21], in a treatment process study conducted alongside a clinical trial, investigated primary care psychosomatic therapy. Their findings indicate that a multimodal method of treatment – integrating verbal exploration and body-oriented interventions – is the experienced working mechanism of treatment. Alternation of psychological talk and somatically oriented engagement (such as accompanied breathing and awareness of posture) enhanced awareness of the linking of the body and the mind and promoted insight into the relational sense of the symptoms.

The therapists in the study underpinned the significance of building a sense of commonality, empathising with subjective experience, and tailoring techniques to the needs of the respective individuals. Such findings resonate with the broader literature on integrative psychosomatic care, which insists on ongoing negotiation across somatic and symbolic conceptions of sickness.

Symptoms in psychosomatic medicine are not only indicators of distress, but they carry symbolic meaning as well. Mentzos [12] and Remmers [15] illustrate how symptoms' shape, place, and wording carry encoded meanings of unconscious conflict, cultural metaphors, or existential dilemmas. For example, a patient who reports "a knot in the stomach" might, in expressive words, indicate inhibited anxiety, guilt, or interpersonal conflict. In therapy, analysing these words and pictures with the patient – using culturally evocative symbols, idioms, and metaphors – creates a mutual emotional topography, allowing for insight and catharsis.

This method borrows from the work of Positive Psychotherapy (PPT) by Peseschkian [14], which invites deciphering symptoms using cross-cultural wisdom sayings, proverbs, and metaphorical thinking. It supports the contention that any treatment starts where the patient is heard, noticed, and linguistically understood.

Such converging findings from different methodologies and disciplines demand an interpersonal, integrative, and meaningful psychosomatic orientation. Successful psychosomatic treatment, regardless of whether it being administered in inpatient rehabilitation, outpatient psychotherapy, or primary care, rests in turn on:

– Early establishment of epistemic trust

– Recognition of the psychosomatic curve of symptom development

– Integration of mentalising and reflective function

– Ongoing validation of subjective and symbolic symptom meaning

– Alternation of verbal discourse and body experience

– Recognition of sociocultural and system factors in the expression of symptoms

To further optimize outcomes, we need to develop relational modules to train health professionals, clinometric measures to measure relational variables (such as trust and mentalising), and integrate body-based language decoding into standard case formulation.

Conclusion. The psychosomatic paradigm provides a revolutionary approach to understanding and managing the intricate interrelation of psychological distress and somatic symptoms. It has developed beyond its roots in psychoanalysis, incorporating knowledge from neuroscience, systems theory, lifestyle medicine, and person-centred paradigms. At its core is the abandonment of dichotomous thinking and the embrace of a biopsychosocial vision that perceives illness as an active, somatically expressed manifestation of personal and contextual determinants. More recent studies have emphasized the role of relational processes, such as epistemic trust, mentalisation, and alliance, in predicting outcomes in the treatment of somatoform disorders. Clinimetric instruments, narrative approaches, and the conceptual template of the psychosomatic arc give the clinician valuable techniques to address the patient not diagnostically but empathically. Psychosomatic treatment that incorporates symbolic communication, lifestyle change, and emotional awareness is potent in promoting patient agency and resilience in the long term.

Finally, however, psychosomatic medicine should not be viewed as a boutique speciality but as a normative orientation of modern psychotherapy and counselling. It requires a remaking of clinical priority: a transition away from protocol-bound treatment towards depth in the interpersonal relating, away from symptom control towards meaning-production, and away from passive patient status towards active health production in partnership. As healthcare systems increasingly deal with chronic disease, morbidity due to lifestyle, and medically unexplained symptoms, the psychosomatic model presents a vigorous and compassionate way forward.

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