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The Masked Depression of Elderly Cameroonians: Modelling the Split Between Body and Psychè, and Outline of Clinical Analysis

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Abstract **Review Article**

For older adults, depression, a major issue in gerontological practice and public health today, constitutes a subjective suffering that does not always present in its "classic" form (sadness, crying, guilt, suicidal thoughts). It expresses itself differently from depressive pseudo-dementia, which is an objectively observable deficit that is most often trivialized, but with which it can coexist. It is often atypical, or rather masked, split between latent depressive affect and visible symptomatic expression, which makes diagnosis more difficult for clinical psychology, insofar as classic depressive syndromes are either not expressed or are expressed differently or insufficiently. What could be the reasons why? Is this due to a pathological rather than a defensive or integrative reorganization of the bodily self - that is, to the subjective transformation of existence and the reconfiguration of bodily and psychic experience following the involution associated with aging, as found in the works of Freud, Schilder, Lacan, Dolto, and Anzieu, who present the body both as the support of the subject's psychic identity and as the seat of their narcissistic foundations? Is it due to psychic defence mechanisms such as denial and somatization? Is it due to sociocultural norms that value the restraint or concealment of emotions in older adults, or to various comorbidities? The clinical psychopathological model adopted in our research (the geriatric depressive masking model) is holistic or synthetic: it unifies the bodily self, narcissism and the cultural anchoring of the subject, taking into account - **a)** - the damage to the aging bodily self, - **b)** - the narcissistic wounds arising from the experience of this aging, with the symbolization or not of the suffering, and - **c)** - the sociocultural mediation of the expression of this suffering. The main hypothesis of our work is thus formulated as follows: in the elderly African subject (Cameroonian in particular), depression can be masked (masking being a dynamic process of displacement from the real depressive core to its visible symptom) and it reconfigures itself in a plurality of forms (somatic form, anxious form, pseudo-dementia form,…) under the simultaneous effect of a disorganization of the bodily Self and a desymbolization of the depressive affect which then moves towards the body; and this desymbolization manifests itself within the framework of a socio-cultural context in full change, and a loss of symbolic recognition.

Keywords: depression, melancholia, masking, narcissistic injury, bodily self, depressive pseudo-dementia, aging, somatization, symbolization.

I - INTRODUCTION

At the outset of our reflection, we will obviously return to these lines by Jack Messy (1992, **The Elderly Person Doesn't Exist**, Petite Bibliothèque Payot, p. 22): *"Should we be afraid of growing old? To ask the question is already to implicitly acknowledge the existence of a fear. How cant' we be afraid of what is similar to death? Growing old has an impact on our temporality,"* and this places us at the heart of aging, an irreversible process that inscribes the individual's life in time, that is, from birth to its destruction in death. Aging, which is thus inscribed within the framework of the individual's temporal experience, certainly refers to a semantic duality, that is, to two opposing connotations, which recall the two drives or the two vital processes at work according to Freud: the death drive and the life drive. The first connotation, negative, evokes wear and tear, weakening, Involution, diminution, regression, and destruction - losses, both qualitative and quantitative, with regard to capacity (degeneration) and value (devaluation) - are twofold. The second connotation, positive or ameliorative, evokes improvement, maturation, construction, and acquisition (which refers to investments made in people and beings, investments that shape life and ensure the various capital gains achieved). Jack Messy (*op. cit.*, p. 27), speaking of the imaginary dimension of the ego and its constitution, states: *"The notion of acquisition can be located in the narcissistic*

relationship of the ego to the object, that is to say, in the relationship with other like-minded individuals."

Aging as a process can be interpreted in this way, based on the dynamics of loss and acquisition, and once again, Jack Messy (*op. cit.,* p. 31) can say: *"By bringing together these two notions of loss and acquisition (...), the theme of aging can be considered in psychoanalytic terms through the ego in its movement of identification with objects. In this sense, the ego ages, that is to say, it is the site where the dynamics of loss and acquisition take place*." Therefore, within this dynamic of the aging process, it is the aging subject who must be examined in order to understand the existential psychic suffering that the process, which imposes a test of reality on the ego, can generate in them. Gilbert Ferrey and Gérard Le Gouès (2008, *Psychopathology of the Elderly,* Elsevier-Masson) clearly demonstrate this here: *"For the aging individual, the arrival of the irreversible on the mental stage, associated with the experience of declining performance, induces a feeling of decline, of embarking on a downward slope"* (*op. cit*., p. 5). This loss is indeed equivalent to a loss of control over one's destiny in the face of the ever-increasing decline of one's biology. The awareness of the time remaining calls upon one's capacity to endure decline and to confront the increasingly certain fear of death. How can one age well by facing the present and the losses that must be confronted? How can one age well by resisting the shock to narcissism, which is inevitably eroded by the passage of time?

As regards this point, Gilbert Ferrey and Gérard Le Gouès (*ibidem* , p. 16 and sv.) speak of two essential spirals, *"on the one hand the relationship of Self to Self, or if you prefer, of the Ego to the Ideal of the Ego, and on the other hand the relationship of Self to Other, or if you prefer, of the Ego to others* ," and in this context, the two authors recall the way in which elderly people present their experience and the distortion of the Ego in the face of the Ideal of the Ego: *"I am no longer myself," or again: "I no longer recognize myself in the me of today, the me of today reminds me every day that I am no longer the me of before* ," (*ibidem,* p. 16). If, as Freud shows us, the origin of the Ego is the projection of a *"bodily surface*," then we clearly see: *"During aging, a tyrannical Ego Ideal seriously exposes the subject to the risk of narcissistic depression"* (*ibid*., p. 16). Doesn't the narcissistic deficit and the destabilization of narcissistic structures due to involution, the diminished attractiveness, the possibility that the Superego might create guilt, and various losses (professional, relational, with their risk of isolation and withdrawal, which can be reinforced within certain cultures) predispose the elderly subject to a certain depression, a certain melancholy as a minimal form (a real change in mood with the consequences of moral suffering and psychomotor retardation) in the face of the reality of these losses? The *Larousse Grand Dictionary of Psychology* shows here that, *"sometimes accompanied by anxiety, depression maintains in the patient a painful impression of overall powerlessness, of despairing fatalism, and sometimes leads them to sub-delusional ruminations on the theme feelings of guilt*, *unworthiness, and self-deprecation can lead him to consider suicide and sometimes even to carry it out."* And Henri Piéron (1973, *Vocabulary of Psychology*. Presses Universitaires de France, p 262) elaborates here by speaking of melancholia and showing that melancholia, which appears as a frequent cause of suicide or murder, is *"a very frequent mental illness characterized by a more or less marked depression, a feeling of inadequacy, a disgust with existence which can go as far as ideas of suicide, anxiety and insomnia, and sometimes delusional ideas of self-accusation, unworthiness, etc,... It sometimes occurs without apparent reason in connection with a manic-depressive psychosis, sometimes following emotional shocks (reactive melancholia) sometimes under the influence of pre-senile involution."*

II - PROBLEM STATEMENT AND GENERAL HYPOTHESIS

This, then, sets the psycho-sociological environment of our work. Indeed, the elderly person, due to multiple losses (disruption of the relationship of self to self and devaluation of the Self in the face of the Ego Ideal with risk of narcissistic depression and decrease in sublimations which can *"reinvigorate healthy narcissism",* Gilbert Ferrey and Gérard Le Gouès (*ibidem* , p 17), professional losses, relational losses with withdrawal and refocusing on oneself of the elderly subject, and modification of the social gaze and the relationship to the community in general), the elderly subject therefore finds themselves subject to multiple forms of depression, the socio-cultural context, with its norms, does not always allow for an appropriate verbalization or expression of the psychic suffering it causes.

II - 1 - Formulation of the hypothesis

In older adults, the expression of depression is generally masked. Therefore, based on an articulation of the bodily, the narcissistic, and the cultural and social (a three-part model of the clinical subject linking - **a)** identity continuity, **- b)** narcissism, and - **c)** socio-cultural recognition), we formulate the central hypothesis of our research: Depression, a mood disorder whose main aetiologies stem from biology, psychic dynamics, narcissism, culture, and society, provokes a crisis of meaning and leads to a disorganization of the link between body, psyche, and culture. As a multidimensional process with varied forms of expression and multiple aetiologies, it causes a serious disturbance as regards symbolization of various losses and, more generally, an alteration of the relationship to oneself, to the world, and to time.

II - 1 - 2 - Multiple deployment of the general hypothesis

The forms in which depression reveals in older adults are numerous: somatic or hypochondriacal depression, anxiety depression, pseudo-dementia depression (depression with cognitive impairment), apathetic or aboulic depression, behavioural depression, delusional depression (melancholic depression), and addictive depression. These forms of depression in older adults often present as masked or atypical symptoms, which greatly complicates diagnosis in geriatric clinics. We are thinking particularly of socio-cultural contexts where psychological expression is more often conveyed through the body or social interactions than through emotional verbalization, and it is from this perspective that our research takes on its full meaning: depression in older adults, with its identity, narcissistic, and socio-cultural implications, can exist, but it is not expressed in a single or straightforward way. Hence the need to take in consideration all aspects of aging: the psychosomatic as well as the socio-cultural aspects.

II - 1 - 3 - Our hypothesis, in the modern African context

Could the aging process, as a holistic phenomenon, unfold without taking into consideration our rapidly changing context, focusing solely on the biological or psychological aspects, given that it is surrounded in a socio-cultural dynamics where traditional uses and values and the demands of modernity coexist? We hardly believe so, and this is why we move beyond the traditional Cameroonian view of aging, which almost unilaterally insists that growing old necessarily goes hand in hand with the accumulation of wisdom, the calming of passions, and the fading of bodily desires, with old age becoming a time for reflection, knowledge, and the art of being…

III - THEORETICAL FRAMEWORK AND LITERARY REVIEW

III - 1 - AXES AND DYNAMICS OF THE RESEARCH MODEL

The model we refer to in our research, which focuses here on the masked forms of depression in the elderly, functions in an integrative way, as we have seen in the preceding lines which outline it, along three main axes, which are fundamentally intertwined and interacting:

- **has) - the body axis,** the body being the support for the expression of the psychic suffering of the elderly person in a situation of depression (a weakened bodily self: biological aging, somatic pains and alteration of the body image);
- **b) - the psychic axis** (which takes into account the damage to narcissism and identity: loss of role for example parental, economic, social, narcissistic damage and feeling of uselessness, with the collapse of the feeling of subjective existence);
- **c) - the socio-cultural axis**, which takes into account the modification of family and cultural structures and representations in general, (loss of the symbolic place of the elderly, erosion of traditional solidarities, devaluation of the status of the elderly…

The semantic duality we mentioned earlier, which unfolds in the two opposing connotations of aging, is then taken up again, essentially in its negative connotation, generating depression in the elderly, the main features of which we will outline below. This does not, however, obscure the reality of the positive or ameliorative connotation, insofar as the elderly person experiencing depression can fight against this depression through sublimatory solutions (notably sublimation through intellectual and artistic investment) as well as resort to defence mechanisms (such as repression, denial of external reality, projection or idealization, narcissistic defences, etc.).

III - 2 - AUTHORS FACING THE DEPRESSION ISSUE

A - Sigmund Freud

In his text *Mourning and Melancholia* (1915a), *in Metapsychology*, Paris, Gallimard, Collection Idées, 1976, Freud indeed uses the term melancholia to describe depression, presenting it as a problem of mourning, loss, narcissism, and intrapsychic conflict. To begin, Freud distinguishes between normal mourning, which refers to: **a)** the psychic reaction following the loss of a loved one, an ideal, or a status; **b)** temporary withdrawal from the outside world; and **c)** the progressive psychic work of disinvesting from the lost object. It is from this point that Freud will discuss melancholia, which certainly resembles mourning but in its pathological form, with the following components: the internalization of loss within the ego (the lost object incorporated into the ego and the turning of aggression directed towards the object against oneself), self-devaluation, excessive guilt and self-accusations, the desire for punishment, and suicidal tendencies… Depression, whose origins are psychodynamic, will then refer, for Freud, to a narcissistic injury (loss of love or ideal, ambivalence of love/hate towards the object, collapse of self-esteem, emotional dependence, libidinal frustration and emotional dependence, conflict between the ego and a persecutory superego…)

To explain depression, Freud links it to an unconscious need for punishment (expiation, self-punishment, masochistic satisfaction, etc.) of a weakened ego dominated by the superego; it then becomes the suffering of loss where hatred for the lost object turns against the subject himself. It is therefore the conjunction of mourning, narcissism, guilt, redirected aggression, and object loss. Applied to aging, which is an accumulation of losses as Freud shows in *Mourning and Melancholia* (*op. cit.*), depression then refers, through the lens of narcissism, to an examination of aging as experiences of cumulative losses (loss of loved

ones, objects, professional or narcissistic status, the role of elder, the reshaping of the body image, the experience of abandonment, and the conflict between tradition and modernity, particularly in Cameroonian society, the awareness of finitude, etc.) with a weakened mourning process. Depression can then manifest itself in older people in various masked forms: somatic complaints, hypochondria, irritability, self-deprecation, apathetic withdrawal, overinvestment in the painful body, exacerbation of the feeling of guilt…So specifically in older people, depression occurs when the psychic work of aging (mourning objects and people, the body and ideals) is transformed into melancholization of the Self.

The psychodynamic hypothesis derived from the Freudian view of depression can be presented as follows: depression whose masked forms correspond to defensive mechanisms is a displaced suffering (displacement of the conflict and return of this conflict itself in a symptomatic form), converted or disguised in other psychic or somatic manifestations, or else in silent melancholia. Depression, as suffering referring to an impeded mourning process for losses, to a narcissistic fragility linked to aging, to masking through somatic, pseudo-cognitive, relational means, or within the framework of the pressure of the Superego on the Ego, speaks or presents itself in a completely different way: it is not extinguished.

B - Françoise DOLTO

Françoise Dolto, whose thought can be considered in dialogue with Freud's, offers interesting perspectives on understanding depression as a psychic suffering that marks the subject's fundamental disruption to their vital desires and life dynamics, with a collapse of their subjective drive. It is thus a displaced, encrypted psychic suffering, a psychic suffering that expresses itself differently. Françoise Dolto presents four axes of perspective: the axis of desire (loss of desire masked by bodily complaints), the axis of narcissism (hidden narcissistic collapse), the axis of lack (the body experienced as emptied or fragmented), and the axis of the relationship to the body and its unconscious image.

Speaking of the unconscious body image affected by depression as a central concept in her thinking, Françoise Dolto clearly shows that the various symptoms that appear (chronic fatigue without sufficient organic basis, diffuse pains or hypochondria, irritability or defensive aggressiveness, inhibition without verbalized sadness, compensatory overactivity, eating disorders, silent self-devaluation and self-sabotaging behavior…) are then to be interpreted less as simple dysfunctions of an organic nature than as a true language, due to the subject's inability to symbolize their pain other than through the body which now "speaks depression" : psychic suffering is thus translated into somatic language, the symptom taking the place of speech, according to the following articulation proposed by Françoise Dolto: **-** a) – unsymbolized loss - b) – narcissistic injury, - c) – disorganization of the body image, - d) – symptom masking depression.

Psychological depression thus appears under various masks: **a)** somatic masks (pain, asthenia, functional disorders, bodily preoccupations), **b)** character masks (anger, irritability, rigidity, hostility), **c)** relational masks (emotional withdrawal, excessive dependence, enmeshed needs, repeated conflicts). Generally speaking, the mask proves protective: it protects against psychological collapse. The bodily complaints of the depressed elderly person mask a narcissistic loss, while their somatic preoccupations mask their loneliness and various losses, with irritability replacing sadness and psychomotor slowing being interpreted as simply related to aging. We could thus put Freud and Dolto in dialogue or correspondence, specifically with regard to the masked depression of the elderly (displacement of the psyche towards the body or towards behavior), the loss of object, melancholy and the turning of the subject against himself in Freud finding their equivalent in Dolto in the somatic complaints which cover desire, loneliness and mourning and transform into somatic language psychic suffering.

C - Donald Winnicott

Winnicott starts from the fundamental idea that, for people experiencing depression, the goal is to avoid psychic collapse; in these cases, depression appears as a defensive mechanism, a mask for the fear of collapse. Furthermore, Winnicott argues that this masking of depression occurs through the false self constructed by the depressed person to conceal the depression (even though the individual is internally empty), to continue appearing adapted, functional, and above all, dignified. This explains: **a)** the trivialization of complaints, - **b) -** over-adaptation (to combat inner emptiness and libidinal withdrawal) and hyper-conformity, and - **c) -** an artificial self-sufficiency manifested by a defensive smile.

For older adults specifically, psychological collapse can be triggered by the aging process itself, dependency, physical frailty, bereavement, and other factors. Aging weakens what Winnicott calls internal holding, creating a diffuse anxiety that fuels feelings of abandonment, regressive vulnerability, and loneliness, ultimately disorganizing the individual. Masked depression thus emerges as a genuine defence against psychological collapse, a masked defensive organization (somatic masks, character masks, false self, and pseudo-dementia). This suggests that Winnicott's work reveals defence mechanisms against depression that are more or less identical to those we identified in Freud and Françoise Dolto.

D – Jacques LACAN

Several Lacanian concepts can be used to organize an appropriate clinical reading of depression in general, and of masked depressions in the elderly in particular. For Lacan, depression, which fundamentally

stems from the logic of lack and therefore from the loss or losses to which the elderly subject is violently confronted (bodily alterations, loss of loved ones, loss of social status), is a present, real suffering, but one that is expressed differently, that is, with another mode of symbolization (the body, as the site of the symptom and the inscription of loss in the body, and a return to the real through the mediation of the somatic, inhibition as silent withdrawal and disengagement). Mood disturbance and the logic of melancholia then take on an important dimension through certain forms of depression (self-devaluation and loss of value, guilt and feelings of ruin) which, according to Lacan, allow us to consider depression that masks sadness as a "subjective modality of processing a lack, a loss, or what he calls a vacillation of desire." In the masking of depression, it is therefore fundamentally a "troubled relationship to desire, to lack, to enjoyment".

According to Lacan, masked depression thus refers to an inhibition of desire that takes symptomatic forms he considers displaced (somatization, apathy, bodily complaints, hypochondria). And if aging weakens the imaginary unity of the self due to the narcissistic wound to the image of the self, which provokes a silent self-deprecation, somatic complaints, for example, will serve to mask this wound. But it is not only the somatic order that comes into play in depression here; there is also the symbolic order, with, for example, memory complaints, where depression is linked to various losses that create what can be called a "symbolic vacillation," which indeed constitutes a fracturing of narcissistic identity.

E - Didier ANZIEU

Didier Anzieu's contribution to the reading and understanding of masked depressions in the elderly (depressive somatization, attempts at psychic restoration through complaints and the body as a place of broken symbolization) adds to or complements in an appreciable way the readings of Freud (who emphasizes losses, the work of mourning and melancholy), of Lacan (depression as a mask of desire), and of Winnicott (whose thought is centered on holding, the false self and collapse).

Lacan's contribution can be taken from analysis and implemented into clinical practice (where the care of depressive affect and the repair of the psychic envelope are intertwined) with an emphasis on listening to bodily complaints as the language of depression, on bodily mediations, on supporting aging narcissism, and on working with relational envelopes. This enables us to say that, for Anzieu, masked forms of depression as regards the elderly persons are interpreted as a call for containment in the face of suffering and the damage to the ego-skin, which is constructed from a containing, protective psychic envelope derived from bodily and relational experiences, an envelope that is reshaped and weakened by aging. The somatic, characterological, or relational symptom (the shift from manifest depression to masked depression, with an alteration of the subject's lived relationship to his body image and therefore to his world) then functions as a supplement to a psychic envelope weakened by the aging process.

After this brief review of depression in the elderly in the five authors we have chosen as references, we can then develop a picture of the masked forms of depression in the elderly around our general hypothesis based on a number of themes including the way in which the subject experiences their body, the image of this body for the subject, their narcissistic experience and that of their temporality, (that is to say the way in which the subject perceives and represents themselves, feels, their relationship to the other, to others and also their relationship to the community as a whole).

III - 3 - TABLE OF MASKED FORMS OF DEPRESSION

	Depression	Manifestations
1	**Somatic or hypochondriacal form**	- In the foreground, physical complaints (diffuse pain, lower back pain, headaches), then digestive problems, and fatigue, which testify to the weakening of the unconscious body image, - Multiple medical consultations without any organic cause found or proven, (body, language and symbolization: what is not symbolized is expressed in the body, cf : Dolto) - Excessive preoccupation with health on the part of the individual, - Exclusive focus of the subject on the body, hyperattention) which becomes a mouthpiece for the disengaged unconscious…, disorders, muscle tension;
2	**Anxious form as psychological tension**	- Identity disturbances: intense anxiety, agitation, excessive worry and fear without a clear object, with rumination and hypervigilance - Fear of the future (fear that something threatening could happen), insecurity, - Sleep disturbances, insomnia, associated somatic complaints, loss of appetite; - Panic attacks, anxiety as a signal of a conflict or psychic danger (Freud); - Anxiety masking sadness.
3	**Pseudo-dementia form (depression with cognitive impairment)**	- Cognitive manifestations take central stage; - Memory, attention, and concentration problems, and loss of mental energy; - Intellectual slowing, attention difficulties, slow thinking, executive dysfunction (initiative and organization); - Possible resemblance to dementia (Alzheimer's disease), sadness rarely verbalized;

	Depression	Manifestations
		- Rapid installation method with significant complaints from the patient himself) ...
4	**Apathetic or aboulic form**	- Loss of vital energy, decreased emotional reactivity, disinterest, social withdrawal, feelings of emptiness, self-devaluation, feelings of guilt; - Emotionally blunted subject, lack of engagement; - Loss of initiative, apparent indifference (possibly confused with normal aging)
5	**Behavioral form**	- Atypical form of expression of suffering characterized by excessive irritability, unusual aggressiveness, (anger, sensitivity, hostility, insufficient symbolization of affect; - Refusal of care by the individual, - isolation, relational disengagement but increased dependence… - Overall change in habits regarding diet, hygiene, etc…
6	**Delusional form (melancholic depression)**	- Radical damage to the Self and organization of depressive suffering into delusional ideas and convictions related to mood: delusions of guilt, ruin, unworthiness, and depression; - High risk of suicide and nihilistic delusions…
7	**Addictive form**	- Depressive suffering expressed through addiction, compulsive use of an object, substance, or behavior with the aim of numbing psychological pain, providing relief, and achieving self-regulation - Fighting against emptiness, anxiety or depressive collapse through the mediation of addiction to certain substances (increasingly accelerated consumption of alcohol, medication) or to behaviors; - The depressive core is therefore masked, with the thymic suffering shifting towards a compulsive addictive behavior.

IV – OPERATIVE FRAMEWORK

Our operational framework includes a section presenting several clinical cases illustrating masked forms of depression and an analytical section on these forms of depression. Depression will be presented here: - **1** - in its somatic expression, - **2** - within the context of pseudo-dementia and narcissistic wound (the significance of aging), - **3** - in its apathetic form, and - **4** – in its delusional form, that is to say, the culturally specific form of anxiety. The analysis of the data gathered from the interviews will be based on the work of our key authors (Freud, Dolto, Lacan, Winnicott, and Anzieu), in order to better understand the various psychological mechanisms (adaptive, defensive, or pathological) used to mask depression in older adults. These mechanisms are employed by these individuals in the context of displacing the actual depressive core to its visible symptom and in the reconfiguration of depression into a plurality of forms within a rapidly changing sociocultural context. This explains our choice of four types of vignettes illustrating depression in older adults.

IV – 1 - CLINICAL VIGNETTES

A - Clinical vignette nº I. The depression masked in its somatic expression: "The body that speaks". The painful body.

Contextual elements: - **Mrs. Hermine**, 72 years old, widowed following the recent death of her husband (2 years ago). She lives very modestly and alone on the outskirts of the city of Yaoundé, after having previously been a trader, in progressive social isolation and a loss of economic role.

Reason for consultation: Ms. Hermine complains of diffuse pain, a "heat in her head," persistent fatigue for the past eight months, and severe insomnia. Multiple consultations with formal healthcare providers (health centres) and traditional healers have failed to identify any psychiatric history or identifiable organic cause.

Speech: Madame Hermine's recurring speech is presented both in the following terms: "my body is finished", "the medicines do nothing", "my whole body aches, especially at night; I can't sleep anymore, I'm suffering too much", and in this disillusioned assessment: "the doctors say I am in good health, but I feel that something is wrong, I don't feel like I used to."

Clinical observations: A physical examination of Mrs. Hermine appears entirely normal; her gaze is sad, but she does not verbalize this sadness. Psychomotor retardation is also noted. Mrs. Hermine rarely discusses her emotions, but she talks extensively about her chronic pain, for which there is still no real explanation.

Analysis: Madame Hermine is experiencing a masked depression with bodily expression: the body then becomes the culturally legitimate language of suffering; this is indeed an overinvestment of the body as a support of expression; but this overinvestment of the body constitutes a denial of psychic suffering, a translation, that is to say a transformation of loss into bodily pain, and at the same time a priority recourse to the somatic register which does not pose a socio-cultural problem because it is considered more legitimate with regard to the expression of suffering.

Clinical interpretation: The pain that Mrs. Hermine The feeling at the level of the body constitutes a somatic translation of unprocessed grief; the body then becomes the place of inscription of an unsymbolized loss, as Françoise Dolto shows; what is not symbolized is expressed through the body.

B - Clinical vignette nº II: The depression taking the form or the mask of failing memory and pseudo-dementia.

Contextual elements: Mr. Kevin, aged 72, is a former civil servant, now retired, living with his family in the countryside, in a certain precariousness given the modesty of his income and in a relatively closed manner to contact with his entourage.

Reason for consultation: Mr. Kevin complains of memory (neurocognitive) problems that appeared over three months.

Subject's speech: Mr. Kevin repeats endlessly: "I'm going crazy," "I'm no longer useful"; "I'm losing my mind," "I'm forgetting everything now," "I don't recognize myself any more, I'm not the same as before."

Clinical observations: At this stage, significant memory complaints are evident. The cognitive tests Mr. Kevin underwent were negative, but his thinking remains incoherent, and he frequently answers questions with "I don't know." The intense anxiety he exhibits appears to be linked to both significant fluctuations in performance and difficulties concentrating, as well as general psychomotor slowing. Having recently retired from the civil service, Mr. Kevin is therefore experiencing both a loss of status and a strong sense of uselessness.

Statements from his family and friends. Mr. Kevin's family and friends say, without any medical basis, that he has Alzheimer's disease…

Analysis: Mr. Kevin is suffering from severe depression with cognitive inhibition, and his depression is manifested here as cognitive deficit. Mr. Kevin's frequent complaints, in which he no longer recognizes himself, reveal a rapid onset of depression, unlike dementia, which develops gradually. His depression has shifted from the body to cognitive functioning, and his suffering has also shifted to a neurological level, based on the social value placed on intellectual performance.

Clinical interpretation: - Mr. Kevin's massive and recurrent cognitive complaints actually constitute an acceptable form of narcissistic collapse: this is indeed masked depression with pseudo-dementia expression, which must obviously be distinguished from Alzheimer's disease.

C - Clinical vignette nº III: "Silent withdrawal": persistent anxiety as a culturally apathetic, socially inserted form of depression.

Contextual and cultural elements: Mr. Jonathan is a 75-year-old retired civil servant who returned to his village upon retirement, where he lives with his extended family. He is a respected and even feared traditional chief. Mr. Jonathan is experiencing a serious erosion of his prestigious social status as a traditional chief, but this symbolic devaluation is linked to the very process of aging.

Reason for consultation: Mr. Jonathan has paradoxically withdrawn into silent social isolation and relative muteness.

Persons close to him describe him as follows: "He no longer speaks"; "He is no longer interested in anything"; he appears completely disinterested in everything despite the responsibilities associated with his position as a traditional ruler and this cannot coexist with silent social withdrawal and any kind of muteness…

Clinical observations: Mr. Jonathan exhibits significant apathy (emotionally blunted) linked to a loss of vitality, initiative, lack of engagement, and decreased emotional responsiveness. Mr. Jonathan rarely complains; in fact, his complaints are not verbalized or spoken. His diffuse anxiety seems to partly explain his social withdrawal, which is incompatible with his traditional responsibilities, his feelings of emptiness, his self-deprecation, and also his sense of contributing to it. His loss of initiative and apparent indifference can nevertheless be considered part of normal aging.

Analysis: The apathetic or abulic form (impairment of will) of the Mr. Jonathan's depression is nothing more than a form of subtle depression characterized by a near extinction of psychic and motor drive and by an apparent insufficiency of affect.

Clinical interpretation: For Mr. Jonathan, this is linked to his physical aging (impairment of the bodily self as a power to act, a heavy body lacking momentum), a profound inhibition of the self (narcissistic wound), masked emotional suffering, a loss of investment, and a culturally apathetic form of depression. Indeed, there is a real risk, when making a diagnosis, of confusing this apathetic or aboulic form of depression with frontal dementia.

D - Vignette nº IV: The anxious and culturally shaped form of delusional depression in a sociocultural context: "The accusation of old age witchcraft".

Contextual and cultural elements: Madame Jeannine, a widow, is 75 years old; a farmer all her life, she now lives in the countryside with her extended family.

Reason for consultation: Accused of witchcraft by those around her, Madame Jeannine is brought in for consultation due to internal tension, agitation, anxieties centred on the body (bodily oppression), the family (relational or family fears) and the future, and constant worry.

Patient's statement: Without any formal justification to support her claims, Madame Jeannine declares: "I have hurt my family," "I deserve to be punished"; "I have committed an unforgivable sin."

Clinical observations: the depressive core is clearly present, therefore it is indeed a melancholic depression with delusions of guilt, and the discourse reveals culturally mediated forms of anxiety, as well as mystical, religious, and persecutory preoccupations. This means that the discourse is entirely consistent with the local cultural context: the social dimension is inscribed in the very form of the symptom.

Analysis: melancholic dependence with delusions of guilt, a guilt more or less founded with regard to the subject's responsibility, a delusion taking a culturally mediated form. Delusions of guilt may be associated here with delusions of ruin, delusions of unworthiness or damnation, and nihilistic delusions…

Clinical interpretation: For Mrs. Jeannine, this is a delusional depression with psychotic characteristics (delusional guilt according to Freud) in a cultural context, and this nihilistic depression is a psychotic one because the relationship to reality is highly altered or modified.

IV – DIAGNOSTIC AND CLINICAL CONTRIBUTIONS

IV - 1 - ANALYTICAL AND DIAGNOSTIC

Referring here, for example, to Anzieu and the suffering of the skin-ego, we can see that the imbalance between the real body (aging and subject to all forms of fragility), the symbolic body (viewed from the perspective of social status), and the lived body (subjective experience and narcissistic wounds) produces, as simultaneous and sometimes cumulative effects, the somatization of depression, withdrawal, pseudo-dementia, and culturally structured delusions. This transcends the usual opposition between the organic and the psychic, with the added integration of the cultural as a structuring element of symptomatic expression.

In short, depression presents itself as an embodied language, with somatic, characterological, or relational symptoms functioning as a supplement or substitute for a psychic envelope weakened by aging. This clearly highlights the central nature of the translation process that unfolds in somatization, for example. The reason we are discussing the analytical and diagnostic contributions of the theoretical study of depression and its possible manifestations in masked forms is due to the risk of confusion in diagnosis between depression and dementia, as the two phenomena can resemble each other (particularly in the context of depressive pseudo-dementia), coexist, or even mask one another. This is why we propose here a brief comparative table between depression (impairment of desire and vital impulse, distress) in the elderly and dementia (impairment of initiative and organization of action), based on data from Freud, Anzieu, and Donald Winnicott, from a psycho-dynamic perspective, with regard, for example, to the mode of onset, the awareness of the disorders and the various risks, for the elderly.

Comparative table of depression and dementia

Criteria	Depression (distress)	Dementia
Onset and progression of depression	A rapid, and often brutal, onset of depression frequently linked to an event such as bereavement or the onset of illness. Potentially reversible	Slow, progressive, and insidious onset. Slow loss of autonomy and progressive disorganization. Continuous, irreversible, and cumulative evolution of deficits.
Request and status of the subject, verbalization	Complains a lot about her body, somatizing suffering, object loss, narcissistic injury, hindrance to the grieving process; insistence on various deficits	Minimizes or even denies the disorder, verbalization is appro-ximate or more or less tinged with fabrication, weakens the self, and causes anxiety about disintegration.
Awareness of the disorders	Present but weak/fragile (hypo-consciousness), partial, or denied consciousness; awareness of diminished self. Depression exacer-bates executive function disorders: inability to desire or act. These disorders are seen as related to aging (Donald Winnicott, Jacques Lacan).	Altered consciousness (anosognosia is common), but present at the beginning, particularly in the case of Alzheimer's disease, progressive loss or fluctuation of awareness of the disorder and misrecognition or trivialization of deficits, and indivi-dual overestimating their abilities.
Memory	Difficulties and attention disorders (pseudo-disorders) linked to psychomotor slowing. Difficulties in retrieving memory material and complaints from the subject.	Actual cognitive impairment, especially with regard to recent memory, possible disorientation, impaired memory encoding, aphasia, apraxia, agnosia.
Mood	Sadness, anxiety, moral suffering, melancholy and delusional awareness of disorders, pessimism, imagined ruin, anhedonia,	Indifference or labile mood, low awareness of deficits, concealed or ignored; irritability and possible blunting of mood, less congruent affects.

Criteria	Depression (distress)	Dementia
	thoughts of possible death, difficulty making decisions.	
Motivation	Strong inhibition, impaired avolition and decreased motivation; loss of initiative, lack of effort and mental fatigue, passivity and loss of initiative, difficulty deciding and paralysis of choice, apathy not necessarily being depression.	Effort sometimes maintained but ineffective, impaired initiative and not simple demotivation, motiva-tional executive disorders, dys-executive syndrome affecting frontal functions enabling planning, organization, adaptation, apathy…
Language	Slowed, impoverished, and inhibited speech; reduced verbal spontaneity, poor associations, and delayed responses, loss of the impetus for speech. The subject speaks little because of disengagement and a general poverty of discourse. The subject suffers in and through their speech (Jacques Lacan). Possible intertwining with dementia.	Progressive disorganization and alteration of language as a neurocognitive function, difficulty finding words, paraphasias and lexical impoverishment, impaired comprehension and discursive disorganization. Symbolic fabric potentially unravelling and comorbidity of depression and dementia.
Pathological perspective	Crisis of the subject, pathology of affect and of the subject's relationship to itself (Freud), attack on the ego and collapse of desire. High risk of suicide, rupture, collapse, crisis. Time experienced as frozen, empty and without future, cessation of lived time. Pathology of lost meaning.	Pathology of the subject's relationship to the world (Impairment of world memory, weakening of identity and disin-tegration/dissolution of symbolic landmarks. Rare risk of suicide (except in the early stages), erosion, slow disorganization of the relationship to the world, fragmented time and blurring of reference points)

IV - 2 - CLINICAL PERSPECTIVES

The table above, developed based on the work of Freud, Winnicott, Lacan, and Anzieu, demonstrates the existence, for clinical psychopathology, of a theoretical and practical framework that necessarily articulates, within analysis, listening to the body - narcissistic restoration - the subject's social reintegration, and the integration of cultural dimensions. It then becomes a matter of listening to the elderly subject and considering that the manifest complaint they express is nothing other than a symptom, and therefore a message to be decoded. The table shows, in this regard, that depression (a pathology of affect and of the suffering subject in their relationship to themselves) and dementia (a pathology of cognitive functioning and the subject's relationship to the world), which can sometimes present similar manifestations and even be associated (depression-dementia comorbidity), must be distinguished with regard to their clinical management.

V - CONCLUSION

Following our research, we can affirm that depression in older Africans generally manifests itself in masked forms. Here, depression is essentially a suffering that affects both the body (somatic) and the entirety of the individual's relationships with themselves, others, and the world. This suffering is inscribed within the transformations of the aging body, social bonds, and symbolic status. In our African context, we must consider a psychopathological reconfiguration with regard to depression. Within this reconfiguration, the body, social bonds, and symbolic status must be considered privileged sites for the translation of depressive suffering into various somatic forms (embodied suffering: Freud and Anzieu), relational forms (social withdrawal, emotional hyperdependence, and the pathology of broken solidarity), and narcissistic-apathetic and pseudo-dementia (affecting the individual's status and sense of meaning). The clinical psychopathological model adopted in our work (the geriatric depressive masking model) is holistic or synthetic: it unifies the bodily self, narcissism, and the subject's cultural grounding, taking into account - **a)** the impairments of the aging bodily self, - **b)** the narcissistic wounds stemming from the experience of this aging, with or without the symbolization of suffering, and - **c)** the sociocultural mediation of the expression of this suffering. Our hypothesis is thus verified: in elderly Cameroonians, depression can be masked due to the displacement of the actual depressive core to its visible symptom and reconfigure itself in the forms we have examined under the effect of a disorganization of the bodily self and a desymbolization of depressive affect.

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