



REVIEW ARTICLE

A Case Report of a Man with Melancholy 60 Years Old Following Psychoanalytical Psychotherapy for Four Years

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Introduction

Age is often overlooked in discussions of diversity in clinical practice. In recent years, the interest of psychodynamic therapists has been extended to later stages of life. Psychodynamic psychotherapy with older individuals views them as continuing to face developmental challenges and navigating major experiences and various life transitions.

Freud in 1905 stated that individuals in the second half of life were unsuitable for psychoanalytic treatment [1]. Contemporary writers, following Karl Abraham's (1919) observation "the age of the neurosis is more important than the age of the patient (p.316)", have treated people over the age of 50 and suggest that adults later in life could be good candidates for psychodynamic psychotherapy, Patients over 50 are more competent in emotional regulation than younger individuals, and they are likely more motivated and focused on relationships and meaning [2].

In Psychodynamic work, symptoms, and personality difficulties and behaviors have meaning that serves multiple functions, and are often unconscious but interact powerfully with someone's conscious life. A developmental process exists throughout life and transference and counter transference influence the relationship with the analyst providing valuable understanding as both a diagnostic and a therapeutic tool. Psychoanalytic therapy aims to uncover unconscious conflicts and bring them to consciousness to promote healing [3].

Some contemporary analysts argue that instinctual drives and wishes are timeless and persistent, retaining

their force throughout life. A reductive approach that focuses on early infantile experiences is also suitable for older patients. Therapeutic techniques used in psychoanalytic therapy for melancholy in older age include free association, dream analysis, and interpretation [3]. On the other hand, some support the view that the second half of life is different. Jung (1929) believed that psychodynamic psychotherapy could be extended beyond the age of 50, using a synthetic rather than a reductive approach with modifications in technique. His interpretations would be more about who the patient is, involving broader issues than childhood experiences and relationships with parents, and with fewer transference interpretations so that psychotherapy becomes more like an intimate conversation [4].

Erikson moved away from a child-centered theoretical system and described a model of continuing development using "The Eight Ages of Man" that covers the life cycle applicable to an older age. In this epigenetic model, Erikson characterized the psychosocial gains of adult ego development with the terms: Intimacy, generativity, and integrity. He argued that their very alternatives, isolation, self-absorption, and despair can be held in check only by the individual's fitting participation in social endeavors. There is an interaction between current development and early experience. The developmental task in late life is to negotiate between the two poles of ego-integrity versus ego-despair, with integrity defined as the acceptance of one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted no substitutions [5].



Citation: Argyropoulos K (2023) A Case Report of a Man with Melancholy 60 Years Old Following Psychoanalytical Psychotherapy for Four Years. Int J Psychol Psychoanal 9:064. doi.org/10.23937/2572-4037.1510064

Accepted: May 10, 2023; **Published:** May 12, 2023

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Melancholy

Melancholy, also known as depression, is a common mental health condition among older adults [6]. Psychoanalytic theories suggest that melancholy is a result of unresolved conflicts and repressed emotions from early life experiences [7]. In older age, these conflicts may resurface due to the loss of loved ones, physical decline, and retirement [2].

Freud clearly described the symptoms of melancholy: "... A profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity, and lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-reviling's and culminates in delusional expectations of punishment." These features match the current DSM diagnostic criteria for depression [7].

Melancholy arises from the loss of the object's love and is an unconscious process that causes a serious decrease in self-esteem. Ambivalence towards the lost object plays a key role as the individual struggles with both survival and destruction, leading to feelings of guilt. The subject may attack the lost object in fantasy or reality and desires the loss due to the object's unsatisfactory presence and love.

According to Abraham, the melancholic process consists of an initial frustration due to the loss of an object. After the individual reacts to the externalization of the introjected object and its destruction, they regress to an early anal-sadistic stage. Identification with the object and primary narcissism results in its introjection, explaining the sadistic vengeance against the object as part of the subject's ego [8].

Klein later elucidated that in melancholy, there is a regression to an earlier failure to integrate good and bad partial objects into whole objects in the inner world. The depressive person believes they are omnipotently responsible for the loss due to their inherent destructiveness, which has not been integrated with loving feelings. Klein supports that mourning, pining, guilt, possibly delusional thinking, reparation, omnipotence, denial, and idealization characterize individuals with depression [9].

Psychoanalytic therapeutic techniques for melancholy in older age include exploring the loss and ambivalence towards the object, facilitating the integration of good and bad partial objects into whole objects, and addressing the individual's guilt and feelings of responsibility for the loss. Additionally, clinicians may encourage the patient to express and work through their feelings of sadness and anger towards the lost object and help them mourn and re-establish their sense of self-worth [9].

Transference refers to the unconscious projection of emotions and experiences onto the therapist [10]. In the case of melancholy in older age, patients may

transfer feelings of loss, sadness, and abandonment onto the therapist. The therapist must recognize and acknowledge these feelings while remaining objective and non-judgmental.

Countertransference, on the other hand, refers to the therapist's unconscious emotional reactions to the patient [11]. In the case of melancholy in older age, therapists may experience their own feelings of loss and sadness, which may influence their treatment approach.

Case Description

This article will examine Peter's four years twice a week psychodynamic psychotherapy and discuss several significant aspects of his case. Peter, a 60-year-old man, sought psychotherapy for the second time in his life due to depressive symptoms, including decreased energy, and loneliness. There was no use of antidepressants or other psychotropic medication during his treatment.

His father passed away when he was 12-years-old, leaving him feeling alone. He experienced a long-lasting melancholic phase for five years following his father's death, where he isolated himself and was unable to have a sexual life or make friends. Later, he had one close friend, who would say they were the same, both timid and fearful but they lost contact after his friend began a relationship with a girl.

He describes his father as strict, and authoritarian, they had no emotional connection with each other, and their contact was limited to the level of school performance. He speaks of his mother with admiration and describes her as a very intelligent woman who while studying did not work, married someone she did not love, and sacrificed herself as a widow devoted to her children.

After a failed relationship with a woman at around 30-years-old, Peter experienced a type of delusional episode, where he believed that others accused him of being gay. He turned to his first therapist for psychotherapy, which he found beneficial. He then entered group psychotherapy where he formed a close friendship with a gay man in the group. Although he admired homosexuals, he did not identify himself as gay. He had short-lived relationships with girls until he met his last partner, Anna, with whom he stayed for 15 years.

His mother has been diagnosed with cancer for the last ten years, and Peter has been taking care of her since his separation from Anna and has returned to his paternal home. He admits that he has not wished to enter into a romantic relationship with another woman since the breakup, and his sexuality is again suspended, as in his adolescence.

The presenting problem of the conflict with Anna was only the tip of the iceberg of Peter's internal world. In therapy, it became clear that Peter was

also struggling with unresolved feelings about his mother, his aging, and mortality, which reawakened painful childhood memories of loss and separation. Peter's primary methods for defending against affect appeared to be intellectualization and denial. This defense mechanism was an obstacle to uncovering his unconscious emotions. Moreover, despite his attempts to avoid strong emotions, he showed a capacity for insight and an interest in learning more about himself and his problems.

As therapy progressed, it became clear that Peter's presenting problems were linked to unresolved issues from his childhood, including the loss of his father at a young age and his difficult relationship with him. He also struggled with unconscious homosexual desires, which he had repressed since his adolescence.

When Peter first came into analysis, he presented with classic symptoms of melancholy but as the sessions progressed, it became clear that his depression was rooted in a deep sense of dissatisfaction with his life. He felt that he had not accomplished enough and that his relationships with others were unsatisfying.

As the analytic psychotherapy continued, he began to reveal more about his past, including experiences of rejection and feelings of inadequacy. He was constantly seeking validation from others and felt that he needed to be perfect in order to be accepted.

It was during the second year of his therapy that Peter was able to think and speak about his sexuality. This was a major revelation for him, as he had never fully come to terms with his bisexuality. Internalized homophobia can manifest as feelings of shame, guilt, and self-rejection, as individuals struggle to reconcile their own sexual orientation with societal expectations and norms.

In the following sessions, Peter began to explore his feelings of shame and guilt around his bisexuality. He had been so focused on being perfect in the eyes of others that he had not allowed himself to see his true self.

Over time, his depression began to lift. He started to form deeper, more meaningful relationships with others.

Transference and counter transference are essential components of psychoanalytic therapy. In the early stages of therapy, he tended to think of our relationship as primarily professional, which protected him from feeling more emotionally vulnerable. As the therapy deepened, Peter's investment in the therapy took on a more personal tone, and he began to speak that this felt like a real and significant relationship. He had difficulty examining more negative feelings about me and the therapy. Instead, Peter consistently expressed his deep admiration and idealization towards me. This idealization seemed to serve as a defense mechanism.

His projection onto me served to recreate his internal world in the therapeutic setting. Peter's transference showed a strong emotional connection to me, which was likely due to his unresolved feelings toward his mother. He sought from me what he lacked from his mother - emotional validation and support.

My countertransference was also a crucial element in the therapy. Counter transference involves the therapist's emotional reactions to the patient, which can be used to understand the patient's internal world and provide insight into the therapeutic relationship. I experienced feelings of warmth, empathy, and admiration toward Peter, reflecting my transference projection. In my countertransference experience, it appears to have entered a position similar to that of Peter, as if becoming his double.

As the therapy deepened his transference was evident in his tendency to view me as a parental figure, particularly as a replacement for his absent father. This was exemplified by Peter's idealization of me and his resistance to acknowledging any negative feelings toward me.

To address these transference and countertransference issues, I worked to create a safe and non-judgmental space for Peter to explore his unconscious conflicts and desires. I also utilized techniques such as interpretation and clarification to help Peter gain insight into his patterns of behavior and the underlying conflicts that were driving them.

Through the exploration of transference and countertransference, Peter was able to gain a deeper understanding of his unconscious conflicts, including his repressed sexuality and his idealization of me as a parental figure. This allowed him to develop a more realistic and integrated sense of self and to work towards resolving his internal conflicts.

Conclusions

Repudiating the belief that older individuals are too defended or fragile to undergo psychodynamic treatment, the patient of the present article was able to make excellent use of therapy, confronting anxiety-provoking material and examining long-held fantasies.

From the traditional psychoanalytic and developmental points of view, he was able to mourn for his past, change his coping style (from primarily involving repression and projection to a more mature one, involving sublimation, suppression, and humor) and accept his life and his true self. Winnicott introduced the concept of the true and the false self. He argues that the true self is the authentic and spontaneous expression of one's personality, while the false self is a defensive facade that is constructed in order to meet the expectations of others in order to maintain relationships or avoid rejection [12].

Moreover, Peter was able to form a good working alliance, and he was able to participate in the full intense analytic experience, including having frequent sessions, tolerating frustration, and looking at himself in new and different ways.

Some of Peter's improvement might be attributed to a "transference cure." Transference and countertransference dynamics are integral parts of the therapeutic process in psychoanalytic therapy. In the present case, his transference and the therapist's countertransference highlighted the importance of addressing unconscious conflicts related to his sexuality, parental figures, and idealization. Through the exploration of these issues, Peter was able to gain insight into his internal conflicts and work towards a more integrated sense of self.

Peter's case illustrates the complexity of melancholy and the interplay of past experiences with the present. The therapeutic work allowed him to explore and address unresolved feelings and conflicts, such as those concerning his relationship with Anna, his parents, and his sexuality. The process highlights the importance of considering unique patient experiences and their meaning in psychodynamic psychotherapy.

The story of this man's analytic therapy is a powerful reminder of the importance of self-acceptance. Through a process of self-exploration and reflection, Peter was able to confront his issues of narcissism and shame, and find fulfillment in his life.

Still, overall, it was a successful psychoanalytic treatment, consistent with the notion that older adults can participate in and benefit from deep psychological work and treatment. It also attests to the ability of older adults to change in meaningful ways.

Indeed, Peter achieved robust results that impacted his life in a very tangible way. Although causality cannot be proven from a case study, the process and outcome here strongly suggest that the treatment produced good results and that psychoanalytic treatment may be just the right intervention for at least some older individuals.

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