Abstract

Patient S. I, 52 years of age came to the hospital for a depressive-anxious symptomatology and somatic symptoms. A depressive syndrome was identified, which was then linked - according to the psychotherapeutic method ‘existential analysis’ - to a deficit in the patient’s “way of relating to life”. The method applied was that of “personal existential analysis”. This aims to find, via a four-step process, a way of expression and action for the adoption of a genuine attitude towards one’s self and in relation with others. In this case, the emotionality was processed in relation to some aspects of the patient’s life: his concerns regarding his health and the tense relationships in his family.

Keyword: depression, personal existential analysis, somatic complaints

1. INTRODUCTION

Existential analysis is a phenomenological and person-oriented psychotherapy method that aims at helping persons to discover a way of life that enables them to give their "inner consent" towards their own actions (Längle, 2012).

In other words, existential analysis can be defined as a phenomenological psychotherapy that means to aid the individual to acquire free emotionality, to reach an authentic internal standpoint, and to find a responsible way of expression and action both with oneself and with others. The main method by which this goal is achieved is called "personal existential analysis" (PEA) (Laengle, 2003).

This therapeutic method focuses on clarifying the emotions that accompany life experiences, as these sit at the foundation of any personal accomplishment and gained freedom - by means of decision making processes. Liberated from emotional experiences, the persons are then able to find an authentic position and attitude towards self and towards the rest of the world. By regaining their own essence, the persons will be capable to respond to the world in a personal manner, for which they give their own consent (Laengle, & Kriz, 2012). By analogy, the existential analysis attempts to mobilize the person’s decisive potentials (Jaspers K, 1963), by activating emotionality (Scheler, 1973), and through dialogic exchange (Buber, 2002) with contextual data (internal and external) (Frankl, 1988).

In this work I will present a clinical case which shows some important clues in treating a patient with a depressive-anxious symptomatology and somatic symptoms from the existential analysis point.

2. CLINICAL CASE

2.1. Anamnesis

S. I., a 52-year-old worker from Sibiu, came to the doctor’s office with a severe depressive anxious symptomatology that had lasted about 6 months, and that was represented by: anxiety, depressive mood and ideation, social withdrawal, numerous somatic complaints (headaches, dizziness, “heaviness in chest “,” difficulty in breathing) and insomnia. His depressive-anxious symptomatology debuted two years before, during a medical check-up performed in the emergency service for the onset of some respiratory symptoms, when he was told that he had a “respiratory insufficiency” and that his history showed a previous "acute myocardial infarction".

This information on his health state was brutally delivered to him, and he was not given further details so as to understand the nature of his conditions; then he was recommended a treatment for his respiratory problem.

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(tobacco-use related chronic bronchitis) and was not advised to search any speciality evaluation or treatment for his cardiac problem. Even though he underwent a cardiac check-up where the specialist invalidated the presence of an infarction in his medical history, the patient started to believe that he had serious cardiac and respiratory problems, which led to the onset of an intense depressive-anxious symptomatology.

During this time, he experienced a decrease in his ordinary activities as well as social withdrawal as a result of the occurrence of his depressive-anxious symptomatology and somatic preoccupations (“heaviness in chest”, “difficulty in breathing”). This has had an impact on the patient’s personal life as well. As a consequence, he started harbouring feelings of guilt and thus his depressive-anxious symptomatology sharpened. In a session the patient ask himself “Where am I in my life?”

The patient was admitted twice to the psychiatric clinic, he was administered an antidepressant treatment during that time. However, the symptoms did not improve but, on the contrary, they worsened, which is why the patient has asked for repeated consultations in view of a change of therapy.

**Diagnosis**

From the existential analysis standpoint, the patient presents a deficit in the second fundamental motivation that revolves around the “enjoyment of life” (Laengle, 2003); there has also been identified the presence of a “depressive syndrome” that is part of a “Major depressive episode” (DSM IV TR, 2000).

In this case we see that his relation to values is disturbed, he no longer feels life has value. When sunk into depression, the patient must offer an answer to the question: “I am alive, but do I want to live?”, “What is it like to be alive? Do I like it?” If the answer is “Yes”, but the affirmative answer is not completely certain, then it hides some suffering, usually dealing with a loss of love for life, which has as a consequence the decrease in the motivation to see the beautiful side of life (Laengle, 2003).

2.2. Actual psychotherapeutic interventions (PEA)

The personal existential analysis method (PEA) illustrates the application of existential analysis in the individual therapeutic practice. The person exists in a four-stage dialogic exchange with the world. These stages constitutively mark the three fundamental abilities of man’s networking at a personal level, and create the access to the internal (the self) and external (relationship) realities of the person.

- **PEA 0** (the preliminary descriptive phase) - description of the facts/social issues (Laengle, 2003)

  The home environment of the patient consists of: intra-familial relationships are somehow harmed by the conduct of a son who has behavioural issues; the relationship the patient has with his daughter and his wife is tense due to the difference in opinions related to family priorities, financial investments etc. Besides these, he and his family (4 members) live in a small apartment with 2 rooms (including the kitchen) ranging around 40 m².

  In addition, there were some extra tension between him and other members of the family owing to his social withdrawal and the presence of multiple somatic complaints (which the family doubt they really exist). The patient feels a deep sense of guilt because of his agoraphobia that keeps him from travelling, which in turn makes him unable to visit his ailing mother. The patient’s professional life has also been afflicted by recent increasing tension with management and colleagues, due to his prolonged medical leaves.

- **PEA 1** (taking an attitude) - the integration of impression in personal emotionality (Laengle, 2003)

  At the first episode the patient manifested strong resistance in terms of coping with reality. His hospitalization periods were long because of his persistent symptoms. However, there were some clues relating to the existence of a functional component of his somatic symptoms (headaches, dizziness, thoracic discomfort).

  The patient was subjected to a multitude of investigations: he did present a low degree of respiratory insufficiency that had developed in connection with a turn for the worse of his chronic tobacco-related bronchitis, and his myocardial infarction was later invalidated by specific analyses.

  The patient was shown that all of his somatic manifestations are expressions of his act of running away from himself, that it was better to see reality as it is - the fact that he had an actual pain - and to observe the reality of his family life, that his familial and social relationships were deeply disturbed, and his home and job related activity was also in disarray.

- **PEA 2** - taking an internal stand (integrated emotion - emotional theory) (Laengle, 2003)

  The patient blames himself for all kinds of mistakes. His conscious mind is marked by the predominance of the “possible”. However, he does not adhere to what he truly sees, he does not actually live and act (“the representation of reality”), as he lives amongst suppositions. There is nothing left to say when people make suppositions, as they take into consideration various possibilities. What is characteristic to depressive people, however, is their supposition regarding reality itself. The hypothetical is already settled inside their minds as reality.
There is an excessive preoccupation for the somatic complaints regarding the head and thoracic area of the patient (his breathing and heart). Although he is aware of these diagnoses and has been told that they were not high risk, he insists on speaking about the same symptoms and worry on because “he does not know why he feels what he feels, why it hurts, etc.”

The therapeutic remedy consists of an immersion with the patient in his world of possibilities, and then of a discussion which is meant to evaluate his true possibilities. In order to stabilize his condition, he is given some situations to solve as homework.

- PEA 3 (taking an external stand) - finding an appropriate response that induces an action (Laengle, 2003)

There is a series of conditions that are necessary in order to form a correct perception of the fundamental value of life, the most profound impression about the value of life itself. One of the most important condition is establishing relationship. Relating is like a declaration of love made to life itself. It is only the decision about life (even the unconscious one) that enables people to relate (Laengle, 2003).

Hence, the therapy relies on emphasizing and revitalizing relationships, making the strength and pain entailed by relationships accessible, as well as making contact with life by actually experiencing feelings of both mourning and joy. Knowing that the patient used to be a sportsman (rugby), he was then advised to take up some sports activities in his spare time - the patient thus started to practise invigorating gymnastics and to establish a relationship with nature by taking long walks in parks. He was encouraged to get close to those people whom he temporarily lost communication with his family. In order to do that, he was urged to rebuild his position within the family by setting up some open relationships and taking suitable decisions to unblock certain tense situations. To this end, it is recommended that the patient be shown the importance of giving the self some time, of taking the time to do those activities that awaken some of his interest.

Two months after starting medication therapy with antidepressants, as well as psychotherapy, the patient started to feel more relaxed and have less physical complaints, his sleep pattern improved, his communication became more efficient, and he started to get involved in house chores.

3. CONCLUSIONS

Depression is a mental disorder that can have a great potential of becoming chronic or recurrent if not treated by a psychotherapist. In this case, psychotherapy has had an important contribution in the positive evolution of the symptomatology, due to the existence of some relational issues within the family of the patient, and in the presence of a decreased decisional capacity of the patient, which required therapy; also, the somatoform complaints that did not benefit from a specific pharmacological therapy could be alleviated only through a psychotherapeutic approach.

4. REFERENCES