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OPERATORY THINKING: CONCEPTUALIZATION, PSYCHODIAGNOSTICS AND METHODOLOGY STANDARDIZATION

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This paper presents a comprehensive study of the phenomenon of operatory thinking as a specific form of cognitive-affective functioning characterized by a reduction in symbolic activity, a deficit in the mental representation of emotional experiences, and an excessive attachment to concrete reality. The relevance of this research is determined by the increasing prevalence of psychosomatic disorders in modern psychological practice, where up to 60–80% of individuals demonstrate symptoms of somatization of psychological distress. The aim of the article is the theoretical and methodological conceptualization of the phenomenon of operatory thinking through the systematization of its structural and functional characteristics within seven interrelated domains of mental functioning, as well as the development and standardization of psychodiagnostic instruments for identifying individuals with a heightened risk of psychosomatic disorganization. The study conducts a systematic analysis of the theoretical legacy of the Paris Psychosomatic School (P. Marty, M. de M'Uzan, C. Smadja), identifying seven main domains of operatory thinking manifestation: linguistic (reduction of the symbolic function of language, concreteness, avoidance of metaphoricity), social (disturbance of interpersonal distance, conformity, formalization of contacts), psychodynamic (deficit of sublimation, disturbance of affect regulation, instability of object relations), cognitive (reduction of imaginative life, dominance of concrete thinking, rigidity of cognitive schemas), behavioral-activity (monotony of activity, emotional detachment), emotional-affective (alexithymia, somatization as a form of expression, disruption of emotional differentiation), and the domain of interaction with external reality (hyperinvestment in the external, dependence on social norms). The result of the research is the development of a psychodiagnostic questionnaire of operatory thinking comprising 122 items and 12 scales: energetic-motivational rigidity, alexithymia, control and cognitive rigidity, affective isolation, deficit of imagination and symbolization, avoidance of personal contact, social adaptive dependence, emotional-semantic reduction, emotional distance, deficit of emotional attachment, operational approach to emotions, and rationalization of affect. This methodology operationalizes key theoretical constructs and enables differentiated diagnostics of the intensity of particular components of operatory functioning. The practical significance of the work lies in creating a valid instrument for identifying individuals belonging to the psychosomatic risk group in psychological counseling and psychotherapeutic practice. The integration of classical psychoanalytic concepts with contemporary research in mentalization (P. Fonagy), neurobiology of emotions (A. Damasio), and somatic psychology (P. Ogden) opens new perspectives for understanding psychosomatic phenomena and for developing psychocorrective strategies aimed at enhancing reflexive function, emotional literacy, and symbolic activity.
Keywords: *psychodiagnostics, salutogenic approach, phenomenology of the embodied self, psychological well-being, psychosomatics, operatory thinking, psychoanalytic approach, alexithymia*

INTRODUCTION

Operatory thinking constitutes one of the key concepts of the Paris Psychosomatic School, which has profoundly transformed the understanding of psychosomatic phenomena in contemporary medical psychology and psychoanalysis. The term, introduced by French psychoanalysts Pierre Marty, Michel de M'Uzan, and Claude Smadja in the late 1960s and early 1970s, describes a specific form of cognitive functioning characterized by excessive attachment to concrete reality, impoverishment of symbolic activity, and reduction of the mental representation of emotional experiences [1–6].

The fundamental works of Pierre Marty, *The Psychosomatic Order* (1980) and *Mentalization and Psychosomatics*, established the methodological foundations for understanding the relationship between cognitive features and the predisposition to somatization. Michel de M'Uzan, in his work *The Same and the Other*, developed the concept of operatory thinking within the context of object relations, while Claude Smadja, in his monograph *Psychosomatic Research*, systematized the diagnostic criteria of this phenomenon.

The analysis of studies dedicated to the problem of operatory thinking makes it possible to construct a

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theoretical model that reflects the structural qualities of operatory thinking, which are integrated into seven domains [1–6].

STATEMENT OF THE PROBLEM

The relevance of studying operatory thinking is determined by the increasing prevalence of psychosomatic disorders in contemporary practice. Understanding the mechanisms of operatory thinking and the ways to diagnose it enables psychologists to identify individuals at risk of developing psychosomatic pathology and to design adequate corrective and developmental intervention strategies.

Although the Paris Psychosomatic School has made fundamental contributions to the conceptualization of the phenomenon of operatory thinking and its role in the pathogenesis of psychosomatic disorders, many aspects of this issue remain insufficiently developed, which considerably limits its practical application in psychological practice.

A systemic integration of the structural-functional characteristics of operatory thinking, the analysis of the works of the Paris School (Pierre Marty, Michel de M'Uzan, Claude Smadja), and related research on alexithymia (Peter Sifneos, Graeme Taylor), mentalization (Peter Fonagy, Anthony Bateman), and somatic psychology (Joyce McDougall, Didier Anzieu) reveals a substantial fragmentation in the description of operatory functioning manifestations. There is no unified systemic or metatheoretical framework that synthesizes linguistic (reduction of the symbolic function of language, deficit of metaphoricity), cognitive (disturbance of imaginative activity, rigidity of cognitive schemas, deficit of reflexive function), emotional (alexithymia, somatization of affects), behavioral (monotony of activity), social (conformity, disturbance in the regulation of interpersonal distance), psychodynamic (deficit of sublimation, disturbance of object relations), and perceptual (hyperinvestment in external reality) parameters into an integral conceptual matrix with a defined hierarchy of intercomponent relationships. This gap complicates the understanding of the ontogenetic mechanisms underlying the formation of the phenomenon and the development of psychocorrective interventions [1–6; 7; 9; 11–14].

A critical deficit of comprehensive and valid psychodiagnostic instruments. The fundamental limitation lies in the lack of standardized and psychometrically substantiated tools for the comprehensive quantification of operatory thinking. The Toronto Alexithymia Scale (TAS-20, Taylor et al.), despite its high reliability (α=0.81), focuses exclusively on the emotional-cognitive aspect (difficulty identifying and describing feelings, externally oriented thinking), leaving out linguistic, social, psychodynamic, and behavioral parameters. The Bermond–Vorst Alexithymia Questionnaire (BVAQ) and the Levels of Emotional Awareness Scale (LEAS, Lane et al.) are likewise limited to the emotional domain. Claude Smadja's clinical methods, though possessing high content validity, remain subjective and dependent on the diagnostician's qualifications, which makes them unsuitable for use in mass studies and screening procedures.

The absence of psychodiagnostic tools in psychological practice, along with the fact that the concept of operatory thinking is scarcely represented in scientific discourse and absent from the curricula of psychology training programs, produces a critical deficiency of standardized methodologies. This makes it impossible to identify individuals at psychosomatic risk in psychology, psychological counseling, psychotherapy, and crisis psychology. As a result, systemic underdiagnosis persists, characterized by deficits in the mental representation of emotional experiences, which manifest as somatized forms of psychological distress and lead to inadequate assistance, since traditional insight-oriented approaches prove ineffective in the absence of specialized interventions [1–6; 7; 16–18].

The lack of differentiated diagnostics for components of operatory functioning and existing tools does not allow for a profile assessment of individual components with the identification of an individual psychological profile. Clinical practice demonstrates pronounced heterogeneity of manifestations: predominance of emotional reduction with preserved cognitive flexibility, cognitive rigidity with preserved emotional identification, or social hyperconformity with relatively intact emotional life. The absence of targeted diagnostics makes it impossible to develop personalized psychocorrective programs, which is critically important for evidence-based psychological support.

The lack of an integrative methodological framework for psychosomatic vulnerability is characterized by methodological fragmentation: psychoanalytic concepts (operatory thinking) are developed in isolation from cognitive-behavioral models. Data on disorders of interoceptive awareness are insufficiently integrated with psychological observations, the concept of mentalization is rarely correlated with the psychosomatic discourse, and research on the impact of early attachment is poorly integrated with the theory of operatory thinking. This narrows the prospects for interdisciplinary dialogue and hinders the development of comprehensive models of the psychosomatic profile [1–6; 7; 9; 11–14; 17–19; 20].

There is a lack of representative data on the prevalence of operatory thinking in various socio-demographic and age cohorts, basic normative indicators, and the ontogenetic dynamics remain unclear (age-related developmental patterns, critical sensitive periods, influence of early attachment, role of trauma), as well as gender-specific features considering sociocultural factors. A critically important issue concerns the ontological status of the phenomenon: whether operatory thinking is a stable personality trait, a situational reactive state, or a continuum, which determines the possibilities for psychological intervention and the prognosis for psychotherapy.

Insufficient prognostic research on operatory thinking as a predictor of psychosomatic disorders. Despite theoretical postulates regarding the causal relationship, empirical data remain limited and contradictory.

Prospective longitudinal studies are lacking. Critically absent are data on the specificity of correlations between subcomponents of operatory thinking and nosological forms: cardiovascular (hypertension, ischemic heart disease), gastroenterological (peptic ulcer disease, irritable bowel syndrome), dermatological (psoriasis, eczema), respiratory (bronchial asthma), endocrine (type 2 diabetes), and rheumatological (rheumatoid arthritis, fibromyalgia) disorders.

Theoretical and empirical differentiation of operatory thinking from related phenomena remains unclear: alexithymia (a component, not synonymous), normopathy, mentalization deficit, impairment of reflective function, dissociative states, depersonalization, emotional numbing, repressive coping.

Ontogenetic mechanisms of formation are insufficiently studied: the role of the quality of early attachment, maternal emotional attunement, the function of mental representation of affects, the impact of early trauma, the importance of emotional vocabulary and symbolic play. Preventive programs for risk groups have not been developed (children with histories of hospitalization, separation, emotional deprivation; adolescents with difficulties in emotional regulation). Early screening tools for childhood and adolescence are absent [1–6; 7; 9; 11–14].

Thus, the problematics of operatory thinking remain conceptually underdeveloped, empirically insufficiently researched, and praxeologically limited in implementation in contemporary psychological practice. Numerous methodological and empirical gaps determine the necessity of systematic interdisciplinary research integrating psychoanalytic, cognitive, neuropsychological, developmental, and sociocultural perspectives. The development of a valid, culturally sensitive, standardized Ukrainian-language psychodiagnostic instrument for a multidimensional assessment of operatory thinking constitutes a primary task for psychology, opening prospects for early identification of individuals at psychosomatic risk, development of personalized psychotherapeutic strategies, creation of preventive programs, deepening understanding of mechanisms, and improving the quality of psychological care for the population.

An analysis of research reveals significant progress in the study of operatory thinking and related psychosomatic constructs. A systematic review of scientific literature from 2000 to 2025 identifies key research directions deepening the understanding of mechanisms of operatory functioning and its role in the pathogenesis of psychosomatic disorders.

The review by Georgia Panayiotou et al. in the Annual Review of Psychology systematizes fifty years of research on alexithymia as a multidimensional construct, emphasizing the need for facet-oriented analysis. A meta-analysis by Jihwan Chen et al. established a 35% prevalence of alexithymia among patients with schizophrenia (95% CI: 32–38%), indicating the transdiagnostic nature of the disturbances. Data by Filippo Porcelli and Graeme Taylor on 1,190 patients revealed that 15.8% met DCPR criteria for alexithymia, while cluster analysis identified five clinical subtypes, underscoring the heterogeneity of the phenomenon [9; 11–14].

A systematic review by Susan Van Bael et al. included 32 studies and established a meta-analytic link between alexithymia and aspects of interoception. Global alexithymia was positively associated with interoceptive confusion and autonomic nervous system reactivity but negatively correlated with interoceptive accuracy, trust, and self-regulation, especially for facets of difficulties identifying and describing feelings. The three-component model by Samantha Garfinkel et al. differentiates interoceptive accuracy, sensitivity, and awareness. Research by Ji Li et al. identified differentiated patterns of connections: for somatization, key factors included non-distraction, attention regulation, emotional awareness, and noticing.

Studies by Ali Rostami and Mahnaz Mehdiabadi using SEM revealed that emotional neglect had a direct effect on psychosomatic complaints and an indirect effect mediated by mentalization. A longitudinal study by Nina-Lisbeth Schwarzer et al. demonstrated that mentalization predicts well-being and emotion regulation strategies. A review by Karsten Schnabel et al. identified difficulties at various stages of the emotion regulation process in individuals with functional somatic symptoms.

Itai Shalev and Guy Yaacobi, in experiments, introduced the concept of psychosomatic congruence, demonstrating that focusing on pleasant bodily parts can induce congruent mental content and regulate emotional distress.

A systematic review by Matthias Heime et al. analyzed 31 RCTs of interoception-based interventions: 64.5% showed superior efficacy compared to controls, especially for PTSD, irritable bowel syndrome, and fibromyalgia. Studies by Lindsey Igra et al. confirmed the transdiagnostic nature of emotional dysregulation: all dimensions of emotion regulation difficulties correlated with depression, anxiety, and somatization in schizophrenia, emotional disorders, and control groups. Erika Welkoff et al. established a linear association of interoceptive deficits with suicide severity.

Giovanni Fava et al. emphasized the importance of Diagnostic Criteria for Psychosomatic Research (DCPR). Weiwei Zhou et al. noted the widespread application of neuroscientific methodologies in studying causal mechanisms and correlations between brain functioning and clinical manifestations. Studies using the BMAIA-2 revealed differentiated predictive patterns of interoceptive sensitivity for eating pathology [1–6; 7; 9; 11–14; 17–20].

Thus, the literature analysis demonstrates substantial progress in understanding the multidimensional nature of operatory thinking, its neuropsychological mechanisms, the role of interoceptive awareness and mentalization deficits, which forms the foundation for developing innovative diagnostic tools and therapeutic strategies in psychology.

The objective is to develop a theoretical and methodological conceptualization of the phenomenon of operatory thinking through the systematization of its structural and functional characteristics across seven

interrelated domains of mental functioning (linguistic, social, psychodynamic, cognitive, behavioral-activity, emotional-affective, and the sphere of interaction with external reality); to conduct the validation and standardization of a psychometric instrument for the diagnosis and quantitative assessment of the intensity of operatory thinking functioning as a factor of psychosomatic vulnerability and a predictor of deficits in mental representation and increased risk of psychosomatic disorganization.

PRESENTATION OF CORE MATERIAL

The scope of scientific development of the problem requires a systematic analysis of the concept of operatory thinking through the prism of its seven main domains of manifestation: linguistic, social, psychodynamic, cognitive, activity characteristics, emotional, and the sphere of interaction with external reality.

I. Linguistic Domain: Linguistic Markers of Operatory Functioning

The speech characteristics of patients with operatory thinking were described in detail by P. Marty and his colleagues as one of the most evident diagnostic indicators of this phenomenon. In his monograph "Operatory Life," P. Marty emphasizes that the speech of such individuals is marked by a "white," colorless quality, devoid of metaphorical content and emotional resonance [1–3].

Reduction of the Symbolic Function of Language.

Patients with operatory thinking demonstrate a marked impoverishment of the ability to verbalize inner experiences. Their speech focuses primarily on describing concrete facts, events, and external details, avoiding subjective interpretations and emotional connotations. M. de M'Uzan, in his work "Operatory-Type Functioning," notes that such patients use language not as a tool for symbolization and communication of their inner world, but rather as a technical means of transmitting factual information [4;5].

Clinical studies by C. Smadja have revealed a significant decrease in the use of emotionally charged vocabulary in the speech of individuals with operatory thinking. Analysis of psychoanalytic sessions showed that these patients rarely employ words denoting feelings (joy, sadness, fear, anger), instead preferring descriptive terms that narrate actions and events. This phenomenon correlates with the concept of alexithymia introduced by P. Sifneos; however, operatory thinking is a broader construct that includes not only difficulties in identifying emotions but also a specific cognitive organization.

Concreteness and Attachment to Actuality.

A distinctive feature of linguistic production in operatory thinking patients is excessive concreteness and a focus on the present moment. P. Marty and M. de M'Uzan, in their pioneering work "Operatory Thinking," described the tendency of such individuals to avoid discussions of the past and future, limiting themselves to descriptions of immediately actual events. This is associated with a deficit in the mental representation of temporal perspective and difficulties in integrating biographical narrative.

Research by D. Anzieu in his foundational work "The Skin-Ego" indicates that such patients have difficulty constructing metaphorical descriptions, which reflects a general deficit in symbolization. Metaphor, as a linguistic tool, requires the ability to abstract and establish associative links between various levels of experience—a process problematic for operatory functioning [1–6; 7; 9; 11–14].

Avoidance of Intimate Self-Presentation.

Patients with operatory thinking display a tendency to avoid "soulful conversations" that require self-critical reflection and disclosure of the inner world. C. Smadja associates this with the defensive function of operatory thinking, which protects the psychic apparatus from encounters with potentially traumatic affective material. In the psychotherapeutic context, such patients often complain about the difficulty of maintaining lengthy discussions about relationships, memories, or future plans, preferring to discuss practical matters.

The research of J. McDougall in the monograph "Theatres of the Body" expands the understanding of this phenomenon, indicating that difficulties in verbalizing experiences correlate with a tendency for somatic expression of psychological distress. When language cannot fulfill the function of symbolization and discharge of affect, the body becomes the arena for expressing unresolved emotional conflicts.

II. Social Domain: Features of Interpersonal Functioning

The social domain of individuals with operatory thinking is characterized by specific interaction patterns that reflect profound difficulties in regulating interpersonal distance and establishing emotionally rich contacts.

Disturbance in Regulation of Interpersonal Distance.

P. Marty described that patients with operatory thinking experience difficulties in determining optimal distance in relationships, oscillating between excessive closeness and cold detachment. This is related to a deficit in Self–Object differentiation described by M. de M'Uzan, resulting in an inability to form stable object relations with appropriate boundaries.

Clinical observations by C. Smadja indicate that such individuals often report discomfort in response to expressions of emotional closeness from others. This can be understood as a defense against the threat of disintegration arising from intense affective contact. At the same time, these patients may exhibit excessive dependence on social approval, striving to meet all expectations of those around them [1–6].

Conformity and Orientation toward External Norms.

Research from the Paris School of Psychosomatics has found that individuals with operatory thinking are marked by pronounced conformity and excessive orientation toward social norms. M. Fine in "Structure and Functions in Psychosomatics" associates this with a deficit of internal psychic structure, compensated by rigid attachment to external rules and expectations.

Such patients often exhibit "normopathy"—a term introduced by C. Bollas to describe the compulsive need to

be "normal" and to conform to social standards. This manifests as difficulty refusing others, avoidance of conflict at any cost, and a tendency toward self-sacrifice to preserve social harmony. J.-B. Pontalis in his works emphasized that such excessive adaptability paradoxically leads to increased vulnerability to somatization [20;21].

Formalization of Interpersonal Contacts.

The relationships of individuals with operatory thinking are often formal and stereotypical in nature. P. Marty noted that such individuals are prone to establishing "functional" relationships based on clearly defined roles and responsibilities, avoiding emotional spontaneity and unpredictability. This reflects a general tendency toward structuring and control as a means of compensating for internal psychic instability [1–3].

Research by R. Debré in the monograph "The At-Risk Infant" indicates that the origins of such interpersonal patterns may stem from early disturbances in the mother–child system. A lack of emotional attunement in early life can lead to the formation of an operatory style of functioning as an adaptive strategy in response to emotional deprivation.

Difficulties with Empathic Resonance.

Patients with operatory thinking frequently demonstrate a reduced ability to recognize and resonate with the emotional states of others. M. de M'Uzan associated this with a deficit in affective mentalization—the capacity to understand mental states (one's own and others') in terms of mental processes. P. Fonagy, in his work on mentalization, expanded this understanding by highlighting the relationship between deficits in reflective function and the tendency toward somatization.

III. Psychodynamic Domain: Affective Regulation and Object Relations

The psychodynamic characteristics of operatory thinking constitute a central aspect of this phenomenon's conceptualization within the Paris Psychosomatic School.

Deficit of Sublimation and Creative Activity.

P. Marty emphasized that operatory functioning is marked by a significant limitation in the capacity for sublimation—the transformation of instinctual energy into socially acceptable forms of creative activity. Patients with operatory thinking rarely derive satisfaction from art, literature, or other forms of symbolic activity, reflecting a general impoverishment of imaginative life.

C. Smadja expands upon this point, noting that creative activity requires the capacity for "regression in the service of the ego"—a concept introduced by E. Kris. Operatory thinking, characterized by rigidity of psychic functioning, impedes such productive regression, limiting access to primary thought processes and symbolic material.

Disturbance of Affective Regulation.

A central feature of operatory thinking is insufficient psychic processing of affects. M. de M'Uzan described this as an "absence of an inner theater"—a deficit in the ability for internal dramatization and experiencing emotional states in psychic space. Instead, affects are either blocked or discharged directly through somatic channels [4;5].

Research by L. Kreisler in the field of child psychosomatics revealed that children with operatory functioning demonstrate difficulty channeling emotional energy into constructive activity or symbolic play. This leads to the accumulation of unreleased affective tension, increasing the risk of somatic decompensation.

Disturbance of Object Relations.

M. de M'Uzan's concept of "basic object relations" emphasized that operatory thinking is associated with the formation of superficial, unstable object relationships. Patients often describe relationships that break off without apparent reason, reflecting difficulty sustaining lasting emotional attachments.

P. Marty linked this to the concept of "desomatization"—a process opposite to somatization—in which the external object performs a function of regulating internal psychosomatic balance. Upon loss of such an object, individuals with operatory thinking lose an external support for affect regulation, which may lead to somatic decompensation [4;5].

Difficulties Expressing Aggression and Tenderness.

Studies from the Paris School have found that individuals with operatory thinking experience specific difficulties both in expressing aggressive and tender feelings. J. McDougall described this as a result of the "desymbolization" of aggressive drive, leading to its somatic expression. At the same time, tenderness—which requires the ability for emotional closeness and vulnerability—is likewise problematic for operatory functioning.

C. Smadja emphasized that avoidance of confrontation at all costs, characteristic of these patients, leads to the accumulation of unexpressed aggressive affects, potentially contributing to the development of psychosomatic symptoms. P. Marty's concept of "psychic masochism" suggests that such individuals often turn aggression against themselves, manifesting as somatic symptoms [1;2;3].

IV. Cognitive Domain: Features of Mental Organization

The cognitive characteristics of operatory thinking represent its most evident and well-studied aspect.

Reduction of Imaginative Life.

P. Marty described operatory thinking as characterized by a "disappearance of imaginative life." Patients rarely daydream, possess limited fantasy activity, and report impoverished, dull dreams. This is radically different from neurotic functioning, where the inner world of fantasies is rich and dynamic [1–3].

M. de M'Uzan expands on this notion, suggesting that operatory thinking constitutes "thinking without a dreamer." The absence of active imaginative activity leads to the loss of one of the psychic apparatus's key mechanisms for processing conflicts and regulating affects [4;5].

Dominance of Concrete Over Abstract Thinking.

The cognitive style of individuals with operatory thinking is marked by an excessive attachment to concrete reality and difficulty with abstraction. C. Smadja emphasized that such patients prefer logic over intuition, clear instructions over creative problem solving, and structured activity over spontaneous engagement.

Research by G. Taylor in the context of alexithymia revealed a correlation between a concrete cognitive style and a reduced capacity for symbolization. Patients with operatory thinking struggle to understand metaphors, symbols, and abstract concepts, reflecting a general deficit in secondary process thinking which, according to Freud, serves as the foundation for symbolic activity.

Rigidity of Cognitive Schemas.

P. Marty described operatory thinking as characterized by cognitive rigidity—the difficulty in changing perspectives, considering alternative scenarios, and adapting to new information. This is connected to an excessive need for systematization and categorization of experience, which compensates for internal psychic instability. M. de M'Uzan, in his concept of "thought without psychic quality," indicated that operatory thinking functions mechanically, without emotional resonance or personal investment. This results in the automatization of cognitive processes and reduced adaptability [1–3; 4;5].

Impairment of Reflexive Function.

Contemporary research on mentalization initiated by P. Fonagy has extended the understanding of cognitive features of operatory thinking. These patients have significant difficulty analyzing their own inner experiences, seldom reflect on the causes of their emotions, and demonstrate a reduced capacity for self-observation.

A. Bateman and P. Fonagy, in "Mentalization-Based Psychotherapy," argued that a deficit in reflexive function correlates with an increased risk of somatization. When an individual cannot "think about thinking" and process psychic experience at a symbolic level, the body becomes the primary channel for the communication of distress [7;12;15].

V. Characteristics of Activity: Quality of Life

The sphere of activity of individuals with operatory thinking is characterized by specific patterns that reflect a general reduction of vitality and spontaneity.

Monotony and mechanical nature of activity.

P. Marty described the life of patients with operatory thinking as an "operatory existence" — a monotonous sequence of stereotypical actions deprived of emotional coloring and creative spontaneity. Such activity has a compulsive character, aimed rather at the discharge of tension than at obtaining satisfaction.

K. Smadja indicates that monotonous activity performs for these patients the function of calming and regulating internal tension. However, unlike neurotic compulsiveness, which has symbolic meaning, operatory activity is "empty" — deprived of psychic content and conflictual significance [1–3; 4; 5; 6].

Emotional detachment from activity.

A characteristic feature of operatory functioning is the dissociation between actions and emotional experiences. M. de M'Uzan described this as "de-affectivation" of activity — the absence of emotional resonance even in response to objectively significant events.

The studies of D. Anzieu indicate that such emotional detachment may be understood as a defense mechanism against the threat of psychic disintegration. However, chronic emotional anesthesia leads to a sense of inner emptiness and an impoverishment of quality of life [4; 5; 14].

Orientation toward survival and duty.

P. Marty emphasized that the activity of individuals with operatory thinking is directed primarily at satisfying basic needs and fulfilling obligations rather than at obtaining pleasure or self-realization. This reflects a general reduction of libidinal investment in life activities.

J. McDougall, in her works, develops this statement, indicating that patients with operatory thinking often describe life as "boring" and "monotonous," despite the objectively present variety of activities. This is related not to an external poverty of stimulation but to an internal incapacity for emotional investment and the experience of pleasure [13].

Chronic fatigue and exhaustion.

Clinical observations of the Paris School revealed that patients with operatory thinking often complain of a sense of chronic fatigue and exhaustion without evident physical causes. P. Marty associated this with the constant expenditure of psychic energy required to maintain operatory functioning and to suppress affects.

K. Smadja develops this understanding, indicating that the absence of the possibility for psychic discharge through symbolization leads to the accumulation of internal tension, which manifests in the form of somatic fatigue. This may be an early sign of the risk of somatic decompensation [6].

VI. Emotional Sphere: Affective Life and Its Disturbances

The emotional sphere constitutes the core of disturbances in operatory thinking, directly linking cognitive features with the risk of somatization.

Emotional emptiness and alexithymia.

P. Marty described "emotional emptiness" as a central characteristic of operatory functioning. Patients often complain of a sense of inner emptiness, an inability to experience either positive or negative emotions with appropriate intensity.

The concept of alexithymia, introduced by P. Sifneos and developed by G. Taylor, is closely related to operatory thinking. Alexithymia includes difficulties in identifying feelings, difficulties in describing feelings, externally oriented thinking, and limited imaginative activity. However, as emphasized by K. Smadja, operatory thinking is a broader concept that encompasses not only affective but also cognitive and interpersonal disturbances.

Somatization as a form of emotional expression.

M. de M'Uzan developed the concept of "regressive somatization" — a process in which affects that are not processed on a psychic level find expression through bodily symptoms. J. McDougall, in her monograph *Theaters of the Body*, expanded this understanding, describing the body as a "stage" on which what cannot be articulated in words is enacted.

P. Marty's research revealed that the emotional reactions of patients with operatory thinking often manifest through the body — accelerated heartbeat, muscle tension, gastrointestinal symptoms — without

awareness of the emotional component of these sensations. This reflects a deficit in differentiation between affective and somatic states [1–3].

Disturbances of emotional differentiation.

Patients with operatory thinking experience difficulties in distinguishing different emotional states from one another. K. Smadja described this as "global undifferentiation of affects" — the inability to recognize subtle differences among various emotional experiences.

Research by L. Greenberg within the framework of emotion-focused therapy confirms that the capacity for emotional differentiation is key to adaptive emotional regulation. The deficit of this capacity in operatory thinking leads to disturbances in affective regulation and an increased risk of somatization.

Deficit of recovery after emotional experiences.

P. Marty described that patients with operatory thinking have significant difficulties in restoring psychic balance after emotionally intense events. This is associated with insufficiency of psychic mechanisms for working through affective experiences.

M. de M'Uzan, in his concept of "progressive disorganization" (*désorganisation progressive*), indicated that repeated episodes of emotional overload without adequate psychic processing may lead to cumulative disintegration of the psychosomatic balance, culminating in the development of somatic illness [1–3; 4; 5].

Rationalization of emotions.

A characteristic defensive strategy of individuals with operatory thinking is the tendency to provide rational explanations for their emotional states. K. Smadja emphasized that such rationalization serves to avoid direct confrontation with affect, translating emotional experience into the cognitive register [6].

However, as noted by J. McDougall, this rationalization is superficial and does not lead to genuine insight or emotional resolution. Instead, it maintains emotional distance from inner experiences, promoting chronic alexithymia and increasing the risk of somatic expression of distress.

Delayed and postponed emotional reactions.

Clinical observations by P. Marty revealed that emotional reactions in patients with operatory thinking are often delayed or postponed in time. An individual may fail to respond emotionally to an objectively significant event at the moment of its occurrence, while the emotional reaction (often in the form of somatic symptoms) may appear much later.

This phenomenon is related to what P. Marty called the "anti-representational function" of operatory thinking — the blocking of mental representation of emotionally charged experience. However, as K. Smadja points out, the unprocessed affect does not disappear but "returns" through the somatic channel [1–3; 4; 5; 6; 24].

VII. External Reality: Relations with the Objective World

The sphere of interaction with external reality reveals the fundamental characteristics of operatory thinking, associated with a disturbed balance between the inner and outer worlds.

Excessive investment in external reality.

P. Marty emphasized that operatory thinking is characterized by hyperinvestment in the external, concrete reality at the expense of inner psychic life. Patients perceive life as a sequence of external events rather than as a continuum of internal experiences that give meaning to those events.

M. de M'Uzan developed this idea in his concept of the "external object" — the tendency of individuals with operatory thinking to rely on external objects and circumstances for the regulation of psychosomatic balance. This leads to excessive dependence on external conditions and heightened vulnerability to life changes [1-3; 4; 5; 23].

Dominance of objective facts over subjective sensations.

The cognitive style of individuals with operatory thinking is characterized by excessive trust in objective facts and distrust of subjective sensations. K. Smadja associates this with a deficit of introspective capacity and insufficient contact with the internal experience.

Research by R. Debray indicates that such external orientation may result from early disturbances in the development of the capacity to symbolize internal experience. When the primary object (the mother) fails to perform the function of "containing" and symbolizing the infant's affects, the infant remains bound to concrete external reality.

Conformity and orientation toward social norms.

P. Marty described a pronounced tendency of patients with operatory thinking toward conformity — a striving to meet socially accepted norms of behavior and social expectations. This is related to the insufficiency of an autonomous internal structure, which is compensated by a rigid attachment to external directives.

D. Winnicott's concept of the "false Self" resonates with this aspect of operatory thinking. Patients form an external adaptive shell that conforms to social expectations but remain disconnected from their true, authentic Self. This results in a chronic sense of inner emptiness and alienation [1; 3; 25].

Dependence of self-esteem on external recognition.

Clinical observations by the Paris School revealed that the self-esteem of individuals with operatory thinking largely depends on external recognition and social status. K. Smadja associates this with a deficit of internal representation of the value of the Self, which leads to a constant need for external validation.

J. McDougall describes this as an "addictive need" for external approval, which may manifest in the form of workaholism, perfectionism, or other forms of compulsive productivity. However, since external achievements cannot fill the inner emptiness, this strategy remains ineffective, maintaining chronic psychosomatic distress [6; 13].

Difficulties in differentiating personal needs from social expectations.

P. Marty emphasized that patients with operatory thinking have substantial difficulties in distinguishing their own authentic needs and desires from introjected social demands. This leads to a life oriented toward the

fulfillment of external expectations, often at the expense of personal well-being.

M. de M'Uzan, in his concept of "basic masochism," indicated that such self-sacrifice is not genuine altruism but rather reflects the inability to recognize and articulate one's own needs. This may lead to the accumulation of frustration and resentment, which is expressed through somatic symptoms [4; 5].

The concept of operatory thinking, developed by representatives of the Paris Psychosomatic School, constitutes a significant contribution to the understanding of psychosomatic phenomena. A systematic analysis of the seven spheres of manifestation of operatory thinking — linguistic, social, psychodynamic, cognitive, activity-related, emotional, and interaction with external reality — allows for a comprehensive assessment of this complex phenomenon and its role in somatization.

Psychometric instruments.

For the diagnosis of operatory thinking and related constructs, several psychometric instruments have been developed. The Toronto Alexithymia Scale (TAS-20), developed by G. Taylor, is the most validated instrument for assessing alexithymic characteristics closely associated with operatory thinking [11].

However, K. Smadja emphasized that no psychometric instrument can fully replace the clinical interview and observation of patient behavior in the therapeutic relationship. Operatory thinking is a complex, multidimensional phenomenon that requires comprehensive clinical evaluation.

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Diagnostic Criteria. K. Smadja, in his monograph *Psychosomatic Research*, systematized the diagnostic criteria of operatory thinking as follows:

- Reduction of fantasy and imaginative activity.
- External cognitive orientation.
- Concreteness and attachment to actuality.
- Restriction of emotional expression.
- Formalization of interpersonal relations.
- Monotony of life activity.
- Excessive dependence on external reality.

RESEARCH RESULTS

As a result of the theoretical and methodological analysis of the conceptual foundations of the Paris Psychosomatic School (P. Marty, M. de M'Uzan, K. Smadja) and contemporary studies of alexithymia (G. Taylor, R. Bagby, J. Simm), an original psychodiagnostic instrument was developed — the *Operatory Thinking Questionnaire* [1–26].

Structure of the method.

The questionnaire is a self-report psychometric instrument consisting of 122 statement-indicators, which respondents evaluate using a five-point Likert scale (0 – "Disagree", 1 – "Partly agree", 2 – "Both yes and no", 3 – "Mostly agree", 4 – "Completely agree").

The items are formulated as self-descriptive judgments reflecting various aspects of the individual's cognitive-affective functioning.

The diagnostic structure of the method includes twelve interrelated scales, each of which operationalizes a specific component of operatory thinking as an integral psychological construct.

Characteristics of the Scales of the Operatory Thinking Questionnaire

1. **Energetic-Motivational Rigidity.**

Reflects the degree of reduction in the subject's energetic and emotional dynamics. High scores indicate the predominance of survival and routine behavioral patterns, decreased motivation for novelty, and a loss of the ability to transform emotional energy into activity.

2. **Alexithymia.**

Describes difficulties in the verbalization and differentiation of emotional states. Individuals with high scores demonstrate a limited emotional vocabulary, a tendency to describe actions instead of feelings, and to substitute affective expressions with rational constructions.

3. **Control and Cognitive Rigidity.**

Reflects the dominance of rational control over intuitive processes. It is characterized by a tendency toward structure, rules, algorithms, and difficulties with spontaneity and cognitive flexibility.

4. **Affective Isolation.**

Determines the tendency toward emotional detachment and suppression of deep feelings. Elevated scores reflect difficulties in forming lasting emotional bonds, a deficit of empathy, and a reduced capacity for affective involvement.

5. **Deficit of Imagination and Symbolization.**

Measures the level of development of imagination, metaphorical thinking, and the capacity for symbolic representation of experience. High scores indicate a tendency toward concreteness, avoidance of abstractions, art, and fantasy, reflecting disturbances in the "symbolic function of the Self."

6. **Avoidance of Personal Contact.**

Characterizes a tendency to avoid situations of self-disclosure, personal initiative, and emotional closeness. Such individuals maintain superficial or formal social relations and are inclined toward conformity.

7. **Social Adaptive Dependence.**

Reflects the dependence of self-esteem and behavior on external norms and expectations. The individual is oriented toward social approval, fears conflict, and avoids risk and ambiguity.

8. **Emotional-Semantic Reduction.**

Reflects the simplification of the emotional content of experience. It manifests in difficulties understanding

humor, metaphors, and symbols, as well as in a "mechanical" style of activity.

9. **Emotional Distance.**

Describes the tendency to avoid emotional intimacy, maintaining inner distance even in significant relationships. High scores indicate discomfort with intimacy and difficulties with relaxation.

10. **Deficit of Emotional Attachment.**

Measures the level of affective involvement in relationships. High scores indicate emotional coldness, distrust, lack of tenderness, and difficulties in forming deep attachments.

11. **Operational Approach to Emotions.**

Indicates a tendency toward a pragmatic, procedural approach even in the sphere of emotions and relationships. The individual is oriented toward algorithms, "instructions," and rational actions as a means of controlling internal instability.

12. **Rationalization of Affect.**

Reflects a tendency to explain and control emotions through intellectual schemes. This indicates the substitution of affective experiencing with rational analysis and avoidance of intense feelings.

RESULTS OF FACTR ANALSIS

According to the results of the factor analysis, twelve factors were identified that explain the total variance of the questionnaire. Each factor corresponds to one of the scales of the questionnaire and includes a specific set of indicator statements.

The first factor (10.2% of the variance) reflects energetic-motivational rigidity and includes twenty-six statements related to a constant feeling of fatigue, emotional exhaustion, difficulties with motivation, and problems in transforming the energy of negative emotions into productive activity.

The second factor (6.8% of the variance) represents alexithymia and includes fifteen statements describing difficulties in verbalizing inner experiences, choosing words to describe emotions, and a tendency to describe concrete actions instead of feelings.

The third factor (6.2% of the variance) reflects control and cognitive rigidity, with thirteen statements characterizing a tendency toward clear facts, rules, structured activity, and systematic organization of everything.

The fourth factor (3.5% of the variance) represents affective isolation, including seven statements describing a low need for emotional support, difficulties in maintaining long-term emotional bonds, and difficulties in expressing aggression.

The fifth factor (6.7% of the variance) describes a deficit of imagination and symbolization through fourteen statements about infrequent use of metaphors, difficulties in fantasizing, avoidance of abstract thinking, and philosophical reflection.

The sixth factor (4.1% of the variance) characterizes avoidance of personal contact, with eight statements describing avoidance of discussions about personal life, the future, dreams, or desires, and difficulties with spontaneity.

The seventh factor (7.3% of the variance) reflects social adaptive dependence through fifteen statements concerning the importance of appearing "normal," meeting social expectations, orientation toward others' opinions, and dependence of self-esteem on external approval.

The eighth factor (4.9% of the variance) represents emotional-semantic reduction through eight statements describing difficulties in understanding metaphors, humor, mechanical style of activity, and lack of understanding of the causes of emotional reactions.

The ninth factor (3.7% of the variance) describes emotional distance, including four statements related to discomfort in close emotional contact, emotional detachment, and difficulties with relaxation.

The tenth factor (3.4% of the variance) characterizes a deficit of emotional attachment through six statements about a low need for closeness, difficulties with trust, and experiencing or expressing tenderness.

The eleventh factor (2.6% of the variance) represents the operational approach to emotions through three statements describing an expectation of specific action algorithms from the psychotherapist and resorting to monotonous activity as a means of relaxation.

The twelfth factor (2.4% of the variance) reflects rationalization of affect through four statements describing difficulties in analyzing inner experiences, in living through intense feelings, and a tendency to provide rational explanations for emotions.

CONCLUSIONS

The obtained results confirm and deepen the understanding of the phenomenon of operatory thinking, integrating classical psychoanalytic concepts with contemporary empirical findings. The concept of the reflective function by P. Fonagy, A. Damasio's research on the role of somatic markers in emotional processes, and P. Ogden's work in somatically-oriented psychotherapy together create an interdisciplinary theoretical foundation for expanding the understanding of the mechanisms underlying operatory functioning and for developing psychotherapeutic approaches to its modification.

The present research provides a comprehensive conceptualization of operatory thinking as a specific form of cognitive-affective functioning characterized by a reduction in symbolic activity, limitation of mental representation of emotional experiences, and excessive fixation on concrete reality.

The theoretical analysis demonstrates the productivity of integrating classical psychoanalytic constructs with recent empirical data. The fundamental contributions of P. Marty, M. de M'Uzan, and K. Smadja concerning psychic insufficiency, deficits of mental representation, and progressive disorganization have provided the conceptual basis for understanding the mechanisms of psychosomatic maladaptation. These are complemented by contemporary studies by P. Fonagy on mentalization and the reflective function, A. Damasio on the role of somatic markers in emotional regulation, and P. Ogden's works in somatically oriented psychotherapy, jointly forming an

interdisciplinary framework for a deeper understanding of operatory functioning.

The systematization of theoretical material made it possible to identify seven interrelated domains of manifestation of operatory thinking: the linguistic (reduction of the symbolic function of language, concreteness, avoidance of metaphorical expression); the social (disturbed regulation of interpersonal distance, conformity, formalization of contacts); the psychodynamic (deficit of sublimation, disturbances of affective regulation, instability of object relations); the cognitive (limitation of imaginative activity, dominance of concrete thinking, rigidity of cognitive schemas, deficit of reflective function); the behavioral-activity-related (monotony of activity, emotional detachment, orientation toward survival); the emotional-affective (alexithymia, somatization as a form of expression, impaired emotional differentiation, rationalization of experiences); and the domain of interaction with external reality (hyperinvestment in the external environment, dependence on social norms, difficulties in identifying one's own needs).

The developed psychodiagnostic *Operatory Thinking Questionnaire* (122 items, 12 scales) operationalizes the key theoretical constructs of the Paris Psychosomatic School. The structure of the instrument reflects the multidimensionality of the phenomenon through the following scales: energetic-motivational rigidity, alexithymia, control and cognitive rigidity, affective isolation, deficit of imagination and symbolization, avoidance of personal contact, social adaptive dependence, emotional-semantic reduction, emotional distance, deficit of emotional attachment, operational approach to emotions, and rationalization of affect. The differentiated structure of the questionnaire enables a detailed assessment of individual components of operatory functioning.

The practical significance of the study lies in the creation of a valid psychodiagnostic tool for identifying individuals with an increased risk of psychosomatic disorganization. The questionnaire can be applied in psychological counseling, psychotherapeutic practice, and preventive work for the early detection of deficits in mental representation. Differentiated assessment across scales allows for the identification of specific foci of psychotherapeutic intervention and for the formation of individualized strategies aimed at developing reflective function, emotional competence, and symbolic activity in clients.

The integration of classical psychoanalytic concepts with modern research in mentalization (P. Fonagy), the neurobiology of emotions (A. Damasio), and somatic psychology (P. Ogden) opens new perspectives for understanding psychosomatic phenomena and for developing psychocorrective strategies directed toward enhancing reflective function, emotional literacy, and symbolic activity.

Personal contribution of the authors:

Tamara Khomulenko. Development of the idea and research design.

Valeriia Krynychko. development of the research design, data collection, and manuscript preparation.

Karyna Fomenko. Statistical analysis.

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ОПЕРАТУАРНЕ МИСЛЕННЯ: КОНЦЕПТУАЛІЗАЦІЯ ПОНЯТТЯ, ПСИХОДІАГНОСТИКА ТА СТАНДАРТИЗАЦІЯ МЕТОДИКИ

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Комплексне дослідження феномену оператуарного мислення як специфічної форми когнітивно-афективного функціонування, що характеризується редукцією символічної активності, дефіцитом ментальної репрезентації емоційних переживань та надмірною прив'язкою до конкретної реальності. Актуальність дослідження зумовлена зростанням поширеності психосоматичних розладів у сучасній психологічній практиці, де до 60-80% осіб демонструють симптоми соматизації психологічного дистресу. Мета статті полягає у теоретико-методологічній концептуалізації феномену оператуарного мислення через систематизацію його структурно-функціональних характеристик у семи взаємопов'язаних сферах психічного функціонування, а також у розробці та стандартизації психодіагностичного інструментарію для виявлення осіб із підвищеним ризиком психосоматичної дезорганізації. У роботі здійснено системний аналіз теоретичної спадщини Паризької психосоматичної школи (П. Марті, М. де М'Юзан, К. Смаджа) з виділенням семи основних сфер прояву оператуарного мислення: мовленнєвої (редукція символічної функції мови, конкретність, уникнення метафоричності), соціальної (порушення міжособистісної дистанції, конформність, формалізація контактів), психодинамічної (дефіцит сублімації, порушення афективної регуляції, нестабільність об'єктних відносин), когнітивної (редукція уявного життя, домінування конкретного мислення, ригідність когнітивних схем), поведінково-активнісної (монотонність діяльності, емоційна відстороненість), емоційно-афективної (алекситимія, соматизація як форма експресії, порушення емоційної диференціації) та сфери взаємодії із зовнішньою реальністю (гіперінвестиція у зовнішнє, залежність від соціальних норм). Результатом дослідження є розроблений психодіагностичний опитувальник оператуарного мислення, що включає 122 пункти та 12 шкал: енергетично-мотиваційна ригідність, алекситимія, контроль і когнітивна ригідність, афективна ізоляція, дефіцит уяви та символізації, уникнення особистісного контакту, соціальна адаптивна залежність, емоційно-семантична редукція, емоційна дистанція, дефіцит емоційної прив'язаності, операційний підхід до емоцій, раціоналізація афекту. Методика операціоналізує ключові теоретичні конструкти та дозволяє здійснювати диференційовану діагностику вираженості окремих компонентів оператуарного функціонування. Практичне значення роботи полягає у створенні валідного інструменту для ідентифікації осіб групи психосоматичного ризику в психологічному консультуванні та психотерапевтичній практиці. Інтеграція класичних психоаналітичних концепцій з сучасними дослідженнями ментальізації (П. Фонагі), нейробіології емоцій (А. Дамазіо) та соматичної психології (П. Огден) відкриває нові перспективи для розуміння психосоматичних феноменів та розробки психокорекційних стратегій, спрямованих на розвиток рефлексивної функції, емоційної грамотності та символічної активності.

Ключові слова: *психодіагностика, салютогенний підхід, феноменологія тілесного Я, психологічне благополуччя, психосоматика, оператуарне мислення, психоаналітичний підхід, алекситимія*

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