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Front Pages

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The *Athens Journal of Psychology* (AJPSY) is an Open Access quarterly double-blind peer reviewed journal and considers papers from all areas of psychology. Many of the papers in this journal have been presented at the various conferences sponsored by Psychology Unit of the Athens Institute. All papers are subject to Athens Institute's Publication Ethical Policy and Statement.

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The current issue is the third of the second volume of the *Athens Journal of Psychology* (AJPSY), by the published by the **Psychology Unit** of the **Athens Institute**. All papers are subject to Athens Institute's Publication Ethical Policy and Statement.

Gregory T. Papanikos
President
Athens Institute

Athens Institute for Education and Research

A World Association of Academics and Researchers

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- **Dr. Thanos Patelis,** Head, Psychology Unit of Athens Institute & Research Scholar, Fordham University, USA.

Important Dates

- Abstract Submission: **7 October 2026**
- Acceptance of Abstract: 4 Weeks after Submission
- Submission of Paper: **26 April 2027**

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- Athens Sightseeing: Old and New-An Educational Urban Walk
- Social Dinner
- Mycenae Visit
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Important Dates

- Abstract Submission: **6 October 2026**
- Acceptance of Abstract: 4 Weeks after Submission
- Submission of Paper: **5 April 2027**

Academic Member Responsible for the Conference

- **Dr. Domenico Maddaloni,** Head, Sociology Research Unit, Athens Institute & Associate Professor, University of Salerno, Italy.
- **Dr. Philip G. Cerny**, Director, Social Sciences Division, Athens Institute & Professor Emeritus, University of Manchester (UK) and Rutgers University (USA).
- **Dr. Nikolaos I. Liodakis,** Associate Professor, Wilfrid Laurier University, Canada.
- **Dr. Sharon Claire Bolton**, Head, Management Research Unit, Athens Institute & Professor, The Management School, University of Stirling, Scotland.
- **Dr. Maria Pallotta-Chiarolli,** Academic Member, Athens Institute & Fellow, Deakin University, Australia.

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More information can be found here: https://www.atiner.gr/social-program

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Trauma and Psychological Experience in Hidradenitis Suppurativa: A Qualitative Study of 10 Patients

By Ermioni Ofidou[*] & Nathalie Dumet[*]

Hidradenitis suppurativa (HS), is a chronic and painful dermatological condition, has significant psychological repercussions that remain underexplored. This exploratory qualitative study, conducted with ten affected women, aims to understand the link between prior traumas and the experience of the disease. Ten semi-structured interviews per participant were conducted over a one-year period, allowing for thematic analysis following Braun and Clarke (2006). Three main themes emerged: early familial traumas, traumatic relational and sexual experiences, and positive events and emotional support. The narratives reveal a connection between bodily experience, psychological suffering, and the reactivation of traumatic memories during flare-ups. These findings highlight the importance of an integrated approach, combining psychological support and dermatological care, to better understand the psychosomatic dynamics of this condition.

Keywords: *Hidradenitis suppurativa – Skin disease – Psychosomatic approach – Traumatic experiences*

Introduction

Hidradenitis suppurativa (HS), is a chronic inflammatory dermatological condition that primarily affects intertriginous areas such as the axillae, groin, genital, gluteal, and inframammary regions. It is characterized by painful inflammatory nodules that may progress to abscesses, sinus tracts, and purulent, often malodorous, discharge. The etiology of the disease is multifactorial and involves a complex interaction of genetic, hormonal, immunological, environmental, and psychological factors.

Beyond its physical manifestations, a growing body of research has demonstrated that HS has a profound impact on patients' quality of life, mental health, and social and intimate relationships. Chronic pain, lesions affecting intimate areas of the body, unpleasant odors, scarring, and the relational difficulties frequently reported by patients are often associated with experiences of shame, stigmatization, and social isolation.

Within this context, psychodermatological research has increasingly emphasized the importance of exploring the psychological, emotional, and relational dimensions involved in the experience of chronic dermatological diseases. Recent studies have particularly highlighted the role of traumatic experiences and relational contexts in shaping the subjective experience of chronic skin disorders.

It is within this framework that the present exploratory qualitative study was conducted. Its aim was to explore the psychological experiences of women living with hidradenitis suppurativa, the traumatic or emotionally significant experiences

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present in their life histories, and the relational and subjective contexts within which inflammatory flare-ups appear to emerge or intensify.

Literature Review

HS: Psychological Experience, Interpersonal Relationships, and Quality of Life

Several studies have shown that hidradenitis suppurativa (HS) affects women more frequently and has a substantial impact on quality of life, psychological functioning, and social and intimate relationships (Krajewski et al. 2021, Revankar et al. 2021). Physical symptoms, often located in intimate areas of the body, may be accompanied by feelings of shame, embarrassment, stigma, and difficulties in interpersonal relationships (Krajewski et al. 2021). HS affects not only patients at an individual level but also has repercussions on marital, family, and social relationships. Limitations in daily activities, sexual difficulties, chronic pain, and the feelings of shame and isolation reported by patients can affect their interactions with others and their participation in social life (Revankar et al. 2021). These findings highlight the profoundly relational and intersubjective nature of the experience of living with HS.

Comparable observations have been reported in other chronic dermatological conditions, particularly psoriasis and atopic dermatitis, for which several studies have also identified significant impairments in self-esteem, relational difficulties, experiences of stigmatization, and reduced quality of life (Dalgard et al. 2015, Zhang et al. 2021). These findings suggest that psychological and intersubjective consequences constitute a central dimension of the experience of chronic skin diseases, beyond their physical manifestations alone.

Other studies have also documented a high prevalence of anxiety and depressive symptoms among individuals with HS, as well as significant impairments in psychological and emotional well-being (Phan et al. 2020). Qualitative research further describes psychological suffering characterized by feelings of loneliness, misunderstanding, rejection, and social isolation among patients living with HS (Esmann et al. 2019).

Psychodermatology and Psychological Issues in Hidradenitis Suppurativa

Research in psychodermatology conceptualizes chronic dermatological diseases as arising from a continuous interaction between inflammatory processes, psychological functioning, and the relational environment (Ghosh et al. 2013, Bewley 2017). This perspective is grounded in a biopsychosocial framework, which considers biological, psychological, and social dimensions as jointly contributing to the experience of illness. Several authors have highlighted the importance of emotional regulation difficulties, alexithymia, and mentalization processes in the experience of chronic somatic illnesses, particularly dermatological conditions (Giovannelli et al. 2016, Conversano & Di Giuseppe 2021).

Among chronic dermatological diseases, HS is distinguished by the severity of its psychological and psychosocial burden. Chronic pain, recurrent lesions,

discharge, unpleasant odors, and the frequent localization of symptoms in intimate areas of the body are associated with substantial impairments in quality of life, interpersonal relationships, and sexuality (Krajewski et al. 2021, Revankar et al. 2021, Alavi et al. 2018). Research has also demonstrated a high prevalence of anxiety and depressive symptoms among individuals with HS (Phan et al. 2020). Furthermore, several studies indicate that people living with HS are at increased risk of suicidality and suicide compared to the general population, reflecting the considerable psychological burden associated with this condition (Thorlacius et al. 2018, Patel et al. 2022).

Available studies also describe frequent experiences of stigma, shame, embarrassment, social isolation, and difficulties in intimate and sexual relationships (Krajewski et al. 2021, Revankar et al. 2021). However, although the psychological and psychosocial consequences of HS are now relatively well documented, research focusing on patients' psychological functioning remains limited. Most studies have concentrated on quality of life, psychological distress, sexuality, or symptoms of anxiety and depression, whereas relatively few have explored how individuals experience and psychologically process their illness, attribute meaning to their symptoms, or mobilize psychological resources in response to the challenges they face. Clinical psychology, psychodynamic, and psychosomatic perspectives remain underdeveloped within the field of HS research, leaving several questions unanswered regarding the psychological functioning associated with this condition.

Trauma and Dermatological Diseases

Within this context, several recent studies have examined the role of traumatic experiences in chronic dermatological conditions. Some findings suggest that patients with chronic dermatoses report a higher prevalence of traumatic experiences, dissociative manifestations, and significant difficulties in emotional regulation (Giovannelli et al. 2016).

With regard specifically to HS, some studies have reported a higher frequency of traumatic experiences among patients with the disease, while emphasizing the need for caution in interpreting these findings (Gielen et al. 2020). Several authors have also stressed that the experience of living with a chronic dermatological condition may itself be highly distressing, particularly when accompanied by persistent pain, unpleasant odors, sexual difficulties, social stigmatization, or a lasting sense of exposure to the gaze of others (Gupta et al. 2017, Szabó 2020).

Qualitative studies conducted with individuals living with HS describe significant psychological suffering characterized by feelings of loneliness, rejection, shame, and misunderstanding (Esmann et al., 2019). At the level of subjective experience, several patients report periods of relational tension, emotional insecurity, loss, or psychological vulnerability coinciding with the onset or worsening of cutaneous symptoms. These subjective associations do not establish a causal relationship between trauma and illness; rather, they highlight the importance of exploring the emotional and relational contexts in which inflammatory flare-ups emerge or recur.

Despite growing interest in the psychological dimensions of hidradenitis suppurativa, few qualitative studies have investigated how patients themselves

make sense of the onset and evolution of inflammatory flare-ups within the context of their relational and emotional histories.

Two main research questions guided the present study:

- In what specific or non-specific contexts did the first symptoms of hidradenitis suppurativa emerge?
- In what relational, emotional, or life-event contexts do inflammatory flare-ups appear to recur or intensify?

Method

Study Design

This study adopted an exploratory longitudinal qualitative design involving ten women diagnosed with hidradenitis suppurativa (HS). Each participant took part in ten semi-structured interviews conducted between 2023 and 2025, resulting in a total corpus of one hundred interviews.

The longitudinal design was chosen to explore the evolution of participants' psychological experiences, relational contexts, and perceptions of disease flare-ups over time. Repeated interviews provided access not only to significant life events and traumatic experiences but also to the ways participants progressively reflected upon, interpreted, and integrated these experiences into their understanding of the disease. This approach facilitated a deeper exploration of individual trajectories and enabled the identification of both stable and evolving patterns across the study period.

The authors declare that artificial intelligence was used solely to improve the clarity and quality of the English language and did not contribute to the generation of scientific content, data analysis, interpretation, or conclusions.

Participants and Inclusion Criteria

The sample consisted of ten adult women aged between 18 and 40 years with a confirmed diagnosis of HS and a reported history of physical, sexual, or psychological trauma. Participants presented varying levels of disease severity, ranging from mild to severe forms.

The decision to include only women was based on the higher prevalence of HS among females and aimed to ensure greater homogeneity within the sample.

Exclusion Criteria
Male sex.
Recruitment

Participants were recruited through a Facebook group associated with patient support organizations. A study announcement described the aims of the research, participation procedures, confidentiality measures, and informed consent requirements.

Individuals who expressed interest were contacted individually to verify eligibility and discuss participation.

Data Collection

Data were collected through semi-structured interviews conducted via videoconference. Each interview lasted approximately 45 to 60 minutes and was audio-recorded and transcribed verbatim. All transcripts were anonymized using participant codes (P1–P10).

The interview guide explored four main domains:

1. Personal history and disease trajectory;
2. Traumatic and emotionally significant experiences;
3. Perceived relationships between life events and HS flare-ups;
4. Psychological, emotional, relational, and social consequences of the disease.

Participants were also invited to discuss positive life events and sources of emotional support in order to explore potential protective or moderating factors.

Data Analysis

Thematic analysis was conducted following the framework developed by Braun and Clarke (2006). Analysis was performed on the complete corpus of one hundred interview transcripts.

The coding process was conducted manually. Each transcript was reviewed multiple times to allow for thorough familiarization with the collected material and to identify meaning units related to traumatic experiences, emotional experiences, interpersonal relationships, and the subjective experience of living with hidradenitis suppurativa.

Initial codes were progressively grouped into broader categories and subsequently refined into themes and subthemes through an iterative analytical process.

Given the longitudinal nature of the study, the analysis was conducted at two complementary levels. First, interviews were examined within each participant's individual trajectory in order to identify continuities, changes, and transformations in the meaning attributed to experiences over time. Second, a cross-sectional analysis was performed to identify recurring patterns, shared experiences, and points of divergence across participants.

The identified themes were regularly compared against the original transcripts to ensure consistency with the participants' narratives and with the final thematic structure. Particular attention was paid to preserving the complexity and uniqueness of individual experiences while also allowing for the identification of themes common to the corpus as a whole.

To ensure participant confidentiality, all data were anonymized. Each participant was assigned an alphanumeric identifier (P1, P2, P3, etc.), which was used throughout the analytical process and in the presentation of findings. Any

information that could potentially allow for the direct or indirect identification of participants was removed or modified.

In keeping with the clinical and interpretative nature of the study, the analysis aimed not only to identify recurrent themes but also to preserve the subjective meaning of participants' experiences and the singularity of their narratives.

The coding process was conducted manually. Each transcript was read repeatedly to ensure familiarity with the material and to identify meaningful units related to trauma, emotional experiences, interpersonal relationships, and the lived experience of HS. Initial codes were progressively grouped into broader categories and subsequently refined into themes and subthemes through an iterative analytical process.

Because of the longitudinal nature of the study, analysis was conducted at two complementary levels. First, interviews were examined within each participant's trajectory in order to identify changes, continuities, and evolving meanings over time. Second, data were analyzed across participants to identify recurring patterns, shared experiences, and points of divergence.

Themes were repeatedly reviewed against the original transcripts to ensure coherence between participants' narratives and the final thematic structure. Particular attention was paid to preserving the complexity of individual experiences while identifying common themes across the sample.

Given the clinical and qualitative orientation of the study, reflexivity was maintained throughout the research process. As a clinical psychologist, the researcher continuously reflected on her theoretical assumptions, clinical sensitivity to trauma-related material, and potential influence on interpretation. Regular returns to the original data were used to minimize overinterpretation and maintain close adherence to participants' accounts.

The use of repeated interviews constituted a central methodological choice of this study. Rather than relying on a single retrospective account, the longitudinal design enabled the exploration of how participants' narratives evolved over time and allowed the researcher to capture the dynamic relationship between traumatic experiences, emotional states, interpersonal contexts, and disease flare-ups. This approach provided a richer understanding of subjective meaning-making processes than would have been possible through a single interview.

Ethical Considerations

The study was conducted in accordance with the principles of the Declaration of Helsinki. Written informed consent was obtained from all participants prior to participation, and all collected data were anonymized.

Given that the interviews involved the discussion of potentially traumatic experiences, particular attention was paid to participants' emotional well-being throughout the study. Participants were informed of their right to temporarily pause or terminate the interview at any time without having to provide a reason.

Whenever emotional distress emerged during an interview, time was provided to facilitate emotional soothing and affect regulation before continuing the discussion. Information regarding psychological support resources and services was also made available whenever deemed necessary.

Because interviews involved the discussion of potentially traumatic experiences, particular attention was given to participants' emotional well-being throughout the study. Participants were informed of their right to pause or terminate an interview at any time without explanation. When emotional distress emerged during interviews, time was provided for emotional containment and regulation before continuing. Information regarding psychological support services was available when necessary.

Table 1. *Interview Guide: Main Themes and Open-ended Questions*

Main theme	Open-ended questions
1. Personal background and HS trajectory	1. Can you tell me how the disease first appeared in your life? 2. How would you describe the evolution of your symptoms over time? 3. Which moments have been particularly significant in your experience with HS? 4. What situations or events have influenced the intensity or frequency of your flare-ups? 5. Can you share positive or meaningful moments in your life, whether or not they are related to the disease? 6. How did you experience your first flare-ups and initial treatments?
2. Past traumatic experiences	1. Have you experienced difficult or painful events in your life? 2. How have these experiences influenced the way you perceive yourself and the world? 3. Are there particular moments or memories that you feel are connected to your current emotional experience? 4. How did you experience your body and your emotions during these events? 5. What forms of support or resources were available to you in dealing with these traumas?
3. Perceived link between trauma and HS flare-ups	1. In your view, are there moments or situations that tend to trigger your flare-ups? 2. How do you experience the connection between your past experiences and the disease exacerbations? 3. Can you describe what you feel before, during, and after a flare-up? 4. Are there any warning signs that, in your opinion, announce an upcoming flare-up? 5. How do these flare-ups affect your emotions or your relationships with others?
4. Psychological and emotional impact of	1. What emotions do you most often

HS	experience in relation to your disease? 2. How has the disease influenced your relationship with your body? 3. How do you experience periods when your symptoms subside? 4. How do you cope with difficult moments related to the disease? 5. In what ways does the disease influence your relationships with others (family, friends, partner, work)?

Table 2. *Table 2. Life Trajectories of Participants: Significant Events and Symptomatic Manifestations*

Participant	Nature of Event	Category	Event	Age	Symptom Present
P1	Negative	Family	Announcement of sister's death before her birth	7 years	No
P1	Negative	Assault	Sexual assault and humiliation	18 years	No
P1	Negative	Social	Loss of best friend / accomplice in the assault	18 years	No
P1	Negative	Professional	Toxic supervisor	20 years	No
P1	Negative	Family	Rejection / humiliation by her sister	33 years	Yes
P1	Positive	Professional	New professional training	33 years	Yes
P2	Negative	Assault	Sexual touching	6 years	No
P2	Negative	Relational	Forced marriage	26 years	No
P2	Negative	Relational	Separation from her children	28 years	No
P2	Negative	Relational	Divorce	29 years	No
P2	Negative	Relational	Toxic relationship with an alcoholic partner	29 years	No
P2	Negative	Family	Conflict with her mother	31 years	Yes
P2	Positive	Relational	Marriage	30 years	Yes
P3	Negative	Family	Physical and psychological abuse by her mother	Childhood	No
P3	Negative	Relational	Forced sexual relations within the couple	21 years	No
P3	Positive	Academic	Degree attainment	22 years	Yes
P3	Negative	Relational	Toxic relationship	37 years	Yes
P3	Negative	Family	Separation from her family	35 years	Yes

P4	Negative	Family	Loss of adoptive brother	7 years	No
P4	Negative	Relational	Relationship breakup	25 years	No
P4	Positive	Travel	Significant travel experience	27 years	No
P5	Negative	Family	Death of grandmother	14 years	No
P5	Negative	Family	Conflicts with her mother	15 years	Yes
P5	Negative	Family	Death of cousin	15 years	Yes
P5	Negative	Family	Relocation and change of city	16 years	Yes
P5	Negative	Health	Period of obesity	Adolescence	Yes
P5	Negative	Relational	Difficulty refusing sexual relations	16 years	Yes
P5	Positive	Professional	Professional promotion	33 years	Yes
P6	Negative	Assault	Sexual touching by a stranger	7 years	No
P6	Negative	Family	Death of a close relative	13 years	No
P6	Positive	Family	Birth of her son	13 years	No
P6	Negative	Relational	First sexual experience perceived as negative	Adolescence	No
P6	Negative	Relational	Forced sexual relations with current husband	30 years	Yes
P6	Negative	Family	Conflicts with her mother	30 years	Yes
P7	Negative	Family	Conflictual relationships with parents	Childhood–adolescence	No
P7	Negative	Family	Raised by grandparents	Childhood–adolescence	No
P7	Negative	Family	Conflicts with older brother	Adolescence	No
P7	Negative	Assault	Sexual touching by brother of first boyfriend	17 years	No
P7	Positive	Medical	Surgeon who saved her life	26 years	Yes
P8	Negative	Family	Father in a coma	17 years	Yes
P8	Negative	Academic	Regret over discontinuing schooling	17 years	Yes
P8	Negative	Relational	Attempted non-consensual sexual relationship (first boyfriend)	17 years	Yes
P8	Positive	Travel	Cultural travel experience	32 years	Yes
P9	Negative	Family	Physical and psychological abuse	Childhood–adolescence	No

P9	Negative	Relational	Toxic relationship and forced sexual relations with an alcoholic partner	20 years	No
P9	Negative	Family	Repeated ruptures with parents	Adulthood	Yes
P10	Negative	Health	Difficulty conceiving a child	24 years	No
P10	Negative	Professional	Employment instability	24–34 years	Yes
P10	Negative	Professional/Relational	Contact with abused children and difficulties in relationship with parents (aggressiveness)	34 years	Yes
P10	Negative	Relational	Repeated separations from partner due to difficulty conceiving	Adulthood	

Results

In line with the objective stated in the Introduction, the thematic analysis of the narratives collected from the ten participants identified three main thematic axes:

1. early trauma and the family environment;
2. the relational, sexual, and emotional dimension of trauma;
3. positive events and emotional support as modulating factors.

Early Trauma and Family Environment

The majority of participants (7 out of 10, 70%) reported negative experiences within the family environment during childhood or adolescence, including physical or psychological violence, repeated conflicts, and significant losses. These experiences were often associated with a persistent sense of emotional insecurity.

Violence and Familial Control

Three participants (30%) described a family climate marked by violence or excessive control:

> P3: "As a child, I faced words and attitudes from my mother that constantly belittled me… always imbued with control and humiliation."
> P5: "I had many conflicts with my mother, and these relational difficulties persisted throughout my life."
> P9: "I experienced physical and psychological violence during my childhood and adolescence."

Parental Conflict and Rejection

Three other participants (30%) reported an atmosphere of rejection or persistent tension:

> P1: "At the age of 33, I felt deep rejection and humiliation from my mother, which coincided with a flare-up of my disease."
> P2: "At 31, I was still experiencing conflicts with my mother, and the family climate remained very difficult."
> P7: "During my childhood and adolescence, my relationships with my parents and my older brother were constantly conflictual."

Bereavement and Significant Losses

All participants (100%) experienced at least one real or symbolic loss (death, separation, or family rupture). These events often appeared to be temporally linked to the onset or intensification of symptoms. Examples include the loss of a loved one (P4, P5, P6), rupture with the family (P3, P9), or repeated separations (P2, P10).

Theme 1 Summary

Type of Experience	**Number of Participants**	**Percentage**
Physical/psychological violence	3	30%
Parental conflict or rejection	3	30%
Bereavement or significant loss	10	100%
Persistent trauma in adulthood	3	30%

Relational, Sexual, and Emotional Dimensions of Trauma

This second axis encompasses traumatic experiences occurring in the relational or intimate sphere. These experiences profoundly affect participants' relationship to their bodies, sexuality, and relational trust.

Early Sexual Contact or Assault

Three participants (30%) reported experiences of sexual touching during childhood or adolescence (P2, P6, P7). These early events appear to represent ruptures in the perception of bodily boundaries and personal integrity.

Traumatic Romantic or Conjugal Relationships

Four participants (40%) described toxic relationships or non-consensual sexual experiences in adulthood (P2, P3, P5, P9). These situations were often accompanied by feelings of helplessness and shame, with a direct impact on dermatological symptoms:

> P3: "In my relationship, I accepted things for a long time that I did not want… every argument ended with a new flare-up."

Sexual Violation in Adolescence

One participant (10%) reported an attempted non-consensual sexual encounter at the age of 17 (P8), experienced as a major triggering event in her bodily history.

Theme 2. Summary

Type of Traumatic Experience	**Number of Participants**	**Percentage**
Sexual touching/assault (childhood–adolescence)	3	30%
Toxic relationships or non-consensual sex (adulthood)	4	40%
Attempted or completed sexual violation (adolescence)	1	10%

Positive Events and Emotional Support as Modulating Factors

Despite traumatic experiences, six participants (60%) identified positive events that contributed to emotional stabilization or improved management of the disease.

Personal and Professional Achievements

Two participants (20%) mentioned academic or professional successes as sources of validation and renewed self-esteem (P1, P3).

Restorative Support

One participant (P7) described encountering a compassionate healthcare professional, experienced as a reparative relationship in the context of bodily suffering.

Experiences of Freedom and Reconnection

Two participants (20%) reported meaningful travel experiences that fostered a sense of freedom and reconnection with themselves (P4, P8).

Supportive Romantic Relationships

One participant (10%) emphasized the importance of a balanced romantic relationship in emotional regulation and stress reduction (P2).

Theme 3. Summary

Type of Positive Experience	**Number of Participants**	**Percentage**
Personal achievements	2	20%
External restorative support	1	10%
Moments of freedom/reconnection	2	20%
Balanced romantic relationships	1	10%

Discussion

Trauma and the Context of Disease Onset

The primary aim of this study was to explore the psychological experience of ten women living with hidradenitis suppurativa (HS) and to examine the subjective links they establish between previous traumatic experiences and the onset or intensification of inflammatory flare-ups. Through a qualitative approach, this research sought to gain a deeper understanding of how participants make sense of the interactions between their traumatic histories and their illness within the unique context of their psychological and relational trajectories.

For the majority of participants, the first manifestations of hidradenitis suppurativa emerged during periods marked by loss, family conflict, physical or psychological violence, or sexual assault. These events frequently occurred within

painful or emotionally unstable relational contexts and occupied an important place in participants' narratives concerning the onset of their disease.

This observation is consistent with findings from psychodermatology showing that particularly stressful life events are frequently present in the histories of patients with chronic inflammatory dermatological conditions (Ghosh et al. 2013, Yu et al. 2020).

Analysis of the narratives revealed three major thematic areas: early experiences within the family environment, significant relational and sexual experiences, and the role of positive experiences and emotional support. Together, these themes provide a framework for understanding how certain life experiences become integrated into the subjective experience of illness.

Early Trauma and Psychosomatic Vulnerability

Seven participants reported difficult early experiences within their family environments, including physical or psychological violence, chronic conflict, experiences of rejection, as well as losses or separations occurring during childhood. Across these narratives, what emerges is not merely exposure to painful relational experiences, but also the presence of vulnerabilities in emotional containment and psychological elaboration processes. More than any particular form of parental violence, these accounts appear to reflect situations in which certain emotional experiences could not be sufficiently represented, thought about, or psychically integrated.

These observations are consistent with research that has explored the role of adverse relational experiences in chronic dermatological diseases. Several studies have shown that individuals with chronic dermatoses more frequently report histories of traumatic experiences, dissociative manifestations, and significant difficulties in emotional regulation (Giovannelli et al. 2016). More specifically, patients with hidradenitis suppurativa reported a greater number of traumatic life events than healthy controls, with emotional trauma occurring during childhood being particularly common (Gielen et al. 2020). The authors nevertheless emphasize that such findings primarily invite clinicians and researchers to consider patients' psychosocial histories when seeking to understand their lived experiences and healthcare trajectories.

The findings of the present study are consistent with this perspective. Many participants described experiences of loss, violence, rejection, or relational insecurity that they considered significant both in their personal histories and in the ways they understood the course of their illness. These narratives highlight the place such experiences occupy in the construction of meaning surrounding the disease, without presupposing the mechanisms that may be involved.

These findings may be approached from different theoretical perspectives. While contemporary research highlights the importance of psychosocial factors in the experience of chronic inflammatory diseases, psychosomatic approaches have focused more specifically on the ways in which emotional experiences may be elaborated, transformed, or, conversely, remain difficult to represent within psychic functioning.

From a psychosomatic perspective, Dejours (1993, 2009) argues that somatic disorganization may occur when psychic activity becomes overwhelmed by excitations that cannot be mentally elaborated. In such situations, the body may

become the site of expression for experiences that fail to achieve sufficient psychic representation, without reducing somatic manifestations to the experiences reported by participants. This perspective offers a framework for understanding the psychosomatic vulnerability observed among participants while respecting the heterogeneity of their experiences.

Similarly, Fain (1992) notes that adults who later develop psychosomatic disorders frequently recall childhood experiences perceived as traumatic, even when the content of these experiences remains difficult to specify or verbalize. The focus is therefore less on identifying a specific traumatic event than on highlighting a more general vulnerability linked to early failures within the relational environment.

This interpretation appears consistent with the diversity of situations reported in the present study, where experiences of violence, rejection, conflict, or loss seem less related to isolated events than to relational contexts enduringly marked by emotional insecurity.

Szwec (2012) further emphasizes that psychosomatic manifestations may arise in contexts characterized by early depressive states or failures of the primary environment, whether these take the form of overt aggression or a lack of emotional availability and protection. Such experiences contribute to the development of a vulnerable psychic organization that may increase sensitivity to later situations involving stress, loss, or relational rupture.

From this perspective, the experiences reported by the participants may be understood as elements of their affective and relational histories that contribute to the development of a particular psychological vulnerability. The findings of this study therefore invite consideration of symptom emergence within the broader context of participants' subjective histories, in line with the psychosomatic and psychodermatological perspectives presented in the literature.

Absence of Reported Trauma and Defensive Processes

Three participants did not report any explicitly traumatic events. One participant described an inability to recall her childhood, which may suggest the presence of defensive mechanisms such as repression or dissociative processes. Another participant was raised by her grandparents due to her parents' professional obligations and did not report any overt experiences of violence; this situation may be better understood as a form of emotional deprivation rather than trauma in the strict sense. The third participant described chronic stress and emotional difficulties without linking them to any clearly identifiable event.

These narratives highlight the complexity of identifying traumatic experiences. They also underscore the importance of considering defensive processes, as well as individuals' capacities for mentalization (Marty 1990) and for representing and processing emotional experiences, when seeking to understand psychosomatic trajectories.

Loss, Separation, and the Continuity of Vulnerability

Across all narratives, experiences of loss or early bereavement were present, regardless of whether participants identified an explicit trauma. In both the psychosomatic and dermatological literature, significant life events are frequently associated with losses such as the death of a loved one, separation, job loss, or relocation (Pomey-Rey 1992). Such situations may reactivate earlier experiences of separation or abandonment that are sometimes only partially accessible to memory. Consoli (2003) also emphasizes the destabilizing effects of loss and disruptions in emotional bonds on psychological functioning.

In the present study, the losses described were often concrete and emotionally significant, particularly the death of a close relative. For example, one participant lost her sister at a very young age and, although she retained no conscious memory of the event, she described its lasting impact on family dynamics. The theme of loss thus emerged repeatedly through fears of losing important attachment figures or of being deprived of essential relational anchors.

Relational and Sexual Trauma and the Relationship to the Body

Eight participants reported experiences such as unwanted sexual touching, sexual assault, or coerced physical and sexual relationships occurring during childhood, adolescence, or adulthood. These experiences appeared to have profoundly shaped their relationship to both their bodies and to others. Several participants described difficulties with physical contact, associating touch with fear, disgust, or intrusion. Others expressed a form of ambivalence, oscillating between a desire for closeness and the reactivation of painful memories.

This transformation in the relationship to the body may be understood as a form of libidinal disinvestment, whereby the body becomes more closely associated with pain, threat, or shame than with pleasure. The skin, as a boundary between self and other, thus appears as a particularly sensitive site upon which tensions linked to traumatic relational experiences may become inscribed.

The experiences of sexual violence reported by several participants may also be considered in light of Herman's (1992) work, which emphasizes the enduring effects of sexual trauma on the relationship to the body, the sense of safety, and interpersonal relationships. The difficulties related to physical contact, intimacy, and trust described by some participants are consistent with these observations and highlight the impact of such experiences on their bodily and relational lives.

Similarly, Van der Kolk (2014) underscores the central role of the body in traumatic experience, arguing that certain traces of trauma may persist through bodily sensations, physical experiences, and patterns of relating to others. The difficulties with physical contact, the ambivalence toward relational closeness, and the feelings of shame and vulnerability described by several participants appear consistent with these observations. While these findings do not allow for the establishment of a specific link between trauma and somatic manifestations, they provide additional insight into the bodily, emotional, and relational consequences of the traumatic experiences reported in this study.

Among the two participants who did not report a history of sexual trauma, one described significant distress related to infertility despite multiple attempts to conceive. This experience may be understood as another form of bodily and narcissistic injury, illustrating how bodily limitations and repeated disappointments can profoundly affect an individual's subjective experience of the body. More broadly, it highlights the extent to which the body may become invested with issues of identity, self-worth, and personal fulfillment, particularly when it is experienced as failing to meet deeply held desires or expectations.

1.

Emotional Support and Resilience

Participants primarily focused on the painful aspects of their life histories, and few spontaneously referred to experiences of support, repair, or recovery. Nevertheless, some described personal achievements, professional accomplishments, or moments of self-reclamation, reflecting psychological resources and capacities for resilience.

One participant, in particular, emphasized the importance of a therapeutic or relational experience that was perceived as containing, supportive, and validating. Such accounts suggest that, even within a context marked by chronic pain and bodily shame, the presence of a benevolent and recognizing other may foster psychological relief, facilitate processes of emotional elaboration, and support a gradual reinvestment of the body.

More broadly, these findings highlight the potential protective role of supportive relationships in the subjective experience of illness. They suggest that experiences of recognition, emotional support, and interpersonal security may constitute important resources in coping with the psychological burden associated with hidradenitis suppurativa.

Theoretical Implications and Limitations

Overall, the findings of this study highlight the frequent presence of adverse early experiences, relational difficulties, and significant life events in the histories of women living with hidradenitis suppurativa, as well as the persistence of certain forms of emotional and bodily vulnerability over time. Experiences of loss, separation, relational insecurity, and bodily distress emerged as recurring themes in participants' narratives and appeared to form part of a broader subjective continuity throughout their life trajectories.

These findings may be considered in light of psychosomatic approaches that focus on the psychic elaboration of emotional experiences. From a psychosomatic perspective, hidradenitis suppurativa may be understood within contexts in which the elaboration of affective experiences appears limited and where the body occupies a central place in the management of emotional tensions (McDougall 1989, Dejours 2009, Dumet 2019). Such a perspective does not imply that the disease functions as a form of communication or represents the direct consequence of traumatic experiences.

Rather, it invites attention to situations in which certain emotional experiences remain difficult to represent, elaborate, or integrate psychically.

This reflection is also consistent with Marty's (1990) work, which places greater emphasis on the ways in which life events are mentalized, elaborated, and integrated into psychic functioning than on the nature of the events themselves. From this perspective, the experiences of loss, violence, and relational insecurity reported by participants may be understood as elements contributing to the development of a particular psychological vulnerability, without reducing somatic manifestations to these experiences.

The findings also resonate with the work of Fain (1992) and Szwec (2012), who emphasized the importance of early failures within the relational environment in the development of certain psychosomatic vulnerabilities. Participants' narratives revealed recurring contexts characterized by affective insecurity, conflict, separation, and experiences of rejection, suggesting the importance of considering relational history when seeking to understand the subjective experience of illness.

Furthermore, the experiences of emotional support, recognition, and self-reclamation described by some participants highlight the importance of affective relationships in processes of psychological transformation. This dimension echoes Consoli's (2003) reflections on the structuring role of emotional bonds in maintaining psychological equilibrium and facilitating emotional elaboration.

The findings may also be discussed in light of contemporary research in health psychology and psychodermatology. These approaches emphasize the importance of emotional, relational, and psychosocial factors in the experience of chronic illness while highlighting the complexity of interactions between psychological experience, life circumstances, and bodily manifestations (Ghosh et al. 2013, Conversano & Di Giuseppe 2021). Recent studies have shown that individuals with chronic dermatological conditions more frequently report difficulties in emotional regulation, traumatic experiences, and relational vulnerabilities (Giovannelli et al. 2016, Gielen et al. 2020). The findings of the present study are consistent with this literature, highlighting the central role that certain affective experiences occupy in the ways participants understand and make sense of their illness.

Nevertheless, several limitations should be acknowledged. The sample was relatively small and consisted exclusively of women, limiting the generalizability of the findings to the broader population of individuals living with hidradenitis suppurativa. In addition, the data were based on subjective and retrospective accounts, which primarily reflect the meanings participants attribute to their experiences and should therefore be interpreted with caution. Finally, the qualitative design of this study does not allow conclusions to be drawn regarding the mechanisms involved in the onset or progression of the disease. Rather, its purpose was to deepen understanding of participants' subjective experiences and the meanings they attribute to their life histories and illness trajectories.

Perspectives for Future Research

Future studies could explore processes of symbolization, emotion regulation, and psychological repair through longitudinal and therapeutic approaches, to better

understand how some patients transform bodily pain into psychically integrated experiences. Additionally, findings suggest that clinical interventions addressing trauma, emotional regulation, and relational support may benefit individuals with HS.

Conclusion

In conclusion, this study highlights the prevalence of early relational and sexual adversity among women with HS, suggesting a potential psychosomatic continuity in which the skin reflects unprocessed psychic experiences. Despite chronicity and associated suffering, narratives of emotional support indicate that psychological transformation and reinvestment in the body remain possible. These findings underscore the importance of considering both trauma history and relational context in understanding HS, and they offer directions for future research and clinical practice in psychodermatology.

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Axiogeniality and Herzl's Neurosis Capitalist Discourse and Transvalorative Psychology

*By Jorge Hernando Pacheco Gómez**

Building on Freud's analogy between paranoid delusions and philosophical systems (Systembildungen), this article establishes a clinical-genealogical framework to analyze contemporary value production and subjective formation. Drawing on Nietzsche's drive-dynamic psychology, recent cognitive-evolutionary readings of his Trieb theory, and Lacan's formalization of the Capitalist Discourse, it is argued that this discourse can be productively analyzed as functioning as an axiologically closed, secular religion. By anchoring systemic demands into internal psychological structures, this regime converts surplus-alienation (plus-de-jouir) into existential guilt, normalizes self-exploitation, and subjects speech and listening to performance-driven, market-rationalized imperatives. To characterize this structural malaise, the clinical category of Herzl's Neurosis is introduced: a historical, non-idiographic modality of neurosis defined by the foreclosure of Agential Integrity,operationalized here as a fractionated disruption between drive economics (Triebökonomie), affectivity, semantic meaning, and self-determined action. As a clinical-critical counterpoint, this paper outlines Transvaluative Psychology as a diagnostic matrix for evaluating the subjective costs of dominant value systems, positioning Axiogeniality as an active organismic operator capable of subverting pathogenous axiological hierarchies, reorganizing meaning, and restoring the symbolic bond.

Keywords: *Transvaluative Psychology, Axiogeniality, Herzl's Neurosis, Capitalist Discourse, Agential Integrity, Nietzschean Genealogy.*

Introduction

The relationship between psychic pathology and the production of meaning constitutes a structural axis for philosophy, psychoanalysis, and the cultural sciences. Since Freud's early formalizations, psychopathological formations have not been conceived as external to cultural dynamics, but rather as structures maintaining a formal continuity with major symbolic productions, even when appearing as their distorted images (Zerrbilder) (Freud 1912, 45). This conceptual displacement shifts the locus of the symptom from a merely individual, idiographic dysfunction to a historically situated modality of the organization of meaning (Pacheco 2015, 4-5).

On the basis of this premise, this article argues that contemporary capitalism does not merely reorganize socio-economic practices, but can be productively analyzed as functioning as an axiologically closed, secular religion. Within this regime, the market-driven imperatives of performance, productivity, and permanent optimization acquire an absolute character. By anchoring these systemic demands into internal psychological structures, a process that modern organismic psychology

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identifies as the internalization of external controls (Deci & Ryan 1985), this discourse converts existential suffering into a generalized guilt for structural insufficiency. This dynamic significantly erodes self-efficacy and the subjective capacity for behavioral control (Bandura 2009, pp. 6-16). The resulting distress is irreducible both to classical psychiatric nosography and to purely sociological explanations.

To characterize this contemporary subjective matrix, this article introduces the clinical category of Herzl's Neurosis. Rather than designating a new, isolated clinical syndrome, it represents a historical modality of neurosis defined by the progressive foreclosure of Agential Integrity. This integrity is operationalized as the dynamic, integrated coherence between drive economics (Triebökonomie), affectivity, semantic meaning, and self-determined action. Under late-capitalist conditions, this coherence suffers a fractionated disruption (Deci & Ryan 1985, pp 8, 21): the mind, understood here through contemporary 4E cognitive science as inherently embodied and embedded, becomes uncoupled from its somatic and affective foundations due to the relentless acceleration of digital-operational demands. Phenomenologically, this structural fracture manifests as severe systemic exhaustion and chronic burnout (Maslach & Leiter 2022), threatening the very narratives through which the self-constructs vital coherence and personal myths.

From a clinical standpoint, this structural mutation manifests decisively within the economy of discourse. As Lacan demonstrated through his formalization of the Capitalist Discourse, discourse does not merely regulate the utterable, but structures distinct subjective positions, modalities of jouissance, and the very fabric of the social bond. Within this specific subjective economy, speech loses its function as a symbolic mediation open to alterity and conflict, becoming subordinated to standardized metrics of performance, evaluation, and self-surveillance. Concurrently, the presence and search for structural meaning in life is systematically blocked, while the dimension of clinical listening is impoverished or automated, hindering the psychical working-through (Durcharbeitung) of contemporary distress.

This analysis adopts a genealogical perspective rooted in the critical tradition inaugurated by Nietzsche, for whom cultural pathologies stem from specific modes of organizing drive conflicts under dominant value systems. Within his framework, the historical phenomenon of religious neurosis appears as a structure where suffering is managed and endowed with meaning by fixing the subject within an economy of guilt, bad conscience (schlechtes Gewissen), and the ascetic ideal. The central hypothesis developed here is that late capitalism immanentizes and exacerbates this sacrificial structure in a secularized form. The ascetic ideal is no longer directed toward a transcendent deity, but is reinvested into the ego through imperatives of self-exploitation, transforming existential lack into a quantifiable, structural deficit of the self.

Consequently, capitalism operates as an axiological configuration isomorphic with religion, characterized by the absolutization of values, the demand for non-negotiable sacrifice, and the systematic foreclosure of any critique regarding its own criteria of legitimacy. To deconstruct this pathogenous matrix, this paper proposes Transvaluative Psychology as a clinical-genealogical diagnostic framework oriented toward interrogating the genesis, function, and subjective costs of value systems.

Within this horizon, Axiogeniality is positioned as an active organismic operator of value reorganization. Rather than treating genius as an individual anomaly or a romantic idealization, it is redefined as a critical capacity within the contemporary economy of meaning. Axiogeniality serves as a clinical and theoretical differentiator, allowing us to distinguish between neurotic, self-destructive adaptation to reactive axiological hierarchies, such as Herzl's Neurosis, and effective processes of transvaluation (Umwertung) that restore self-determined agency, reopen genuine symbolic bonds, and revitalize the creative dimensions of speech and listening.

Capitalism, Religion, and Neurosis: A Clinical-Genealogical Reading

In psychoanalysis, speech does not constitute a mere means of communication, but a fundamental clinical operator. Since Freud's early formulations, psychic suffering becomes clinically legible only insofar as it finds a symbolic inscription that allows drive conflict to be worked through (durcharbeitet) beyond somatic discharge or automatic repetition. The symptom thus does not appear as an executive or functional failure, but as a compromise formation (Kompromissbildung): a symbolic solution which, even when pathogenous, preserves an internal logic and a specific economic function within psychic life.

This conception articulates with the Freudian thesis of a structural continuity between psychopathological formations and major cultural productions. Freud maintains that neurosis does not constitute an outside of culture, but one of its distorted expressions (Zerrbilder), insofar as symbolic conflicts become fixed under rigid forms of meaning: hysteria as a distorted image of artistic creation, obsessive neurosis of religion, and paranoid delusion of philosophical systems (Systembildungen) (Freud 1912).

The function of speech is not to abolish conflict or eliminate suffering, but to render it interpretable by inscribing it within a symbolic economy. Where speech remains open to listening and to the reorganization of meaning, the symptom retains its character as a compromise; where, by contrast, it becomes subordinated to absolutized axiological hierarchies, suffering turns self-reproductive and loses its elaborative potential. This mediating function can only be sustained where listening exists, understood not as empathy or immediate understanding, but as a structural operation that keeps lack and the equivocity of saying open. As Lacan (1957) showed, if the unconscious is structured like a language, such structuration includes cuts, silences, and displacements that acquire clinical value only when listening is not colonized by imperatives of interpretive performance. The Lacanian notion of discourse allows this dimension to be formalized with precision: discourse does not designate simply what is said, but an underlying structure that organizes subjective positions, modalities of jouissance, and forms of social bond (Lacan 1969–1970, 17).

The subject does not pre-exist this structure, but is constituted as a function of the symbolic conditions that regulate what may be said, what must be silenced, and how distress can be received.From this perspective, the Capitalist Discourse does

not constitute merely another historical variation of the social bond, but a structural mutation characterized by the erosion of the symbolic limit that makes mediation through speech possible. Rather than producing a social bond in a strict sense, this discourse tends to dissolve it, fragmenting subjective experience into isolated units of performance and jouissance (Soler 2007, 135).

Within this regime, speech proliferates but loses its mediating function: it becomes oriented toward performance evaluation, self-exposure, and behavioral optimization, while listening is degraded or automated. Silence, the structural condition of listening, is recoded as unproductivity or failure, and the excess of enunciation produces saturation rather than symbolic elaboration. This displacement amounts to a systemic axiological reorganization. Where speech is subordinated to a single ideal of performance, drive conflict ceases to be elaborated and intensifies under forms of guilt and self-exigency. This mutation is sustained by a specific modality of rejection (Verwerfung) that does not fall upon a particular signifier, as in classical psychosis, but upon castration itself,that is, upon the recognition of the structural limit that founds desire (Braunstein 2013, 141).

Capitalist discourse does not foreclose a determinate symbolic element; rather, it disavows constitutive impossibility, recoding structural lack into a quantifiable deficit to be corrected, an insufficiency to be compensated, or a level of performance to be optimized (Braunstein 2013). From a clinical standpoint, this rejection of the limit does not produce a psychotic rupture of the symbolic bond, but rather its saturated and totalizing functioning. The subject is captured within the symbolic order without any possible exteriority, subjected to an unlimited demand for jouissance and productivity, where lack returns in the form of permanent debt and infinite self-exigency. Precisely for this reason, capitalism operates as a fully functional, secular religion.

As Nietzsche (1887) showed in his analysis of religious neurosis, the religious is not defined by reference to transcendence, but by its capacity to organize suffering, produce guilt, and foreclose critique of the value system that sustains it. In late capitalism, this function is radicalised: the promise of salvation no longer refers to an afterlife, but to an immanent and indefinitely deferred optimization of performance and self-realization. From a genealogical perspective, this logic does not entail a negation of vital forces, but their reactive reorganization. Suffering does not vanish; rather, it is fixed within an economy of debt and bad conscience (schlechtes Gewissen) that captures potency under rigid axiological hierarchies, thereby blocking its creative reorganization (Nietzsche 1887, Welshon 2014).

Contemporary philosophical psychology and organismic approaches allow this point to be specified with greater precision. The self does not constitute a substance or a sovereign center, but a dynamic relation of drives whose hierarchical organization determines both action and the experience of meaning (Katsafanas 2013, pp. 15-20). Pathology thus emerges not from drive weakness, but from the failure to achieve an evaluative unification of intense forces under criteria capable of reordering (Katsafanas 2013 pp. 8, 15, 19-20).

A clinic oriented toward Agential Integrity does not aim to reinforce external control or optimize performance metrics, but to restore the capacity to articulate desire, valuation, and action,a condition for a non-reactive reorganization of drive

conflict. This formulation directly parallels contemporary organismic psychology, which establishes that while the human organism is innately inclined toward developing an internal, unified structure of the self, it remains highly vulnerable to developing fractionated structures when its psychological functioning becomes rigidified by external controls (Deci & Ryan 1985, pp. 116-120). Under late capitalism, pathology is not a volitional deficit, but a reactive and fractionated configuration of the drive economy, where impulses are subordinated to rigid, heteronomous axiological hierarchies that the subject experiences as autonomous choice (Deci & Ryan 1985, pp. 143-147).

This fragmentation constitutes a structural effect of particular ideological regimes in which language operates as an imaginary repair that sutures conflict without elaborating it (Bornedal 2010). Consequently, sacrifice ceases to be oriented toward transcendent salvation and becomes immanentized in the imperatives of performance, productivity, and self-optimization. Suffering is no longer symbolically interrogated, but normalized as guilt for insufficiency and unlimited self-exigency. In this context, speech ceases to mediate between the forces that inhabit the subject and instead comes to subordinate them to abstract ideals of success, while the listening of distress is replaced by evaluative dispositifs that foreclose the critical interrogation of suffering.

It is within this horizon that Transvaluative Psychology becomes necessary, conceived as a clinical-genealogical framework oriented toward interrogating the processes of production, fixation, and transformation of values. Within this framework, Axiogeniality does not designate a subjective ideal or a heroic exception, but an active organismic operator of value reorganization. It is capable of instituting new axiological hierarchies where existing ones have become pathological, thereby restoring conditions of speech, listening, and symbolic bond not captured by the logic of performance or by the ideological foreclosure of meaning. What has been developed thus far makes it possible to establish that capitalist discourse introduces an axiological mutation that structurally transforms the economy of suffering. By operating as a secular religion, this discourse fixes drive conflict under absolutised value hierarchies, producing normalized modalities of suffering and eroding the conditions of Agential Integrity. With this clinical-genealogical framework in place, the analysis of Herzl's Neurosis as a specific historical form of neurosis proper to late capitalism is prepared.

Genealogy of Contemporary Suffering: From Capitalist Discourse as Religion to Herzl's Neurosis

The preceding analysis makes it possible to formulate, in genealogical terms, the central hypothesis of this work: the Capitalist Discourse does not constitute merely an economic regime or a system of social organization, but can be productively analyzed as functioning similarly to an axiologically closed, secular religion that organizes meaning, administers suffering, and produces a historically situated modality of distress (Marx 1844, Weber 1905, Benjamin 1921, Loy 1997, Han 2014). This distress does not manifest as a marginal deviation or an individual

pathology, but as a normalized structure integrated into the ordinary functioning of the contemporary social bond. Within this framework, suffering ceases to present itself as a conflict to be elaborated and becomes a functional condition of belonging and recognition. Guilt for insufficiency, unlimited self-exigency, and the normalization of distress do not operate as system failures, but as necessary effects of a symbolic economy that forecloses critique of its own values. It is from this perspective that it becomes necessary to reconstruct genealogically what is here termed Herzl's Neurosis.

Far from designating an individual, idiographic syndrome, Herzl's Neurosis is proposed here as an ideal-typical construct to understand a prevalent structural modality of contemporary suffering. It is characterized by a subjective logic of guilt for insufficiency and by the internalization of an immanent superego that drives unlimited exigency in the name of a secular promise of fulfillment. This is not a localized conflict, but a totalizing axiological configuration that colonizes psychic life and reorganizes the experience of time, the body, and value. From a clinical standpoint, this configuration is expressed in practices of permanent self-evaluation, in the structural difficulty of suspending performance without acute guilt, and in therapeutic demands oriented toward "functioning better" rather than interrogating the meaning of suffering. Distress is no longer organized around prohibition, but under the imperative to produce and optimize, experienced as personal failure rather than as an effect of discourse.

The Ascetic Ideal and Cultic Guilt: Nietzsche, Freud, and Benjamin

To understand the genesis of this structure, we must return to Nietzsche's (1887) critique of religious neurosis. In *On the Genealogy of Morality*, Nietzsche demonstrated that major cultural configurations are sustained by drive economies (*Triebökonomien*) and historically determined value systems, wherein vital force that cannot outwardly affirm itself turns back against itself in the forms of guilt, debt, and bad conscience (*schlechtes Gewissen*). Suffering does not disappear; it is moralized and endowed with a meaning that justifies and reproduces it within a closed axiological order.

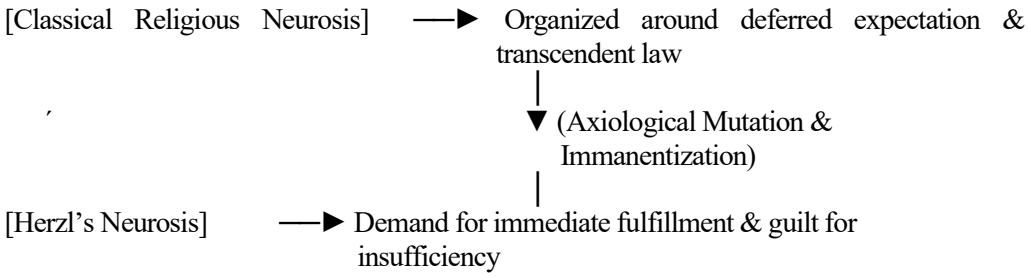
This logic was radicalized by Walter Benjamin (1921), who argued that capitalism functions as a purely cultic religion,the most extreme to have ever existed,without dogma or redemption, which universalizes guilt and debt (*Schuld*) without offering any possible exit. Along convergent lines, modern critiques of neoliberal psychopolitics have shown how this sacrificial economy is translated into self-exploitation, systemic exhaustion, and culpabilization for structural insufficiency (Loy 2002, Han 2014). Freud (1927) converges with this genealogy by proposing that religion may be understood as a universal obsessive neurosis,not as a generalized individual pathology, but as a cultural formation designed to stabilize drive conflict and protect a value system from critical revision. Religious doctrines function as substitute formations (*Ersatzbildungen*) that fix suffering and confer upon it a normatively regulated meaning, transforming raw distress into duty and guilt into a principle of rigid self-regulation (Lehrer 1994).

The thesis developed here is that contemporary capitalism inherits, immanentizes, and exacerbates the structure of religious neurosis in a secularized form. Without explicitly presenting itself as a religion, it fulfills its fundamental operations: it institutes absolute values, demands daily sacrifices, promises an immanent salvation (indefinitely deferred optimization), and proves structurally resistant to self-critique. Capitalism operates as a religion without transcendence, but not without dogma, ritual, or guilt, giving rise to a normalized and metaphysically intensified form of suffering: Herzl's Neurosis.

Performative Temporality and Narrative Disarticulation

This axiological mutation produces a decisive effect on subjective temporality. Whereas traditional religions organized time around a transcendent and deferred promise, capitalist discourse imposes a performative temporality oriented toward immediate performance and constant optimization. Time ceases to be a symbolically shared experience and is transformed into a consumable, measurable, and sacrificable resource. This mutation does not imply acceleration alone, but rather a narrative disarticulation of time, fragmented into atomized, operative instants oriented toward sheer performance (Han 2014, 2017).

From a clinical standpoint, this temporality produces a form of suffering distinct from classical religious neurosis:



Guilt ceases to be linked to the transgression of an explicit, transcendent moral law; instead, it becomes guilt for insufficiency, for not performing, not producing, or not optimizing oneself enough, thereby absolutizing immanence itself. From a Lacanian perspective, this logic articulates with the emergence of a limitless superego, one that no longer commands the renunciation of jouissance, but its permanent intensification in the form of performance. Capitalist discourse is distinguished by the disavowal (*Verleugnung*) and rejection (*Verwerfung*) of castration, the annulment of the structural limit that regulates desire, producing a subjective economy marked by compulsion, self-exigency, and self-exploitation (Braunstein 2013).

Clinically, this regime does not produce the alternation characteristic of classical religious neurosis (sin and repentance), but rather an exhaustive continuity without respite or ritual. Phenomena such as burnout or karoshi should not be read as mere occupational accidents, but as paradigmatic expressions of a subjective configuration in which the subject self-exploits and is consumed as a resource within a productive machinery that replaces it without mourning once it is exhausted.

Disembodiment, Abstraction, and the Fractionated Self

From a Nietzschean reading, this dynamic does not imply a simple diminution of vital forces, but their reactive reorganization. The intensification of performance and jouissance takes place at the cost of a progressive disembodiment of the subject: the body ceases to operate as a primary instance of orientation and meaning and becomes a functional support, an object of optimization and wear. Where classical religious neurosis mortified the body in the name of transcendence, capitalist neurosis consumes it in the name of an absolutized immanence, producing an increasingly abstract, performative, and disembodied self.

This abstraction does not manifest as chaotic disorganisation, but as an impoverished functional coherence sustained by metrics of efficiency that replace listening to the body and foreclose the lived experience of conflict. Contemporary philosophical psychology specifies this mechanism: the self does not constitute a substance or a sovereign center, but a dynamic relation of drives whose hierarchical organization determines both action and the experience of meaning; identity is the always provisional effect of an evaluative synthesis (Katsafanas 2013, pp. 15-20).

In late capitalism, this relational structure of the self becomes progressively decoupled from the body and from lived experience, and is reorganized around abstract, quantifiable, and comparable criteria. Agency no longer unfolds in the singular integration of drives, but is translated into indicators of performance, visibility, and exchange value. The self thus becomes a profile, a score, or an avatar: a formalized, optimizable, and replaceable identity.

This process represents a metaphysical exacerbation of neurosis. Where classical religious neurosis produced a moral doubling of the self, Herzl's Neurosis produces an abstract self, permanently evaluated and structurally insufficient. Just as money separates value from concrete labor, subjective identity is separated from the body, lived time, and drive conflict, becoming subjected to systems of abstract equivalence. Distress is no longer experienced as a tension between living forces, but as a quantifiable deficit of identity, an insufficiency of value, or a failure of self-optimization. Herzl's Neurosis does not entail a loss of agency, but its axiological capture, insofar as the capacity to value becomes subordinated to a system that blocks transvaluation (*Umwertung*) and the embodied, integrated reintegration of meaning.

The Loss of Agential Integrity as Clinical Criterion

As Bornedal (2010) has shown, this type of axiological closure fulfills a precise ideological function: it offers an imaginary coherence that conceals the subject's internal fragmentation at the cost of neutralizing any possibility of critical transformation. Clinically, this coherence does not constitute integration, but fixation, thereby reinforcing the structural loss of Agential Integrity.

This loss can be systematically mapped in dialogue with contemporary organismic psychology and the Self-Determination Theory (SDT) framework of Deci and Ryan (1985), which counters traditional psychiatric nosography by locating the pathology in the fracturing of the self under external control:

Analytical Category	**Classical Nosography (Burnout / Depression)**	**Classical Religious Neurosis (Nietzsche / Freud)**	**Herzl's Neurosis (Transvaluative Framework)**
Etiological Matrix	Occupational overload, cognitive exhaustion, or neurochemical deficit.	Transgression of a transcendent Moral Law; conflict with a paternal, punishing Superego.	Structural foreclosure of castration; immanentization of the ascetic ideal into performance metrics (Braunstein 2013).
Subjective Economy	Apathy, loss of executive functioning, and emotional depletion.	Alternation between drive transgression, guilt, and ritualized repentance/expiation.	Saturated functioning; permanent guilt for insufficiency; infinite debt experienced as personal deficit.
Status of the Body	Somatic exhaustion treated as a functional breakdown or an industrial accident.	Mortification and suppression of the flesh in the name of transcendent salvation.	Systemic Disembodiment; the body is reduced to an abstract object of optimization, wear, and evaluation.
Status of Agency	Temporary deficit in self-efficacy or volitional control.	Agency restricted by moral heteronomy and guilt-driven self-regulation (Lehrer 1994).	Fractionated Disruption; loss of Agential Integrity due to the decoupling of drive economics (*Triebökonomie*) from self-determined action.

In clinical listening, this configuration is recognized by the absolute predominance of self-evaluative statements, "I don't perform," "I don't measure up," "I'm not enough", which displace speech from desire toward the endless measurement of the self. When discourse ceases to sustain lack, saying is no longer organized around the subjective question, but rather in function of imperatives that saturate meaning and cancel elaboration (Lacan, 1969–1970). In transferential terms, the demand shifts from interpretation toward optimization: what is requested are rapid relief, behavioral techniques, or increased psychic performance rather than an elaboration of conflict. This displacement responds directly to the logic of the performance-oriented superego that commands production, jouissance, and self-optimization without admitting interruption or remainder (Braunstein 2013).

The decisive clinical criterion for reading this configuration is not the phenomenological intensity of distress, but the loss of Agential Integrity. When drives,

affects, meaning, and action are subordinated to a single, heteronomous axiological hierarchy, experience becomes fixed in a performative repetition that does not return as an interpretable symptom, but as a demand for infinite adaptation. This fractionated state mirrors what Deci and Ryan (1985) identify as the rigidification of psychological functioning when internal structures merely anchor external, controlling social demands. Far from expressing a lack of force, Herzl's Neurosis testifies to a reactive organization of value that prevents the creative integration of forces, precisely as Nietzsche diagnosed in religious neurosis and its economy of bad conscience.

By operating as an axiologically closed secular religion, capitalist discourse captures agency under absolutized value hierarchies, producing an abstraction of the self, a progressive disembodiment of experience, and a structural loss of Agential Integrity. On the basis of this diagnosis, the need is established for a clinical framework capable not only of describing this configuration, but of critically interrogating the systems of values that sustain it,a task that will be undertaken in the following chapter through Transvaluative Psychology and the clinical-critical operator of Axiogeniality.

Conceptual Novelty and Differential Contribution

To clarify the epistemological status of the paradigm proposed here, it is clinically indispensable to differentiate its core constructs from existing contemporary psychological models. While mainstream clinical psychology addresses performance distress and existential disorientation through empirical categories, Transvaluative Psychology addresses the structural capture of the subject's drive economy by ideological regimes.

Herzl's Neurosis versus Burnout (Maslach)

The contemporary clinical landscape frequently encapsulates performance-related suffering under the construct of Burnout, defined by Maslach (2022) through the triad of emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout is conceptualized as an occupational syndrome resulting from chronic workplace stress,a functional breakdown of occupational coping mechanisms.

In contrast, Herzl's Neurosis does not represent a situational or vocational localized dysfunction, but a globalized, structural modality of the social bond. It cannot be resolved by workplace adaptations or stress-management techniques because it implicates an internalized, immanent superegoic matrix. Where Burnout registers an executive depletion of functional energy, Herzl's Neurosis marks a saturated, high-functioning economy of guilt where the subject's core identity is structurally tied to the very metrics causing their depletion.

Agential Integrity versus Agency (Bandura)

In cognitive-behavioral paradigms, Agency is primarily understood through Bandura's (2009) social cognitive theory as a set of intentional capabilities, including self-reflectiveness, self-reactiveness, and forethought. For Bandura, agency is largely

functional and mechanistic, operating as an executive capacity for volitional control and self-efficacy within environmental constraints.

Agential Integrity, conversely, shifts the clinical focus from functional self-efficacy to drive synthesis. It is not merely the capacity to execute a goal successfully, but the dynamic, integrated coherence between drive economics (*Triebökonomie*), somatic affectivity, semantic meaning, and self-determined action. A subject can exhibit high behavioral agency in Bandura's terms, optimizing performance, meeting metrics, and exhibiting high self-efficacy, while suffering from a total collapse of Agential Integrity, executing actions that remain radically alienated from their organismic drive baseline.

Transvaluative Psychology versus Cultural Critique

Finally, Transvaluative Psychology must not be mistaken for a speculative exercise in sociology or cultural critique. While it acknowledges the historical matrix of late capitalism, it remains strictly a clinical framework. Its locus of intervention is not the macroeconomic structure, but the singular, transferential space of clinical listening. It diagnoses how socio-historical value systems crystallize into concrete, individual psychopathology, offering a specialized diagnostic and therapeutic framework to restore the symbolic bond through the speech of desire.

Transvaluative Psychology and Axiogeniality: Toward a Clinic of Agential Integrity

The diagnosis developed in the preceding chapters makes it possible to establish that contemporary suffering cannot be adequately understood or clinically treated through traditional paradigms centered on adaptation, moral correction, or the optimization of performance. In Herzl's Neurosis, suffering ceases to appear as a symptom to be structurally interrogated; instead, it is experienced as a deeply individualized, personal insufficiency in relation to absolutized axiological ideals. By becoming seamlessly integrated into the ordinary functioning of the social bond, this distress loses its status as a clinical question.

As established in the foundational outlines of this framework, this specific configuration produces an unrelenting guilt for performance, systemic self-exploitation, and a progressive erosion of meaning, while simultaneously neutralizing the structural conditions necessary for transvaluation. It does not constitute an isolated, idiographic pathology, but rather a historical modality of suffering that is structurally inseparable from the discursive and axiological regime that produces and sustains it.

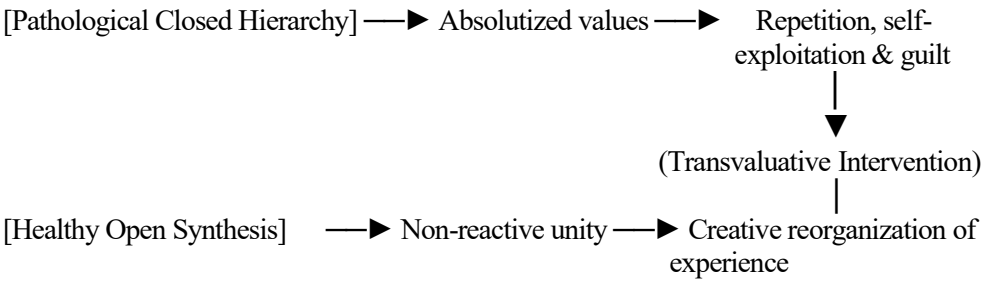
Faced with this axiological closure, the clinical question can no longer be formulated in terms of adaptive calibration or symptom reduction. Contemporary psychological distress is not explained by a lack of norms, but by an acute excess of normativity; it stems not from an absence of meaning, but from an axiological hypertrophy that systematically blocks the creative reorganization of experience. In this context, clinical practices oriented toward optimizing psychological functioning or reinforcing behavioral adaptation run the critical risk of therapeutically reproducing the very pathogenic logic they purport to treat.

Methodological Foundations of Transvaluative Psychology

From these epistemological premises, Transvaluative Psychology is defined as a clinical-genealogical framework explicitly oriented toward interrogating the genesis, function, and subjective effects of value systems when they crystallize into closed, pathological orders. Its clinical point of departure is neither observable behavior nor metric performance, but the drive-dynamic and axiological economy that organizes experience, orients action, and conditions the modality of suffering. Consequently, the framework does not primarily ask *what* the subject does, but *under which hierarchies of value* the subject speaks, acts, and suffers, and at what vital cost.

Unlike adaptive psychologies, Transvaluative Psychology does not prescribe a normative set of "correct" values, nor does it reduce psychic distress to a functional or volitional deficit. Clinically, it is diagnostic of this malaise through precise indicators, such as the total dominance of rigid, self-evaluative statements and the structural impossibility of interrogating the very value organizing the suffering. Transvaluative intervention aims to reopen the evaluative space, restoring speech to its function as an open symbolic mediation, and rendering possible a dynamic reconfiguration of axiological hierarchies. This serves as the baseline clinical condition for the recovery of Agential Integrity.

This perspective explicitly inscribes itself within the Nietzschean genealogy, for which values are neither transcendent principles nor autonomous rational constructions, but historical symptoms of specific configurations of forces (Nietzsche 1887). From this premise, every clinic of suffering is, ultimately, a clinic of value. The central clinical criterion shifts from normative conformity or adaptive stability to the preservation of effective agency:



Where value systems allow for a non-reactive synthesis of impulses, affects, and actions, experience can be creatively reorganized. Conversely, where axiological hierarchies are absolutized, life becomes fixed in reactive repetition, self-exploitation, or chronic culpabilization. Transvaluative Psychology thus evaluates value structures not by their moral content, but by their capacity to sustain or erode the subject's Agential Integrity.

Operationalizing Agential Integrity Under Systemic Capture

Agential Integrity is not defined here in terms of rational autonomy or conscious, cognitive control, but as a complex capacity for synthesis: the possibility

of articulating drives, affects, evaluations, and acts into a dynamic, organismic unity capable of orienting self-determined action over time. The aim of the clinic is not to eliminate conflict,which remains an inevitable, vital condition of life,but to integrate it under evaluative hierarchies that are neither reactive nor heteronomously imposed. As contemporary philosophical psychology establishes, agency depends entirely on the manner in which drives are unified under shared evaluative commitments; its loss refers not to a lack of intrinsic force, but to the structural impossibility of sustaining one's own evaluative synthesis (Katsafanas 2013 pp. 8,20).

From this framework, Herzl's Neurosis is read precisely as a specific foreclosure of Agential Integrity induced by an axiologically closed system. This does not amount to a simple behavioral subordination to external demands, but to a total capture of drive organization by a single, unquestionable hierarchy of market-rationalized value:

- **Drive Capture**: When the totality of impulses is oriented toward an abstract, quantifiable ideal, the evaluative synthesis rigidifies, and agency loses its creative capacity.
- **Reactive Fixation**: Clinically, this fixation does not resolve drive conflict but intensifies it reactively. What cannot be integrated returns as normalized suffering,expressed through guilt for insufficiency, chronic anxiety, self-exploitation, and an impoverishment of meaning.
- **Failed Performance Metrics**: This suffering no longer presents itself as an interpretable symptom; instead, it is recoded as an indicator of failed performance. It ceases to open a subjective question and becomes permanent proof of inadequacy, sealing the loss of Agential Integrity.

From a psychoanalytic standpoint, this dynamic is formalized through the contemporary mutation of the superego. While Freud (1930) demonstrated that superegoic severity becomes pathogenic when the ideal takes the form of an impossible moral command, Lacan (1972) radicalized this insight by showing that under the Capitalist Discourse, the superego no longer commands the renunciation of *jouissance*, but rather demands unlimited production, optimization, and *jouissance*. Because castration, the structural recognition of the limit, is systematically rejected, this mutation produces isolated, atomized subjects who are held absolutely responsible for their own success or failure, entirely deprived of a shared symbolic framework capable of reinscribing their distress as a historical effect of value systems (Soler 2007).

Axiogeniality as a Clinical-Critical Operator

Faced with this configuration, Transvaluative Psychology directs its efforts toward the critical interrogation of the value systems structuring this normalized suffering. Its clinical task does not consist in correcting behavior or reinforcing imaginary, defensive coherences; rather, it seeks to reopen the evaluative space, restoring to values their historical, contingent, and transformable character. Within this horizon, we position the category of Axiogeniality.

Axiogeniality is defined as a clinical and genealogical operator of active value reorganization wherever prevailing hierarchies have become pathological. Rather than treating genius as an individual anomaly, a biological elite, or a romantic idealization, this framework operationalizes it as a critical capacity within the contemporary economy of meaning.

Axiogeniality names the precise structural possibility of an affirmative transvaluation (*Umwertung*) that does not foreclose conflict, but integrates it creatively, restoring the structural conditions of speech, listening, and action necessary to recover Agential Integrity.

To guide diagnostic evaluation, the clinical distinction between the adaptive-pathological response and the axiogenial-transformative response can be systematically mapped as follows:

Diagnostic Dimension	**Pathological Fixation (Herzl's Neurosis)**	**Axiogenial Transformation (Transvaluative Clinic)**
Status of the Value System	Closed and Absolutized: Value structures are immune to internal critique; metrics of efficiency are accepted as absolute truths.	Open and Transformable: Value hierarchies are recognized as contingent historical symptoms, subject to active transvaluation.
Discursive Demand	Optimization: Demand for rapid behavioral relief, increased psychic performance, and techniques to "function better."	Interrogation: Reopening of speech and listening; questioning the underlying axiological criteria organizing the suffering.
Superegoic Matrix	Imperative of Performance: Unlimited demand for productivity and *jouissance* that treats structural lack as personal deficit.	Restoration of the Limit: Integration of conflict and lack as the necessary foundation for creative, self-determined desire.
Dynamic of the Self	Fractionated Disruption: Subjective identity is split into abstract profiles, scores, or avatars, decoupled from lived experience.	Organismic Integration: Unified alignment between drive economics (*Triebökonomie*), somatic affectivity, and action.

Clinical Application and Operational Protocol

To bridge the gap between speculative metapsychology and the pragmatic reality of the consulting room, Transvaluative Psychology operates through a rigorous, non-directive clinical protocol. This section delineates the sequential stages of the transvaluative process, instantiates them through a brief clinical case vignette, and establishes the strict boundary constraints and scope limitations of this framework.

Sequential Stages of the Transvaluative Process

The therapeutic trajectory is structured around four distinct, non-linear operational phases designed to guide the subject from alienating performance metrics back to an integrated drive baseline:

1. **Deconstruction of the Evaluative Demand (*Axiological Mapping*)**
   - *Objective*: To isolate and visualize the rigid metrics under which the subject suffers.
   - *Clinical Action*: The clinician systematically tracks the absolute "should-be" statements, performance indicators, and structural self-reproaches that contaminate the patient's speech. The demand for "rapid behavioral adaptation" or "psychic optimization" is systematically suspended and treated as a symptom of systemic capture, rather than as a legitimate therapeutic goal.

2. **Genealogy of the Personal Imperative (*Superegoic Decoupling*)**
   - *Objective*: To transition from a phenomenological experience of personal inadequacy to a historical, discursive understanding of the internalized ideal.
   - *Clinical Action*: Through transferential listening, the clinician historicalizes the client's current guilt metrics. The patient begins to recognize how their localized sense of "not being enough" acts as an internalized reflection of late-capitalist psychopolitics, effectively tracing the roots of their immanent superego back to its social and discursive origins.

3. **Restoration of Symbolic Lack (*Reintroducing Castration*)**
   - *Objective*: To break the exhaustive continuity of the performance imperative by reinscribing structural limits.
   - *Clinical Action*: The clinician actively punctuates moments where the subject's somatic limits, systemic fatigue, or unfulfilled desires rupture the seamless illusion of total self-optimization. By validating exhaustion not as a technical failure but as an organismic expression of castration, the clinical space allows the subject to transition from cultic guilt to an authentic engagement with subjective lack.

4. **Axiogenial Synthesis (*Active Transvaluation*)**
   - *Objective*: The autonomous, creative reorganization of the subject's value hierarchy.

- *Clinical Action*: The subject begins to construct alternative, non-reactive value schemas that honor their unique drive baseline (*Triebökonomie*) and somatic affectivity. The clinical locus shifts from external adaptation to internal integration, facilitating self-determined action that accommodates vital tension instead of sacrificing it to market-driven indicators.

Case Vignette: The Case of "Subject M"

Subject M, a 34-year-old software engineer living in Santiago, sought psychotherapy because of persistent physical exhaustion, recurrent panic episodes, and an inability to rest without feeling overwhelming guilt. At first glance, his presentation could reasonably be understood within existing diagnostic frameworks, particularly severe burnout or Generalized Anxiety Disorder. His initial request reflected this perspective: he wanted practical strategies to improve time management and recover the level of productivity that had gradually declined as his symptoms became more frequent.

During the initial phase of Axiological Mapping, it became evident that M consistently evaluated himself through measurable indicators of performance. He spoke almost exclusively about productivity metrics, peer-review scores, software output, and the various applications he used to monitor his sleep, exercise, and nutrition. Rather than focusing exclusively on symptom reduction, the therapeutic work explored the value system that gave those metrics their authority. When M remarked, *"I'm no longer able to perform at the level I used to,"* the therapist responded by asking whether he was describing himself as a person or as a system designed to maintain constant efficiency. This question gradually shifted the focus of the sessions from performance itself to the assumptions that sustained it.

This transition marked the beginning of what Transvaluative Psychology describes as Superegoic Decoupling. Over subsequent sessions, M began to recognize that his persistent sense of inadequacy was not simply an individual characteristic but had developed within a professional culture that praised permanent availability, continuous optimization, and the absence of personal limits. What had previously appeared to him as personal failure gradually became understandable as the internalization of a particular evaluative order.

A decisive moment occurred when M experienced a panic attack during a critical software deployment. Instead of interpreting the episode solely as a symptom requiring greater behavioral control, the therapeutic process explored it as an expression of the body's resistance to demands that had become psychologically unsustainable. Within the transvaluative framework, the panic episode was understood less as a failure of adaptation than as an indication that the prevailing system of values had reached its subjective limits.

Over the course of treatment, M gradually reorganized his relationship to work, achievement, and personal value. Rather than attempting to maximize every measurable indicator of performance, he began to establish clearer personal boundaries, reconsider his relationship with time, and make professional decisions that were more consistent with his own priorities. From the perspective of Transvaluative Psychology, this process illustrates the movement toward Axiogenial Synthesis, understood not as the elimination

of occupational demands but as the recovery of Agential Integrity through the reorganization of one's evaluative framework.

Scope Boundaries and Clinical Limitations

Although Transvaluative Psychology proposes a different way of understanding certain forms of contemporary psychological suffering, its clinical application is intentionally limited.

Diagnostic Scope. The framework has been developed for neurotic and borderline personality organizations in which symbolic elaboration remains sufficiently preserved to support reflective clinical work. It is not intended for acute psychotic conditions, where interventions aimed at restructuring value systems may increase rather than reduce psychological instability.

Limits of Clinical Intervention. Transvaluative Psychology operates within the context of the therapeutic relationship and therefore does not claim to alter the broader social, economic, or institutional conditions that shape subjective experience. Its objective is more modest: to help patients critically examine the evaluative frameworks they have internalized and to strengthen their capacity to relate to those structures with greater autonomy, flexibility, and psychological coherence.

Methodological Conclusions

Ultimately, Axiogeniality functions as the primary differential criterion for evaluating the health or pathology of a value system. Where axiological hierarchies allow for a dynamic integration of impulses and sustain open processes of meaning-creation, subjectivity preserves an effective margin of agency. Where values are absolutized and insulated from critique, neurosis intensifies and becomes normalized.

Transvaluative Psychology does not present itself as a normative proposal nor as an adaptive clinic, but as a clinical-genealogical intervention into the axiological conditions of possibility for human agency, offering a critical operator capable of introducing creative reorganisations of meaning wherever dominant value systems have become profoundly pathological.

Conclusion

Axiogeniality and the Clinic of Value in Capitalism as Religion

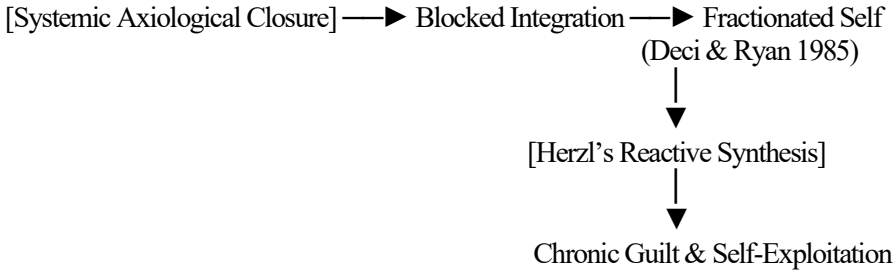
The trajectory developed in this article makes it possible to sustain a central thesis: contemporary capitalism can be productively analyzed as functioning similarly to an axiologically closed, secular religion that structures, normalizes, and intensifies subjective malaise. Although devoid of explicit transcendence, this regime organizes experience around absolute values, performance, productivity, and permanent success, which function as ultimate criteria of legitimacy. Within this framework, suffering is neither elaborated nor transfigured; instead, it is internalized as structural guilt for insufficiency, becoming a functional condition of the contemporary social bond.

The convergence between Freud, Nietzsche, and Lacan allows us to understand why this configuration historically exacerbates neurosis rather than attenuating it. Religion, conceived as a collective neurotic formation, stabilizes drive conflict at the cost of foreclosing its critique. Nietzsche demonstrated that this foreclosure does not weaken the will, but inverts it, producing reactive economies of suffering and bad conscience (*schlechtes Gewissen*). Lacan formalized how the Capitalist Discourse radicalizes this logic by rejecting the structural limit of castration, sustaining an imaginary promise of unlimited satisfaction, and decomposing the social bond under performance-driven, superegoic imperatives.

The Legacy of Herzl's Neurosis and the Loss of Integrity

Within this critical matrix, Herzl's Neurosis is proposed as a historically situated, ideal-typical construct to understand a prevalent structural modality of suffering proper to late capitalism. It does not designate an individual pathology nor an idiographic, delimited syndrome, but a normalized structure of suffering produced by a value system that presents itself as natural, self-sufficient, and unquestionable. Its distinctive clinical feature is not the classic repression of conflict, but its structural fixation under a single, heteronomous axiological hierarchy that blocks the creative reorganization of meaning.

From a clinical-genealogical perspective, this fixation constitutes a severe foreclosure of Agential Integrity. As contemporary readings of Nietzschean psychology demonstrate, human agency does not depend on the complete absence of conflict, but on the organismic capacity to integrate heterogeneous forces and drives under one's own evaluative commitments (Katsafanas 2013, pp. 15-20). This dynamic unification mirrors what organismic psychology defines as the fundamental tendency toward a unified structure of the self (Deci & Ryan 1985). Where this integration is blocked by systemic axiological closure, the subject remains trapped within a fractionated disruption:



The resulting fractionated state intensifies psychological distress, transforming it into a quantifiable, internal deficit rather than an interpretable, transferential symptom.

The Transvaluative Alternative and the Axiogenial Turn

In direct response to this contemporary diagnosis, Transvaluative Psychology establishes itself as a clinical-genealogical framework oriented toward interrogating the genesis, function, and subjective effects of value systems. Its aim is neither to adapt the subject to the prevailing order nor to replace one closed system of values with another equally dogmatic one. Rather, its clinical target is to restore the historicity and contingency of all axiological hierarchies, thereby reopening the critical dimensions of speech and listening as conditions for structural transformation.

Within this horizon, Axiogeniality operates as a critical, active operator of value reorganization:

- **De-romanticizing Genius**: Axiogeniality is stripped of any exceptional privilege, biological elitism, or romantic idealization. It is redefined as an active organismic capacity within the economy of meaning.
- **Affirmative Transvaluation**: It names the structural capacity to institute new axiological hierarchies where existing ones have become pathogenous and rigidified by external controls (Deci & Ryan 1985).
- **Symbolic Re-inscription**: It neither artificially eliminates conflict nor suppresses vital suffering; instead, it re-inscribes them within an open symbolic economy capable of producing creation rather than repetition, and transvaluation (*Umwertung*) rather than blind obedience.

From a clinical standpoint, Axiogeniality serves as the decisive differential criterion for evaluating the health or pathology of a value system. Where axiological hierarchies allow for a dynamic, fluid integration of impulses and sustain effective, open processes of meaning-creation, subjectivity retains a real margin of self-determined agency. Conversely, where values are absolutized and rendered immune to critique, neurosis intensifies, fragmenting the self and normalizing self-aggression.

The conclusion that follows from this work is clear: without an explicit clinic of value, psychological and psychoanalytic practice runs the risk of being reduced to a mere technique of market-rationalized adaptation. Thinking capitalism as a secular religion, Herzl's Neurosis as its structural clinical expression, Agential Integrity as its diagnostic criterion, and Axiogeniality as its operator of transvaluation makes it possible not only to comprehend contemporary suffering, but also to restore the conditions of possibility for a psychic life not captured by guilt, performance metrics, and self-exploitation. In a contemporary context increasingly marked by the foreclosure of meaning and the systematic erosion of listening, this proposal does not constitute one theoretical option among others, but a clinical, ethical, and epistemological necessity.

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The Mind as a Creator: Tagore, Trauma, and the Truth in Healing

By Mariam Melikishvili[*] & Matthew Whoolery[±]

Contemporary psychology defines trauma as a lasting emotional or cognitive response to distressing events, yet it rarely acknowledges how trauma transforms the self's fundamental relationship with reality. Drawing on Rabindranath Tagore's essay The World of Personality, this paper applies his relational model of perception to recast trauma not only as a psychological wound, but as a disruption of the ontological and aesthetic exchange between inner awareness and outer existence. With Tagore's philosophy and the broader Indian, spiritual understanding of human psychology, reality is no longer fixed or objective, but co-created with the personality of the perceiving self. When trauma occurs, this creative dialogue may stagnate, dimming one's perception and engagement with life. Consequently, healing can be understood as a fundamentally relational and holistic process, where the self's relationship and communion is restored to find the ultimate truth and beauty in existence. This theoretical reframing challenges the WElRD model of trauma-treatment and invites a cross-cultural dialogue, bridging philosophy, art, and clinical practice.

Keywords: *Trauma; Relational ontology; Tagorean philosophy; Rabindrik Psychotherapy; Post-traumatic growth.*

Introduction

According to DSM-5 Diagnostic Criteria, trauma can be defined as an exposure to actual or threatened death, violent, or sexually disturbing experiences, all causing lasting negative impact on one's mental and physical health (American Psychiatric Association 2013). The primary focus of trauma-treatment is repairing the internal wounds caused by such events, like cognitive reprocessing, emotional dysregulation, or memory fragmentation (Wilde 2021). Within this framework, the external world is assumed to be fixed, objective, and separate from the individual. Thus, it remains outside the scope of healing, creating a breach between the internal and the external. If left unaddressed, this separation may build a sense of loss, isolation, and distrust.

Rabindranath Tagore, a polymath of the Bengali Renaissance period and the first Asian to receive The Nobel Prize in any category, explores this idea in *The World of Personality*, published within a series of his essays and lectures called *Personality* (Tagore 1917, pp. 55–97). According to Tagore, the individual is not a passive recipient of outside experiences, but an active co-creator of their reality; serving as a consumer and an interpreter of the full spectrum of human experiences. Throughout various essays in *Personality*, Tagore uses the term

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Jagat, meaning "the moving one" for *the world*, further emphasizing the ever-evolving and relational nature of reality and its relationship with the self. On this premise, trauma is no longer just an internal psychological wound, but a fracture in one's relationship with the world, stagnating the pace, nature, and beauty of its development (Banerjee 2021).

This paper argues that Rabindranath Tagore's *The World of Personality* redefines the Western understanding of trauma and its clinical implications for healing (Tagore 1917). More specifically, it can reframe traumatic experience as an ontological and aesthetic disruption that alters one's mental state internally as well as externally, in their co-creative relationship with the world. This is especially related to growing cultural individualism and social isolation, where the gap between the self and the world is not only a symptom of trauma, but a condition of modern life (Das 2025).

This research paper, situated at the intersection of cross-cultural psychology and Indian philosophical thought, primarily draws on Tagorean literature and humanism with the addition of Eastern spiritual frameworks and Western clinical studies. It offers a holistic view on post-traumatic healing beyond the WEIRD (Western, Educated, Industrialized, Rich, and Democratic) paradigms that dominate contemporary psychology practices (Henrich et al. 2010). This paper does not seek to invalidate the latter, but rather to expand it through a broader, interdisciplinary and intercultural dialogue.

Organized into four sections, the paper begins by contrasting mainstream understandings of trauma with Tagore's relational ontology, reviewing existing trauma studies and therapeutic approaches. This synthesis includes Tagore's philosophy and spiritual insights as well as Rabindrik Psychotherapy, exemplifying an emerging pathway to holistic recovery. Having established the scholarly foundation, section three is a discussion on how traumatic experiences can trap the self in a fragmented relationship with the world. The discussion explores how genuine healing is not a restoration of the pre-traumatic self but a transformation towards a more complete and relational existence. The final section serves as a conclusion, calling for a more inclusive discourse between Eastern and Western psychological frameworks and therapeutic practices in the study and treatment of trauma.

Literature Review

The Relational World

Contemporary psychology is increasingly challenging the assumption that reality is passive, fixed, or objective for all individuals. Instead, it is taking on the idea of a fluid and dynamic exchange of information between the observer and their environment, through which truth and meaning are co-constructed (Călinescu 2025). One of the earliest authors of this perspective is Rabindranath Tagore, who described the complete human experience as the one that situates consciousness within a broader "web of life," drawing meaning from interaction, relational unity, and creativity (Banerjee 2021). As Tagore argued, humans possess a unique

"surplus" or "excess," known as *atirikta,* which reflects their creative capacity, allowing transcendence from a purely biological existence into a spiritually and artistically developed one (Skorokhodova 2025). Through this lens, Tagore portrayed people not merely as observers of reality but as active architects and contributors to the ongoing formation of it. As he stated, in a series of essays, *Towards Universal Man*, the agency of an individual as a creator is to "serve as a vehicle of culture" or "mirror of the anguish of their era" (Rabindranath Tagore 1961, pp. 231-252). This creative and cultural agency serves as a fundamental function for situating the individual within a shared narrative – transforming their subjective experience into collective meaning and anchoring the self within a broader relational and existential web. For Tagore, it is precisely this integration – in art, meaning-making, or communal life – that constitutes the fullest expression of selfhood.

Post-classical sciences echo Tagore's relational ontology, as well. For example, quantum mechanics' concepts such as wave-particle duality, superposition, and entanglement, challenge the idea that objects exist with pre-determined physical states (Călinescu 2025). Within this framework, the act of observation in itself influences the physical system, a phenomenon commonly referred to as the "observer effect." This suggests that the observer is not entirely separate from the phenomena being observed, inviting a direct reconsideration of the relationship between inner consciousness and outer reality. Truth may, therefore, be viewed as multidimensional, encompassing intellectual, emotional, social, and vibrational cores, rather than existing as a singular and purely objective construct (Călinescu 2025). This idea strongly aligns with Tagore's vision of a "complete human being," who recognizes their unity with the world and understands their surroundings through subjective and relational observation (Kumar 2017).

Tagore's relational ontology parallels the constructivist approach in political science, which emphasizes that individuals can interpret and develop reality through their cognitive, emotional, historical, or cultural frameworks, all leading to "the world of our making" (Lowndes et al. 2017). The psychological concept of "the looking-glass self" – first articulated by Cooley (1902) and since developed across sociological and psychological traditions – suggests that identity and reality are fundamentally shaped by external perception and societal roles. Humans have a habit of internalizing the beliefs others hold about them, creating either an empowering or disturbing self-fullfilling prophecy for their subjective worldview. Whether it's the psyche's way of confirming its own idea of the truth, "the observer effect" in quantum mechanics, or relational ontology of Tagore's philosophy, the conclusion remains the same – the world is fundamentally multifaceted, fluid, and interactive with its inhabitants.

Defining Trauma: From A Psychological Injury to Ontological Collapse

Clinical psychology, particularly within DSM-based diagnostic frameworks, defines trauma as a severe disruption in memory processing, emotional regulation, and psychological functioning, following deeply distressing, or life-threatening events (Bajpai 2025). This definition reflects the evolution of diagnostic categories, from the

initial concept of "gross stress reaction" in psychiatric manuals to Post-Traumatic, as well as the Complex Post-Traumatic Stress Disorders in ICD-11 and DSM-5. Overall, the consensus is that prolonged stressors, such as abuse, displacement, or war, can profoundly disrupt self-identity, interpersonal communication, and openness towards new experiences (Zoromba et al. 2024). As the majority of negative effects caused by trauma are assumed to be internal, the mainstream therapeutic approaches naturally focus on internal solutions as well. Cognitive Behavioral Therapy (CBT), developed by Dr. Aaron Beck, focuses on modifying maladaptive thought patterns while the psychoanalytic approach, pioneered by Sigmund Freud, explores conflicts between the conscious and the unconscious through techniques such as free association or dream analysis (Dutta & Dey Tapader 2025).

More recent research and theory suggest that trauma extends beyond these internal psychological symptoms, disrupting the very foundation of human experience, such as assumptions about temporality, intersubjectivity, or predictability of reality (Wilde 2021). Biological research supports this argument too. Studies in epigenetics demonstrate that chronic psychological stress can produce lasting changes in gene expression (Mazzoni et al. 2025). Mechanisms like DNA methylation in the brain regions associated with memory and emotional processing, such as the hippocampus, can directly impair the nervous system. These changes, in turn, can also affect the integration of traumatic experiences into one's autobiographical memory, causing an incoherent sense of identity or narrative continuity (Wilde 2021).

Beyond the individual perception and sensory experiences, what counts as traumatic is further defined by the broader social and cultural backgrounds; shared meanings, norms, and historical conditions all influence how traumatic events are interpreted. This encompasses the "socio-political layer" of the self, emphasizing the collective-generational implications of trauma (Wilde 2020). Anthropological research supports this idea with "collective aphasia," a phenomenon where communities respond to catastrophic historical events through silence or suppression of shared narratives (Das 2024). For instance, in the aftermath of the 1945 Partition in India, the majority of survivors avoided verbalizing their experiences as a defense-mechanism against a "collapse of [their] moral universe". Literary representations of trauma also illustrate this ontological disruption. For example, in Saadat Hasan Manto's short story *Toba Tek Singh*, the trauma of displacement becomes so absolute that the boundaries between personal identity and geography dissolve (Das 2025). This culminates in the protagonist's death in a "no-man's land" that symbolizes the ultimate rejection of arbitrary political, social, or cultural identities.

From a developmental perspective, traumatic events can lead to the construction of a "false self," a form of protective facade, designed for meeting the expectations of a given context (Winnicott, 1965). Examples of this phenomenon may include: "The Hero" – A child who prematurely becomes cheerful or strong to save a depressed parent, burying their own needs and fears as a consequence. "The Perfectionist," who adopts rigid behavioral patterns to avoid being disappointed or abandoned. And "The Schizoid Retreat," who dissociates from overwhelming feelings and memories to survive a "timeless, objectless, and selfless nightmare of pain." While these defense-mechanisms enable survival, they frequently result in long-term feelings of emptiness, alienation, or inauthenticity (Winnicott, 1965). A clinical case study of Olivia from the

book *A Relational Perspective on Psychological Trauma*, illustrates how one may even achieve high professional success and social recognition while overcoming a "chronic sense of emptiness" or feeling "fundamentally flawed and unloved" (Athanasiadou-Lewis 2019). Olivia's identity, built on compliance and perfectionism, rather than authenticity, disrupted the creative dialogue between the self and the world that Tagore theorized in *The World of Personality* – leaving her relational engagement with existence fragmented and stagnant (Tagore 1917).

As a final point, trauma may also manifest itself through behavioral patterns where unresolved conflicts are unintentionally repeated. Freud described this phenomenon as "repetition compulsion," when individuals re-enact traumatic experiences in an attempt to gain mastery or closure of the situation (Freud 1920). During this process, one acts as if the traumatic experience is still present, replacing a sense of potential safety or an opportunity for growth, with an anticipation of threat. Contemporary psychological approaches view these patterns as attempts of *failing* to restore coherence and harmony within one's identity and relationships. Trauma, then, fractures not only the internal state but also the self's capacity to engage meaningfully with the external world – its present relationships and future possibilities alike. The question that follows is not whether healing is needed, but what form must it take. An emerging psychotherapy, combining all of the above-mentioned practices with Tagorean understanding of relativity can meaningfully answer this inquiry.

Holistic Healing Practices – Rabindrik Psychotherapy

Rabindrik Psychotherapy (RPT), is a performing arts-based therapeutic model developed by Dr. Debdulal Dutta Roy at The Indian Statistical Institute (ISI) in July of 2018. Inspired by Tagore's literary, musical, and artistic legacy, RPT integrates aesthetic expression with psychological well-being, aiming to restore harmony with the broader flow of human consciousness (Dutta & Dey-Tapader 2025). This framework defines the latter as an "unbounded, free-floating wave of awareness," similar to how it was portrayed in Tagore's poetry collection *Shyamoli* from his older creative period (Tagore 2022). The RPT model views psychological distress, including trauma, as a form of "turbulence," where an accumulation of negative emotions can create a state of disequilibrium or discomfort. Consequently, achieving a healed psychological state requires "laminar flow," characterized by emotional balance, pleasantness of mood, and internal stability (Dutta & Dey-Tapader 2025).

Central to RPT is the concept of Layer Dynamics, which identifies three interconnected levels of awareness (Mitra 2025). The first layer, *Murta,* represents the structural and sensory dimension of experience, where individuals perceive the external world through direct and physical means. The second layer, *Raag*, corresponds to the emotional dimension with feelings, attachments, and affective responses. And the third layer, *Saraswat*, represents the deepest, innermost state of total harmony of the self and the surrounding world. Trauma survivors often become trapped within the *Murta* and *Raag* layers, reacting through sensory triggers and being overwhelmed by emotional turbulence, without ever reaching the *Saraswat* state of awareness (Mitra 2025).

To facilitate the transition between the three layers, the RPT model employs

"buoyant flow," described as an upward movement of suppressed emotions and desires with creative engagement (Mitra 2025). Positive metaphors or mental imagery, all drawn from Tagore's dances, songs, dramas, and paintings, provide a safe space for expressing and transforming internal emotional states. Music plays a particularly central role here. The body of songs composed by Tagore, *Rabindra Sangeet*, is frequently used as an auto-suggestive symbol of reconstructing cognition. Tagore's collection of *Geetobitan*, functions similarly to the latter, with patients selecting and interpreting songs that resonate with their internal conflicts. Through these musical discussions, patients gain insight into their unresolved emotional struggles and reconstruct the "disease semantics" that shape their internal, cognitive narratives (Mitra 2025). By combining vocalization, rhythmic movement, and musical engagement with Tagorean compositions, even the individuals experiencing severe conditions, such as obsessive-compulsive disorder (OCD) or neurotic depression, show significant improvement in shifting their consciousness from the emotional dimension of *Raag* to the harmonious *Saraswat* layers.

Rabindrik Psychotherapy strongly connects to the Post-Traumatic Growth (PTG) framework, developed by Tedeschi and Calhoun (1996), which proposes that individuals can experience profound positive transformation following adversity – not despite suffering, but through meaningful engagement with it (Banerjee 2021). With this combined approach, healing is not as simple as returning to the pre-traumatic state, but as transformation to a more complete form of existence. To illustrate, an individual who has experienced a significant failure or loss may, through creative and relational engagement, develop a deeper sense of purpose, expanded empathy, and renewed connection with others. This is what RPT identifies as hallmarks of growth and what Tagore would recognize as the awakening of one's role as *Viswakarma*, a universal worker whose fundamental responsibility is the act of creation (Kumar 2017). This process of transformation is essential for reaching *Milan* (concord) and *Samanjaysya* (harmony), and connecting with the "spirit of life," the unity of all forms of existence that mark the self's fullest realization (Banerjee 2021).

Taken together, Rabindrik Psychotherapy proposes a holistic pathway to healing, in which aesthetic expression, spiritual reflection, and relational awareness converge (Skorokhodova 2025). Individuals are encouraged to reinterpret their own psychological and existential boundaries – the perceived limits of self, identity, and belonging that trauma often rigidifies – not as fixed barriers that separate the self from others, but as permeable thresholds through which meaning, empathy, and relational exchange can flow. In practice, this may involve open expression of internal suffering with performing arts therapy, or everyday encounters that restore a sense of shared humanity. Through this process, the boundary between the self and the world becomes not a wall, but a meeting point. Recovery, therefore, develops from an integration of individual suffering into the collective understanding of human existence, echoing Tagore's vision of a "one world" (Kumar 2017).

As a whole, the existing literature shows that the world's relational nature and engagement with the self can be fractured by traumatic experiences in various ways. Dominant Western frameworks, particularly those rooted in DSM-based models of PTSD, tend to locate both trauma and recovery within the individual – positioning the suffering self as the primary side of diagnosis and symptom reduction. While

clinically valuable, this approach risks leaving the individual relationally isolated, measuring recovery by the diminishment of internal symptoms rather than by the restoration of one's communion with the world and others. Tagore's relational ontology offers a fundamentally different horizon where healing is no longer a return to the pre-traumatic baseline, but an expansive reintegration – of the self and the world, of the individual suffering and collective human experience. The following section will explore how applying this relational framework reveals the deeper, holistic truth underneath recovery from traumatic experiences.

Discussion

The Paradox of Stars: A Tagorean Perspective on Trauma

The stars are standing still in the night sky, but only for those who are too far from them. Scientists would argue that as one gets closer, the stars will be actively moving. This paradox is how Tagore's *The World of Personality*, one of the many lectures delivered in the U.S., begins to observe the conflict between scientific reasoning and personal, relational model of truth. According to Tagore's poetic understanding, the claim that stars are "rushing about" only proves that the observer is "too near them" (Tagore 1917, pp. 55–60). He supports this by noting scientific inconsistencies from the past, such as the "too-near view" of the Earth being flat, which was later corrected by a more "distant perspective" to find the complete truth.

To resolve the paradox, Tagore concludes by stating that the apparent stillness and the measured movement of stars are not contradictory, but rather master truths of dialectic logic. If seen from a far distance, the stars do appear like "chains of diamonds hanging on the neck of some goddess silence," remaining truly unmoved. However, if astronomy "plucks out individual stars" and examines them from the lens of mathematics, they are found to be moving (Tagore 1917, pp. 61–69). Choosing one side to criticize the other only hurts the ability of understanding both perspectives, as well as the higher meaning. Here, Tagore cites the *Ishopanishad*, a key scripture of the Vedanta sub-schools of Hinduism, "It moves. It moves not. It is distant. It is near" (Śaṅkarācārya & Shukla 1999, verses 3–8). The stars, therefore, are only one example of the dialectic logic of perception. The key takeaway is that the stars are both still and moving, depending on where *the individual* stands upon perception. This reinforces the idea that the world is neither objective or separate, but rather a direct reflection of the individual's personality. Moreover, as Tagore states, such relational understanding of the world is like a poem or a work of art – an expression of one's personality – implemented through a "silent meeting of a soul with soul" (Tagore 1917, pp. 77–97). In light of this, trauma could also have an effect on an individual's meaning of existence and their perception of external reality.

With the mind serving as the principal element of creation, actively engaging the self with the world in given time and space, the effect of a traumatic experience would not just be a collection of symptoms but rather a fundamental dislocation of the mind's principal role in the process of co-creation. Mapping the duality of Tagore's paradox of the stars onto the contemporary debate between biomedical and relational models

of trauma could highlight two sets of truths. On the one hand, the scientific "near view" of trauma may focus on the specific biological or cognitive markers, such as hormonal imbalance, memory fragmentation, or PTSD symptom clusters (Mazzoni et al. 2025). Although this would be true, Tagore argues that substituting laws for personality causes the world to "crumble into abstractions" where things become "nothing at all" (Tagore 1917, pp. 55-97). On the other hand, the "distant view" can perceive trauma as an ontological rupture, shattering an individual's "horizon of possibilities" and "habitual confidence" in a safe world (Wilde 2020).

Consider, for instance, a survivor of prolonged relational trauma who can no longer experience intimacy as anything other than a precursor to harm. Their perceptual world has narrowed to a single, repeating meaning, stripping relationships of their complexity and potential for growth. As Tagore and other constructivist philosophers point out, if the "world is what we perceive it to be," then the traumatized mind becomes a fractured instrument of creation (Lowndes et al. 2017). This is precisely what such a survivor illustrates: reality itself is no longer co-created but compulsively pre-interpreted, turning the dynamic exchange between the self and the world into a fixed and defensive script. Additionally, if one's perception comes from the "central creative power" of personality, the reality itself – a meeting point where "infinite becomes finite"– would also come to be inconsistent and fragmented (Tagore 1917, pp. 55-97). This connection between the dialectic view of traumatic experiences suggests a fundamental rupture between the mind as the creator and the world as an active, relational force. Additionally, it connects to a larger issue of what *disappears* when an individual becomes stuck in a "too-near view" of their pain, as well as what their full recovery from trauma should entail.

Dimming the Light: The Loss of Beauty and Meaning from Trauma

The damage inflicted by trauma extends far beyond cognitive or emotional symptoms, reaching the individual's capacity for experiencing life's aesthetic dimension. The beauty of the world fades; the sun may be shining, the flowers – blooming, and the people – full of humor and energy – can be beaming around. But the person who has experienced trauma unconsciously and uncontrollably fails to notice any of it. In phenomenological terms, this is not merely a psychological injury, but a "shattering of existence itself," where the world ceases to be beautiful, and instead becomes a source of pervasive threat (Wilde 2021). This is also where the development of a "false self" begins, with adaptations such as the Hero, the Perfectionist, or the Schizoid Retreat (Athanasiadou-Lewis 2019). These adaptations function not only as psychological defense mechanisms, but also as deeper survival strategies in a world that failed aesthetically and destroyed the sense of personal agency for one's own reality. New and fruitful experiences may come, but as the creative dialogue between the self and the world stagnates more and more, the individual stops "pouring itself" into new expressions and enters a "gloom of the sunless space" (Tagore 1917, p. 87). The world is no longer a personal gift, but instead, as Tagore would put it, a "stupendous deception" or "an unimaginable shadow of nothingness."

This aesthetic loss can expand to a collective and cultural dimension, as well.

When a society experiences a historical catastrophe, the trauma is not just an event-based wound but a "vivisection" of the collective heart (Das, 2024). Consequently, the shared ethical frameworks and human connections – what Tagore calls the "web of life" – can be violently severed. In response, the traumatized society may experience "collective aphasia," a state of silence used as a psychological shield against memories that can be too daunting to vocalize. This is especially true for societies that never received acknowledgement of their status as 'victims' for the experienced loss. For instance, when the 1947 Partition survivors faced "whataboutism" from across the border, the validity of their narratives and the need for cultural expression was completely silenced (Das 2024). Moreover, if in a healthy society, life moves in a "rhythm of relationship" that is beautiful and dynamic rather than merely utilitarian, trauma can stall this rhythm and force the people into a state of "inner exile." Consequently, members of the society may begin to experience a severed cultural identity and lose sight of possibilities for the future.

Understanding this collective dimension of trauma is vital because clinical diagnostic models, such as DSM-5 or ICD-11, mainly focus on individual cases. These models are inherently products of WEIRD epistemology, built on assumptions of individualism, cognitive primacy, and internalized suffering of human experiences (Henrich et al. 2010). Thus, missing the impact of systematic violence, historical catastrophes, or mass displacement that define shared identities of entire communities (Wilde 2020). As a result, phenomena like "collective aphasia" can be misinterpreted as cognitive deficits, rather than socio-cultural survival strategies (Zoromba et al. 2024). The experience of indigenous communities subjected to generational displacement offers a telling illustration – their communal silencing of the traumatic memory is often pathologized by Western clinical frameworks as 'avoidance' or 'emotional blunting,' when it, in fact, represents a collectively negotiated form of protective and meaning-making mechanism. Healing this collective wound requires a shift toward "one world" thinking, a Tagorean ideal where the "problems of people become part and parcel of the whole mankind" (Banerjee 2021). This perspective also moves beyond the "near view" of shared trauma to a "distant view" that recognizes the foundational interconnectedness of human life (Kumar 2017).

The clinical implications on this shift are profound: if trauma is understood as an ontological and aesthetic wound that destroys one's capacity for appreciating beauty, meaning, and creative engagement, then purely cognitive or pharmacological treatments will always remain incomplete (Zoromba et al. 2024). For that reason, aesthetic therapies like Rabindrik Psychotherapy (RPT) are not merely supplementary or alternative. Their approach would address the impact of trauma at its core by targeting the shattered relationship between the self and existence (Mitra 2025).

From Restoration to Transformation: Reimagining Trauma Treatment

Those who simply cope with their trauma remain within the symptom-management stage. They effectively use coping strategies to regulate their emotions, maintain a positive self-esteem, and improve functioning in their daily life. Although this is part of the recovery process, it is too focused on returning the individual to the pre-traumatic baseline of being "normal" (Zoromba et al. 2024). The symptoms can

disappear with biomedical or psychoanalytic interventions – such as pharmacotherapy or structured behavioral approaches like CBT and EMDR – but the traumatized individual may nonetheless remain trapped in a detached and flat perspective of their own history (Wild 2021). On the other hand, genuine recovery can lead to Post-Traumatic Growth (PTG), a process of personal transformation where an individual emerges into a more complete and relationally grounded existence (Bajpai, 2025). This transformation is not uniform – it manifests differently across personal and cultural contexts – but it commonly involves a heightened sense of priorities, deeper and more intentional relationships, and a revised understanding of one's morality. Drawing on Tagore's philosophy, this level of healing is what brings the "round and continuous" idea of the world forward (Tagore, 1961 p. 58). It enables the individual to move past the fragmented "chapters" of their pain and perceive the broader master truth of existence. In essence, this shifts post-traumatic healing from managing to *mending* the process. It does not disqualify the power of traditional clinical practices, but it does initiate an outlet of growth that can enable the individual to reconnect into their creative and engaged self.

Rabindrik Psychotherapy (RPT) offers precisely this kind of mending rather than managing, and its therapeutic logic is inseparable from Tagore's understanding of the mind as an active, creative force. If conventional therapeutic approaches address the surface of trauma, RPT targets what lies beneath, offering aesthetic and spiritual pathways for restoring the relationship between the self and the world. Through Tagore's literary imagery, RPT works as a performing arts therapy that addresses emotional distress through real-time, object-oriented, and auto-suggestive methods (Mitra 2025). By facilitating a transition from the structural *Murta* layer of sensory experiences, to the *Saraswat* layer of total harmony and equilibrium, RPT gradually reopens the patient's capacity for co-creation (Dutta & Dey-Tapader 2025). This process is further strengthened by fostering sets of positive values in patients, such as self-awakening, serenity, bravery, and enlightenment (Mitra, 2025). With performing arts therapy techniques, the patient releases unresolved feelings and learns self-regulation, but the clinically distinctive aspect of RPT begins specifically during the metaphysical stage of mind-body connection. In this moment, the patient does not only recover from their traumatic experience, but reactivates the capacity to find beauty in existence and believe in the personal power of constructing their world.

From this perspective, post-traumatic growth is not a return into the previous world the individual inhabited, but a *rebirth* of the mind as a creator. After experiencing what Tagore describes as a "gloom of sunless space," the healed self carries something it did not have before – the knowledge that the world can be lost *and* reclaimed. For this reason, genuine healing produces not only psychological resilience, but also depth, which moves the individual into a more grounded, relational, and creatively alive existence.

This paper does not claim that Tagorean philosophy resolves all questions about trauma treatment. The argument that trauma leads to an ontological and aesthetic rupture is mainly grounded in philosophical reasoning and cross-disciplinary synthesis rather than measurable outcomes. Therefore, the theoretical contribution offered here does not allow empirically falsifiable claims. Although this is not an unusual position for theoretical scholarship, it does create a gap between what the paper proposes and

what clinical practitioners can immediately implement. Furthermore, RPT remains in the early stages of development, concentrated in culturally significant areas of Indian and Bengali regions, creating a serious challenge in translating the approach to other parts of the world, or integrating it into the mainstream diagnostic models. Nevertheless, these limitations are not reasons to dismiss the framework, but invitations for future empirical and cross-cultural research on trauma and holistic healing practices.

Conclusion

In summary, this paper has argued that Rabindranath Tagore's relational ontology, drawn from *The World of Personality*, offers a distinctive and clinically relevant framework for understanding trauma – not solely as a psychological wound, but as rupture in the self's co-creative relationship with the world. When trauma occurs, the mind's capacity to actively participate in constructing reality is fractured, narrowing one's perception, severing relational bonds, and dimming the sense of beauty or meaning in existence. Purely cognitive or biomedical interventions, however, no matter how effective their symptom reduction may be, cannot fully address this deeper ontological loss. What Tagore's philosophy suggests to the dialogue is measuring health and well-being not only by the absence of symptoms, but by the quality of the self's engagement with life. Rabindrik Psychotherapy translates this philosophical insight into practice, offering a model of healing oriented towards wholeness rather than baseline functioning. Future research must determine how this restoration succeeds across cultural contexts and whether its outcomes can be empirically validated. However, the broader contribution of this paper is the argument that Tagore's vision of a relational, creative self is not a philosophical curiosity confined in the Indian literary or cultural traditions. It is a framework that speaks to something universal in humanity – the need not to just survive, but to find, on the other side of suffering, a world worth creating again.

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An Examination of the Relationship between Artificial Intelligence Usage Patterns and Loneliness Among Young Adults

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The aim of this study was to examine the relationship between artificial intelligence (AI) usage patterns and loneliness levels among young adults. The study was conducted with 141 participants aged 18–24 who actively use AI tools. Participants' AI usage patterns were assessed using a researcher-developed AI Usage Form, while loneliness levels were measured using the UCLA Loneliness Scale. Quantitative data were analyzed using descriptive statistics and one-way analyses of variance (ANOVA), whereas responses to open-ended questions regarding the use of AI for psychological support were examined through thematic analysis.The findings indicated that AI was most frequently used for educational purposes, followed by personal curiosity, understanding personal problems, decision-making, seeking medical information, increasing motivation, reducing anxiety, alleviating feelings of loneliness, and obtaining psychological support. The results showed that participants who reported using AI frequently or very frequently for reducing anxiety, decision-making, understanding personal problems, and alleviating loneliness had significantly higher levels of loneliness compared to those who did not use AI for these purposes. In addition, participants who used AI for psychological support and perceived it as somewhat helpful reported significantly higher levels of loneliness than those who did not use AI for this purpose. Qualitative findings revealed four main themes regarding reasons for preferring AI for psychological support: accessibility and speed, economic reasons, perceived usefulness and suitability, and distrust toward experts and psychotherapy. Furthermore, among participants who considered AI tools functional for psychological support, the perceived benefits were grouped under four themes: emotion regulation and immediate soothing effects, increased motivation and action-taking, gaining different perspectives and suggestions, and ease of use and perceived functionality. This study contributes to the limited empirical literature by examining the relationship between AI usage patterns and loneliness in young adults through a mixed-methods approach.

Keywords: *artificial intelligence, loneliness, young adulthood, psychological support*

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Introduction

In recent years, the use of artificial intelligence (AI) has become an integral part of individuals' daily lives and has increasingly been preferred across various domains such as education, decision-making, research, and psychological support (De Freitas et al. 2025, Kang et al. 2024, Schäfer et al. 2025). A review of the literature indicates that measurement tools assessing AI usage are limited, and existing studies are predominantly qualitative in nature. Previous research has shown that AI tools are used not only for information acquisition but also for a wide range of purposes, including obtaining emotional support, assisting decision-making, establishing social connections, fostering personal development, and enabling self-expression (Skjuve et al. 2024, Syed 2024, Wang et al. 2025, Zhuang 2025).

It has been reported that users utilize AI to cope with stress and achieve emotional relief, and that AI is perceived as a supportive tool for dealing with the complexities of daily life. These findings suggest that AI can address not only cognitive but also psychosocial needs of individuals (Skjuve et al. 2024, Wang et al. 2025, Zhuang 2025). One study highlighted that AI applications may enhance individuals' sense of self-efficacy and promote creativity and problem-solving skills (Hang et al. 2024). Similarly, Wang et al. (2025) found that particularly young individuals use AI for emotion regulation, which contributes to maintaining psychological balance. Although the relationship between loneliness and technology remains a debated issue in the literature, there has been a noticeable increase in the use of AI tools as a potential means of coping with loneliness (Grudin & Jacques 2019).

With the rapid development of AI technologies and the increasing diversification of their usage purposes, identifying the motivations underlying individuals' use of AI tools has become crucial for better understanding the psychosocial needs of contemporary individuals. However, there is a lack of sufficient research in Turkey examining the underlying reasons for using AI for psychological support. In this context, determining AI usage patterns among young adults and examining their relationship with loneliness levels is expected to contribute to the literature by addressing these gaps.

AI-Based Mental Health Applications

In addition to general-purpose AI tools such as ChatGPT, Gemini, and Bing, there has been a rapid increase in the development of applications specifically designed for mental health, focusing on clinical and psychoeducational purposes (Herbener & Damholdt 2025). Among these applications are Replika, which reached over 10 million users and 30 million downloads in 2023; Character AI, which surpassed 20 million users in the same year; and MyAI, a Snapchat-based social chatbot that facilitated over 20 billion interactions among more than 200 million users in 2024 (Cai 2023, Maples et al. 2024, Patel 2024, Snap Inc. 2023, as cited in Herbener 2025).

A review of studies on AI-based mental health applications indicates that, in a study evaluating Wysa user experiences, users reported positive effects in areas such as engagement and interaction, emotional resilience, and personal development

(Chaudhry & Debi 2024). In a randomized controlled trial conducted by Fang et al. (2025), participants used a chatbot for four weeks, after which significant improvements were observed in emotional well-being and perceived social connectedness. A review study also found that chatbots developed for mental health purposes were effective in reducing symptoms of anxiety and depression, and that users generally developed positive attitudes toward these tools (Limpanopparat et al. 2024).

However, studies also indicate that user experiences with companionship-oriented chatbots are not unidimensional. While some users report reductions in loneliness, others may experience increased tendencies toward social isolation. From this perspective, it has been suggested that adopting a one-dimensional approach in AI-based psychological support applications may lead to ethical concerns (Liu et al. 2024). Overall, AI applications in the field of mental health are still in a developmental stage, with some studies reporting promising results and suggesting that these tools may provide complementary contributions to therapeutic processes (Chaudhry & Debi 2024, Olawade et al. 2024).

Studies conducted in Turkey on AI usage have shown that individuals use AI tools for various purposes, including information acquisition, completing assignments, preparing for exams, facilitating decision-making processes, and enhancing self-regulation skills (Ahmadi & Tekemen 2024, Hoşgör & Güngördü 2025). In a study conducted with students in health-related fields, 64% supported the use of AI in healthcare, while 45% believed that advancements in AI could lead to the disappearance of their professions. In the same study, 83% reported being willing to learn and use AI and emerging technologies, whereas 65% believed that the need for healthcare professionals would decrease as AI becomes more widespread (Seçer 2024). In another study conducted with pre-service teachers, participants found AI to be functional in supporting learning processes by providing fast and well-organized information and contributing to decision-making, while also expressing concerns that it may limit human interaction (Ersöz 2025).

Ediboğlu (2023), in a study examining the use of AI in psychotherapy and psychiatry, reported that AI has significant potential in this field but emphasized the need for caution regarding ethical, security, and privacy issues. Additionally, the study suggested that AI can serve as a supportive resource in mental health, while also highlighting the importance of transparent evaluation of whether these tools effectively fulfill their intended functions.

Attitudes of Young Adults Toward AI Use

A review of studies on young adults' attitudes toward AI use indicates that these attitudes may vary depending on factors such as experience, personality traits, technological knowledge, and academic field; however, overall, a predominantly positive attitude has been observed (Çatman et al. 2025, Deng et al. 2025, Katsantonis & Katsantonis 2024). In addition, it has been shown that AI tools are used not only for academic purposes but also to meet psychosocial needs such as emotional support, coping with stress, and self-expression (McBain et al. 2025, Herbener & Damholdt 2025, Katsantonis & Katsantonis 2024).

A qualitative study conducted with young adults found that AI chatbots are perceived as easily accessible and as providing a space for self-expression without fear of judgment, making them a potential alternative for psychosocial support (Bae Brandtzaeg et al. 2021). It has also been reported that young individuals increasingly turn to online resources and digital tools rather than professional help when seeking psychological support. The main reasons for this tendency include ease of access, anonymity, and the ability to manage the help-seeking process in a more controlled manner (Pretorius et al. 2019).

Finally, it has been found that young individuals who use AI primarily for emotional needs and who prefer more relational and human-like responses from AI tend to have higher levels of loneliness, lower quality of family and peer relationships, and higher levels of anxiety (Kim et al. 2025, Herbener & Damholdt 2025).

AI Use as a Tool for Coping with Loneliness

Since the beginning of human existence, individuals have needed to fulfill certain needs in order to sustain their lives. In addition to basic needs such as food, sleep, and shelter, humans also require interpersonal interaction, as well as the need to love and be loved, which necessitates forming and maintaining relationships with others (Maslow 1970, İmamoğlu 2009).

Loneliness, on the other hand, refers to a state characterized by a lack of social connection or the absence of meaningful social relationships (Farina et al. 1991, p. 351). When considered as a reflection of the discrepancy between the quantity and quality of an individual's existing social relationships and those they desire, loneliness emerges not only as a physical condition but also as a subjective evaluation of insufficient social bonds (Perlman & Peplau 1982).

Loneliness can have profound effects on individuals' psychological and social functioning, leading to negative outcomes such as stress, anxiety, low self-esteem, impaired self-concept, decreased life satisfaction, and depression (Cacioppo & Hawkley 2009, Heinrich & Gullone 2006). In addition, loneliness has been associated with weakened coping abilities due to a lack of social support and inadequate social relationships, which may reinforce a cycle that results in social withdrawal (Qualter et al. 2015).

Although loneliness is a universal experience, it is perceived and experienced differently across cultural and contextual settings. In individualistic societies, loneliness tends to be associated with feelings of personal failure and inadequacy, whereas in collectivist cultures, it is more closely linked to social exclusion and a lack of belonging (Lykes & Kemmelmeier 2014). These differences also influence individuals' social behaviors, help-seeking tendencies, and coping strategies in response to loneliness. Studies conducted in Turkey have shown that loneliness levels are increasing particularly among young adults and urban populations, with factors such as digitalization, social media use, and individualization trends contributing to this phenomenon (Güner et al. 2022, Kurt & Bayrakçı 2021, Yalçın 2023). Recent research further suggests that loneliness is not merely an individual experience but has

become a key variable shaping the quality of social relationships and psychosocial adjustment processes in an increasingly digitalized world (Matthews et al. 2017).

Recent studies indicate that the relationship between AI use and loneliness is complex and multidimensional. Some research suggests that interactions with AI-based chatbots and digital assistants can enhance perceived social support, reduce subjective feelings of loneliness, and increase a sense of connectedness (Chaudhry & Debi 2024, Fang et al. 2025). In contrast, other studies argue that when interactions with AI replace real human relationships, they may lead to increased social isolation and deepen feelings of loneliness (Croes & Antheunis 2021, Liu et al. 2024). A meta-analysis found that physically embodied interactions with AI tend to reduce loneliness, whereas non-physical interactions may increase it (Dong et al. 2025). These findings suggest that the impact of AI tools on loneliness varies depending on context, purpose of use, and individual characteristics.

The literature increasingly indicates that AI use is associated with individuals' cognitive, social, and emotional experiences (Kim et al. 2025, Skjuve et al. 2024, Syed 2024, Volpato et al. 2025, Wang et al. 2025, Zhuang 2025). However, research examining which psychosocial variables are associated with different AI usage purposes, and particularly how these relate to subjective social experiences such as loneliness, remains limited (Kim et al. 2025, Lai et al. 2025). In the context of young adulthood, where AI technologies are widely used, examining AI usage patterns and their associated psychosocial variables is important for understanding loneliness as a key mental health indicator and for informing the development of intervention and support strategies. As AI is increasingly used as a tool to address individuals' social and emotional needs, understanding its role in loneliness and identifying its potential risks and protective effects has become essential. Accordingly, the aim of this study is to examine the relationship between AI usage patterns and loneliness levels among young adults.

To address this aim, the following research questions were formulated:

- RQ1. What are the primary purposes of artificial intelligence use among young adults aged 18-24?
- RQ2. Do loneliness levels differ according to the purposes and frequency of artificial intelligence use among young adults?
- RQ3. What are the reasons young adults prefer artificial intelligence over a mental health professional when seeking psychological support?
- RQ4. What are the reasons young adults perceive artificial intelligence as functional for psychological support?

Method

Participants

Prior to data collection, a set of inclusion and exclusion criteria was established to define the study sample. Accordingly, individuals with a history of serious neurological or psychiatric conditions, those outside the 18–24 age range, those with a

diagnosed psychiatric disorder, those using psychiatric medication, and those who did not use AI tools were excluded from the study.

A total of 233 individuals initially participated in the study. Based on the inclusion and exclusion criteria, 92 participants were excluded due to psychiatric medication use, a psychiatric diagnosis, being outside the 18–24 age range, or not using AI tools. Consequently, the final sample consisted of 141 participants, and all analyses were conducted using this sample.

Of the participants, 99 (70.2%) were female and 42 (29.8%) were male. The sample predominantly consisted of undergraduate students (78.7%), individuals living with their families (77.3%), single individuals (71.6%), and those who had not previously received psychotherapy (82.3%). Detailed information regarding the sample is presented in Table 1.

Table 1. *Demographic Characteristics of Participants*

	N (141)	Frequency	%
Gender	Female	99	70.2
	Male	42	29.8
Employment Status	Student	130	92.2
	Employed	9	6.4
	Unemployed	2	1.4
Education Level	High school	2	1.4
	Associate degree	26	18.4
	Bachelor's degree	111	78.7
	Master's degree	2	1.4
Marital Status	Single	101	71.6
	In a relationship	38	27.0
	Engaged	1	0.7
	Married	1	0.7
Living Arrangement	With family	109	77.3
	With roommates	17	12.1
	Alone	14	9.9
	With partner	1	0.7
Therapy Experience	Yes, currently attending	2	1.4
	Yes, not currently attending	23	16.3
	No	116	82.3

Measures

A Demographic Information Form was developed to obtain participants' demographic characteristics and to collect information on their patterns of AI tool use. The form included questions on age, gender, education level, relationship status, employment status, whether they had previously received psychological or psychiatric treatment, and whether they were currently using psychiatric medication.

Demographic Information Form

The form used to collect information about participants' sociodemographic characteristics was developed by the researchers. It includes questions regarding age, gender, education level, employment and relationship status, whether participants had previously received psychological support, whether they had been diagnosed with a psychiatric condition, and whether they were using psychiatric medication.

AI Usage Form

The AI Usage Form, developed by the researchers, includes questions regarding participants' use of AI tools (e.g., ChatGPT, Gemini, Microsoft, Bing), their frequency of use, and their purposes for using these tools. The form also includes open-ended questions assessing experiences related to using AI for psychological or emotional support, perceived benefits of these tools, and whether participants would prefer AI tools or a mental health professional when experiencing a psychological problem

.

UCLA Loneliness Scale

The UCLA Loneliness Scale, developed by Russell et al. (1978) and adapted into Turkish by Demir (1989), was used to assess individuals' subjective levels of loneliness. The scale consists of 20 items and a single dimension, and it is rated on a 4-point Likert scale ranging from 1 (never) to 4 (often). Higher scores indicate higher levels of loneliness. In the Turkish adaptation study, the internal consistency coefficient of the scale was reported as .96 (Demir 1989).

Data Collection Procedure

The data were collected through an online survey. Participants were informed about the purpose of the study via an informed consent form, and participation was voluntary.

Statistical Analysis

The data were analyzed using the Jamovi statistical software. Following descriptive statistics, the internal consistency of the scales was evaluated using Cronbach's α coefficient. Prior to analysis, the normality assumption was assessed using Q–Q plots, the Kolmogorov–Smirnov test, and skewness–kurtosis values. For the total loneliness score, skewness was found to be 0.599 and kurtosis −0.323. George and Mallery (2010, p. 115) state that skewness and kurtosis values within the range of ±2 are acceptable for psychometric data. Since these values fell within acceptable limits, the normality assumption was considered satisfied. A one-way

ANOVA was used to test group differences. Short responses obtained from open-ended questions were analyzed using thematic analysis.

Results

Descriptive Statistics

The hierarchical ordering of AI usage purposes was measured using Likert-type items rated between 1 and 5, with higher scores indicating more frequent use for the given purpose. The analysis showed that AI was most frequently used for educational purposes (3.50). This was followed by personal curiosity (3.23), understanding personal problems (2.44), decision making (2.42), seeking medical information (2.23), increasing motivation (1.88), reducing anxiety (1.85), psychological support (1.77) and reducing feelings of loneliness (1.50), respectively. The results of the analysis are presented in Table 2.

Table 2. *Descriptive Statistics for Purposes of AI Use*

Purpose of Use	$\bar{x}$	**SD**
Education	3.50	1.05
Personal curiosity	3.23	1.09
Understanding personal problems	2.44	1.24
Decision-making	2.42	1.13
Seeking Medical Information	2.23	1.10
Increasing motivation	1.88	1.12
Reducing anxiety	1.85	0.992
Psychological support	1.77	0.915
Reducing feelings of loneliness	1.50	1.07

Comparison of Loneliness Levels by AI Usage Purposes

Table 3. *Comparison of Loneliness Levels by AI Purpose of Use*

Usage Purpose	Frequency of Use	N	$\bar{x}$	SD	F	*p*
Reducing Anxiety	Never	65	33.0	10.04	3.60	.008
	Occasionally	45	34.0	8.79		
	Moderately	21	36.8	11.78		
	Frequently	7	46.6	11.16		
	Very frequently	3	28.0	6.93		
Decision Making	Never	35	30.7	9.54	4.00	.004
	Occasionally	45	33.9	10.26		
	Moderately	33	35.3	9.33		
	Frequently	23	40.8	11.22		
	Very frequently	5	30.2	3.63		

Level of Loneliness	Understanding Personal Problems	Never	43	31.2	9.88	3.18	.015
		Occasionally	30	33.0	7.02		
		Moderately	41	35.7	11.01		
		Frequently	17	38.1	10.75		
		Very frequently	10	41.2	12.49		
	Reducing Feelings of Loneliness	Never	92	32.9	10.04	6.49	<.001
		Occasionally	28	34.9	8.79		
		Moderately	8	34.5	11.78		
		Frequently	5	50.8	11.16		
		Very frequently	3	51.0	6.93		
	Seeking Medical Information	Never	37	33.3	11.77	0.480	.751
		Occasionally	62	35.5	9.61		
		Moderately	21	33.8	9.18		
		Frequently	14	35.1	12.68		
		Very frequently	7	31.3	7.11		
	Personal Curiosity	Never	4	25.0	5.48	1.40	.239
		Occasionally	38	33.0	10.23		
		Moderately	40	36.3	8.98		
		Frequently	39	34.5	10.44		
		Very frequently	20	35.3	12.72		
	Psychological Support	Never	81	32.9	9.96	2.22	.070
		Occasionally	27	36.3	10.22		
		Moderately	20	35.8	9.89		
		Frequently	10	34.6	12.19		
		Very frequently	3	48.7	8.50		
	Perceived Helpfulness of AI for Psychological Support	Do not use	92	33.0	10.07	3.91	.010
		No	13	33.6	7.91		
		A little	24	40.8	11.31		
		Yes	12	33.3	8.62		

Loneliness levels were examined across AI usage purposes using one-way analyses of variance (ANOVA). The results indicated that loneliness levels differed significantly according to the use of AI for reducing anxiety, $F(4, 136) = 3.60$, $p = .008$, decision making, $F(4, 136) = 4.00$, $p = .004$, understanding personal problems, $F(4, 136) = 3.18$, $p = .015$, and reducing feelings of loneliness, $F(4, 136) = 6.49$, $p < .001$. No significant differences were found according to the use of AI for seeking medical information, $F(4, 136) = 0.48$, $p = .751$, personal curiosity, $F(4, 136) = 1.40$, $p = .239$, or psychological support purposes, $F(4, 136) = 2.22$, $p = .070$. However, loneliness levels differed significantly according to the perceived helpfulness of AI for psychological support, $F(3, 137) = 3.91$, $p = .010$.

Post-hoc analyses showed that individuals who frequently used AI for reducing anxiety had higher loneliness levels compared to those who used it occasionally ($p = .019$) and those who never used it ($p = .007$). Similarly, individuals who frequently

used AI for decision making had higher loneliness levels than those who did not use it for this purpose ($p = .002$). Individuals who used AI very frequently to understand personal problems also had higher loneliness levels compared to those who never used it ($p = .039$).

Individuals who frequently and very frequently used AI to reduce feelings of loneliness had significantly higher loneliness levels compared to those who never used it ($p < .001$; $p = .014$). Additionally, significant differences were found between occasional and frequent users ($p = .007$), as well as between moderate and frequent users ($p = .028$). Finally, participants who reported that AI was somewhat helpful for psychological support had higher loneliness levels compared to those who reported not using AI for psychological support purposes ($p = .005$).

Analyses regarding the use of AI for educational purposes could not be conducted due to insufficient data in some frequency categories. The findings are presented in Table 3.

Qualitative Findings on the Use of AI for Psychological Support

In the study, participants were first asked whether they would prefer artificial intelligence (AI) or a human expert when seeking psychological support. Subsequently, 29 participants (20.56%) who indicated that they would prefer AI were asked to explain their reasons for this preference. The responses were analyzed using thematic analysis, and four main themes were identified by the researchers. The frequencies and percentages of these themes are presented in Table 4.

Table 4. *Themes Related to Reasons for Preferring AI for Psychological Support*

Theme	n	%
Accessibility and speed	15	50
Economic reasons	7	29.16
Perceived usefulness and suitability	4	16.66
Distrust toward experts and therapy	3	12.50

Note. Since participant responses could be coded into more than one theme, total frequencies may exceed the number of participants

Accessibility and Speed

A substantial proportion of participants (50%) stated that they preferred AI for psychological support due to its ease of access and rapid feedback. The following excerpt illustrates a participant's preference for AI because of its immediate availability during moments of distress:

"When I feel upset about something in the moment, I ask ChatGPT because it is easier to access."

Similarly, another participant emphasized the value of receiving instant assistance:

"Since my problems are usually minor and I tend to be a bit indecisive, I get help in that moment."

Economic Reasons

Approximately 29.16% of participants reported that they preferred AI for psychological support due to financial considerations. One participant expressed this as follows:

"Because artificial intelligence is free."

Another participant similarly highlighted the cost-related advantage:

"It is faster and cost-free."

Perceived Usefulness and Suitability

About 16.66% of participants evaluated AI as a useful and suitable option for psychological support. One participant noted feeling more comfortable with AI:

"Artificial intelligence, because I feel more comfortably listened to without being judged."

Another participant suggested that using AI seemed more reasonable:

"AI seems more logical; I don't want to deal with people."

Distrust Toward Experts and Psychotherapy

A smaller proportion of participants (12.5%) expressed their preference for AI in terms of distrust toward professionals and psychotherapy. One participant stated:

"I have met many people studying psychology, and I think topics as deep and meaningful as psychology should be handled by very competent professionals. In a country like Turkey, I don't think psychology is given sufficient importance."

Another participant expressed a lack of trust in psychologists trained in Turkey:

"I don't think a psychologist, especially one trained in Turkey, has the capacity to solve or interpret what I cannot solve myself."

Qualitative Findings on the Perceived Functionality of Artificial Intelligence for Psychological Support

Participants were also asked how functional they found the use of AI for psychological support. Those who reported that AI was helpful were asked to explain their reasons. Among 49 participants who indicated that AI was useful, 32 (22.69%) provided open-ended responses. These responses were analyzed using thematic analysis, resulting in four main themes**.**The frequencies and percentages of these themes are presented in Table 5.

Table 5. *Themes Related to Reasons why AI is Perceived as Functional for Psychological Support*

Theme	n	%
Emotion regulation and immediate soothing effect	13	40.62
Increased motivation and activation	8	25
Gaining different perspectives and suggestions	7	21.87
Ease of use and perceived functionality	5	15.65

Note. Since participant responses could be coded into more than one theme, total frequencies may exceed the number of participants

Emotion Regulation and Immediate Soothing Effect

A large proportion of participants (40.62%) stated that AI provided an immediate calming effect during moments of emotional intensity. One participant described their experience as follows:

"I was going to attend an event voluntarily. I was very excited. I asked ChatGPT for tips to calm down."

Another participant noted that, although not highly effective, AI could still be used at times:

"Even if it is not extremely efficient, it can provide suggestions that make us feel relieved, so it can be used."

Similarly, another participant expressed:

"Sometimes when I get anxious, it can show that the situation is not that serious."

Increased Motivation and Action-Taking

Approximately 25% of participants mentioned that AI helped increase motivation and facilitated taking action. One participant stated:

"It is especially helpful in situations that require courage, and it can listen when you feel that no one will understand you."

Another participant emphasized its usefulness in planning and getting started:

"It is helpful for creating plans. I use it to prepare programs for starting exercise or studying regularly, and it works well."

Gaining Different Perspectives and Receiving Suggestions

About 21.87% of participants indicated that AI was useful for gaining new perspectives and receiving suggestions. Some participants stated:

"It provides a different perspective."

"I think it offers an objective point of view."

Others emphasized its role in providing guidance:

"I use it to get help."

"It helps with basic issues."

"To understand and give advice."

Ease of Use and Perceived Functionality

Finally, 15.65% of participants perceived AI as functional in terms of ease of use for psychological support. One participant highlighted the advantage of quick responses:

"Fast responses provide both practical and emotional ease."

Another participant commented on the nature of AI's responses:

"Its answers seem logical."

Conclusion and Discussion

The present study aimed to examine the relationship between artificial intelligence (AI) usage patterns and loneliness levels among young adults aged 18–24. The findings indicated that participants most frequently used AI tools for educational purposes. This was followed by personal curiosity, decision-making, seeking medical information, increasing motivation, reducing anxiety, obtaining psychological support and alleviating feelings of loneliness. This finding is consistent with previous research showing that young users tend to use AI tools to support learning processes, brainstorm, and acquire information (Common Sense Media et al. 2024, Klarin et al. 2024). Similarly, the literature suggests that AI tools are used by students as resources for problem-solving, idea generation, and supporting learning processes (Habib 2024). It is also likely that the sample consisting predominantly of university students influenced this finding. However, some studies indicate that AI tools are used not only for cognitive purposes but also for psychosocial purposes such as increasing motivation and providing emotional support (Mohamed et al. 2024, Yang et al. 2024).

Analyses conducted to examine differences in loneliness levels across AI usage purposes showed that individuals who frequently used AI to reduce anxiety had significantly higher levels of loneliness compared to those who used it occasionally or not at all. Similarly, individuals who frequently used AI for decision-making reported higher loneliness levels compared to non-users. In addition, individuals who utilized AI frequently or very frequently for understanding personal problems and alleviating loneliness reported significantly higher levels of loneliness compared to those who did not use AI for these purposes. Furthermore, participants who used AI for psychological support and perceived it as somewhat helpful had significantly higher loneliness levels than those who did not use AI for this purpose. These findings are based on cross-sectional data, and no causal conclusions were drawn.

The findings suggest that individuals with higher levels of loneliness may turn to AI tools as a way of coping with this condition or seeking support. Consistent with this interpretation, prior research has shown that individuals with higher levels of loneliness are more likely to engage with online environments (Amichai-Hamburger & Ben-Artzi 2003, Nowland et al. 2018). In particular, individuals experiencing social anxiety and loneliness tend to prefer digital environments over face-to-face communication (Davis 2001, Weidman et al. 2012). Similarly, AI tools are reported to be preferred as emotion regulation tools because they provide advantages such as non-judgmental interaction, a sense of control, and accessibility (Brandtzaeg et al. 2021). However, the literature also suggests that this tendency may not reduce loneliness but may instead reinforce it, indicating a cyclical relationship between loneliness and high levels of internet use (Yao & Zhong 2014, Nowland et al. 2018). The development of AI chatbots has renewed attention to these dynamics, particularly due to their anthropomorphic characteristics and their ability to simulate being understood (Zhuang et al. 2025).

The literature indicates that chatbots provide various forms of support to young adults, including information, feedback, practical suggestions, and emotional support. Participants in previous studies have emphasized that these tools are easily accessible and provide a space where they can express themselves without fear of judgment (Bae

Brandtzaeg et al. 2021). In a study by Herbener and Damholdt (2025), participants reported using chatbots to talk about distressing issues, discuss everyday problems, and receive support related to personal development and mental health. However, some users also reported discontinuing their use due to a lack of meaningful engagement over time (Herbener & Damholdt 2025). In a cross-sectional study conducted in the United States, 13.1% of young individuals reported using AI tools for mental health advice, with this rate increasing to 22% among adults aged 18 and above. While 65.5% of users reported using AI at least once a month, 92.7% found the advice helpful (McBain et al. 2025). Wang and Xu (2026) found that AI use among university students predicted academic stress, with loneliness contributing to this relationship. Similarly, another study reported that loneliness had a significant effect on chatbot use (Zhou & Hu 2026).

Whether AI tools can serve as a solution to the global issue of loneliness remains a debated topic in the literature. One study suggests that while AI may help alleviate loneliness, it cannot fully meet individuals' psychological and physical needs for closeness, according to findings from cognitive neuroscience (Montag et al. 2025). Similarly, Weidman et al. (2012) found that although individuals with social anxiety may express themselves more easily online, this does not lead to better psychosocial outcomes and may instead result in lower quality of life. These findings suggest that although digital interactions may provide short-term relief, they may not fully replace real social connections in the long term.

When participants were asked whether they would prefer AI tools or a human expert for psychological support, 29 participants (20.56%) indicated a preference for AI. The reasons for this preference were analyzed using thematic analysis. The findings showed that participants' reasons clustered into four themes: accessibility and speed (50%), economic reasons (29.16%), perceived usefulness and suitability (16.66%), and distrust toward experts and psychotherapy (12.50%). Similarly, participants were asked whether they found AI tools functional for psychological support. Among those who reported that AI was functional, the reasons were grouped into four themes: emotion regulation and immediate soothing effects (40.62%), increased motivation and action-taking (25%), gaining different perspectives and receiving suggestions (21.87%), and ease of use and perceived functionality (15.65%).

The proportions observed in this study were lower than those reported in a limited number of similar studies. In a study conducted by Rousmaniere et al. (2025) in the United States, AI tools were identified as an informal source of psychological support. Among individuals with mental health concerns who used AI, 49% used it for psychological support, 73% for managing anxiety, 63% for personal advice, and 60% for depression-related support. Additionally, 63% reported that AI improved their mental health, 87% found the recommendations helpful, and 39% considered AI to be as useful as or more useful than human therapists (36%). Accessibility (90%) and low cost (70%) were identified as primary reasons for these evaluations. At the same time, one-third of participants were uncertain about its benefits, and 9% reported encountering harmful or inappropriate responses (Rousmaniere et al. 2025).

Findings regarding attitudes toward AI-delivered psychological support are similarly mixed. Hoffman et al. (2024) found that young adults reported more positive attitudes toward AI-delivered psychotherapy than toward human-delivered

psychotherapy. Similarly, a study conducted with Turkish adults found that 55% of participants preferred AI-delivered psychotherapy over human-delivered psychotherapy (Aktan et al. 2022). In contrast, a study examining medical students' attitudes toward AI in different areas of medicine found that participants showed less support for the use of AI in psychotherapy than in other medical domains (Moldt et al. 2023).

In another study, a chatbot developed for mental health treatment was found to significantly reduce symptoms in participants with major depression, anxiety disorders, and clinically significant eating disorders (Heinz et al. 2025). In a randomized controlled trial conducted with women diagnosed with anxiety disorders in an active war zone, symptom reduction was 45–50% in the traditional therapy group, compared to 30–35% in the chatbot group. These findings suggest that chatbots may serve as supportive tools in contexts where access to therapists is limited, although their effectiveness remains lower than that of traditional therapy (Spytska 2025).

Despite evidence suggesting that AI tools are preferred by some users and that certain AI-based interventions may have positive effects on symptoms, there are also risks and criticisms in this area. An evaluation by the American Psychological Association (2025) emphasized the need for caution in the use of AI tools in mental health contexts. It highlighted that some chatbots may provide misleading or potentially harmful suggestions. Although these tools are accessible and low-cost, they cannot replace licensed mental health professionals and should be used only as supportive and limited tools. A study conducted at Stanford HAI found that such systems may fail to adequately assess high-risk situations and may sometimes reinforce harmful thoughts by providing overly affirming responses (Abramson 2025). Supporting these concerns, another study presented 60 different simulated adolescent scenarios to AI tools and found that 32% of responses actively supported harmful suggestions. Four out of ten AI tools supported half or more of the harmful ideas presented, and none consistently rejected all harmful suggestions (Clark 2025).

The qualitative findings also support each other in that 50% of participants who preferred AI for psychological support cited accessibility and speed, while 40.62% of those who found AI functional emphasized its role in emotion regulation and immediate soothing. These findings may be interpreted as indicating that young adults aged 18–24 may have lower tolerance for negative emotions. In this context, AI tools may function as a form of avoidance. As with other avoidance behaviors, while this may provide short-term relief, it may also contribute to reduced tolerance for negative emotions in the long term. However, further research, particularly longitudinal studies, is needed to allow for more comprehensive interpretations of these qualitative findings.

When considered as a whole, the findings suggest that individuals with higher levels of loneliness tend to turn to AI tools in search of social support. In this context, while AI tools may partially replace face-to-face interaction and help-seeking behaviors in the short term, they are unlikely to play an effective role in resolving underlying issues in the long term. Thus, although AI tools may serve as accessible sources of support, they cannot fully replace human interaction (Montag et al. 2025).

In conclusion, this study examined different purposes of AI use separately and analyzed their relationship with loneliness levels. The findings are important in showing that psychosocial uses of AI are systematically associated with loneliness levels. The qualitative findings also provided insight into why some young adults turn

to AI for psychological support and how they evaluate its usefulness. Participants primarily emphasized accessibility, speed, and low cost as reasons for preferring AI over professional support, while those who perceived AI as useful highlighted its role in emotion regulation, motivation, and gaining alternative perspectives. In this respect, the study highlights that AI use should be considered not only in cognitive terms but also in its psychosocial dimensions, contributing to the limited empirical literature in this field.

The study also has several limitations. First, due to its cross-sectional design, causal inferences cannot be made. Second, the reliance on self-report data introduces the risk of participant bias. Finally, the study was conducted within a specific age group, which limits the generalizability of the findings. Future research should employ longitudinal and experimental designs to better clarify the direction of the relationship between AI use and loneliness. Additionally, examining different patterns of AI use and their relationships with psychosocial variables may provide valuable contributions to the literature. Investigating the role of individual differences, such as personality traits and levels of social anxiety, may also represent an important area for future research.

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