

Application of the OLI IPP Approach in Working with a Woman in Perimenopause: A Case Study Through the Lens of Time

Dr Maja Rueger¹

OLI Centre Ukraine, Kyiv · ORCID: 0009-0005-3632-6541

(professional paper – case presentation)

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Abstract

Aim: This paper aims to illustrate, through a case presentation of a woman in perimenopause, the application of the OLI Integrative Psychodynamic Psychotherapy (OLI IPP) approach and the concept of basic developmental competencies of personality (BEC) in understanding and treating difficulties related to eating behavior, physical activity, and self-regulation, with particular attention to time as a clinical dimension of experience.

Method: A qualitative single-case presentation from clinical practice was used. The client, a 49-year-old woman, sought help due to difficulties in regulating body weight, eating behavior, and physical activity in the context of perimenopause. An integrative approach was applied, combining psychodynamic formulation through BEC with principles of lifestyle medicine and behavioral and coaching interventions.

Results: Psychodynamic analysis revealed deficits in mentalization, neutralization, object constancy and wholeness, tolerance of frustration and ambivalence, will, and initiative, which maintained patterns of impulsive eating, abandonment of physical activity, and self-punitive attitudes. Targeted interventions led to improvements in eating regulation, tolerance of discomfort, physical functioning, and the client's internal dialogue.

Conclusion: Difficulties in changing life habits during perimenopause cannot be adequately understood or treated solely as a lack of discipline or motivation. They require an integrative approach connecting psychodynamic understanding of emotional capacities, medical assessment of bodily changes, and structured behavioral and coaching interventions, together with an understanding of how the person lives in time throughout the process of change.

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¹ E-mail: maja@life-leaf.com

Introduction

Before approaching the analysis of specific symptoms and difficulties, it is important to consider the perimenopausal period through an analytical framework that includes the category of time as a fundamental dimension of experience. Freud observed that the unconscious knows no time - processes in the unconscious are timeless (*zeitlos*), and affects and traumatic experiences do not "age" but remain active as though they are occurring in the present moment. Hence arises the clinical paradox encountered in working with women in perimenopause: the person responds as though the past were the present, as though a loss were still ongoing or had never been resolved, despite the objective passage of time (Freud, 1915/2004).

Jung described this period through the metaphor of the midday of life (*Lebensmitte*) - the moment when the sun crosses its zenith and the psychic organization of the first half of life can no longer sustain itself in the same way. The values, identity, and roles of the first half of life - achievement, adaptation, external validation - lose their former force. If no inward turning occurs, no construction of a new inner foundation, the person remains trapped in a form she has outgrown, caught between a past to which she returns and a future toward which she cannot yet orient herself (Jung, 1930/1981). It is precisely this inner dynamic - between what has been and what has not yet come to be - that constitutes the clinical context in which the difficulties and patterns the client brings to therapy must be understood.

Perimenopause is a developmental period with biopsychosocial specificities, in which hormonal, somatic, emotional, and relational changes frequently intertwine in ways that resist simple explanation. Women in this period often consult multiple specialists due to a range of symptoms: weight gain, changes in blood pressure, sleep disturbances, mood fluctuations, musculoskeletal pain, reduced energy, cognitive fatigue, and difficulties maintaining established life routines. The problem arises when each specialty addresses only its own domain, and the woman herself is left without an integrated account that would connect the body, emotions, identity, habits, relationships, and sense of personal efficacy.

In clinical practice, this frequently leads to a reductive interpretation of difficulties with behavioral change as laziness, lack of willpower, or insufficient discipline. Such an approach is particularly inadequate when the person genuinely wishes to change but does not possess sufficiently developed or sufficiently accessible emotional capacities to sustain, organize, and maintain that change.

Within the OLI IPP framework, basic developmental competencies constitute a key lens for understanding why a person, despite motivation and insight, fails to translate a decision into action or to remain consistent in the face of obstacles. At this juncture, symptoms such as impulsive eating, abandoning a dietary plan, vacillating about exercise, feeling overwhelmed by external criticism, or a self-punitive relationship with oneself cease to be a "character weakness" and become signals for more nuanced psychodynamic inquiry.

This paper proceeds from the premise that understanding and treating perimenopausal difficulties cannot be adequate without integrating multiple levels of intervention: psychodynamic understanding of internal conflicts and emotional capacities, medical assessment of hormonal and somatic changes, and structured interventions from the domains of coaching and behavioral therapeutic approaches.

In this sense, the OLI IPP approach was used as the primary organizing framework, enabling psychodynamic formulation through basic developmental competencies, analysis of secondary gain, and identification of counter-skills as patterns that maintain the presenting problem.

These interventions were directed toward the implementation of lifestyle medicine principles, which involve systematic change across key life domains (nutrition, physical activity, sleep, stress regulation, elimination of harmful habits, social connectedness) with the aim of improving health and functional capacity.

Contemporary approaches oriented toward long-term health and quality of life - including wellness, longevity, and the use of available technological and functional methods (biohacking) for optimizing physical functioning and reducing somatic limitations - were also integrated into the work.

This integrative approach was not an adjunct to the therapeutic work but its necessary foundation, given that the client's difficulties manifested simultaneously across somatic, emotional, and behavioral levels.

Theoretical-methodological framework: OLI IPP approach, basic developmental competencies of personality, and counter-skills

The OLI IPP method represents an integrative psychotherapeutic, counseling, and coaching approach with a fundamentally psychodynamic orientation. Central to this framework are the basic developmental competencies - capacities for the processing and regulation of emotional states (Jovanovic, 2013).

Viewed through the lens of time, each of the basic developmental competencies carries a direct temporal dimension: neutralization is the capacity to survive the interval between impulse and action - to remain in the psychic space "between"; object constancy is the capacity to maintain continuity of self and goals across time, despite emotional fluctuations; tolerance of frustration is, at its core, the capacity to endure waiting and the deferral of gratification; tolerance of ambivalence is the capacity to live between opposing forces without requiring immediate resolution; will is the capacity to persevere across time in the absence of spontaneous pleasure; initiative is the capacity to organize and repeat action over time. Deficits in these competencies, therefore, are not merely deficits in emotional regulation - they are deficits in the way a person inhabits time.

The concepts of counter-skills and secondary gain also contribute significantly to the understanding of the clinical material.

Counter-skills refer to learned behavioral patterns that represent attempts at regulating emotional tension, but which, while reducing discomfort in the short term, serve in the long term to maintain the problem and prevent the development of more mature emotional capacities. In this sense, they may be understood as functional "substitutes" for insufficiently developed basic developmental competencies.

The phenomenon of secondary gain refers to the implicit psychological benefits a person derives from maintaining the problem, such as avoiding unpleasant emotions, conflicts, responsibilities, or relational changes. These benefits are most often not consciously recognized, yet they contribute significantly to the maintenance of resistance to change.

Analysis of counter-skills and secondary gain enables a deeper understanding of resistance, as it points to the inner conflict between the drive toward change and the need to retain existing, albeit dysfunctional, regulatory patterns (Jovanovic & Jovanovic, 2025).

The OLI IPP approach was used as the foundation for psychodynamic understanding, while specific interventions were chosen flexibly, in accordance with clinical assessment and the client's needs.

Alongside the psychological work, interventions also incorporated principles of lifestyle medicine, as well as elements of contemporary approaches oriented toward improving health and quality of life (wellness, longevity, and functional approaches to the regulation of somatic symptoms) (Anekwe et al., 2025; Mosconi, 2024).

Case presentation

Background and Reason for Referral

The client, a 49-year-old woman, sought psychotherapeutic work with a specific aim: she had identified the therapist as someone who works with women in perimenopause and who is able to bridge medical and psychological understanding of the presenting difficulties. Her explicit motivation for coming was not simply a need "to talk," but a need for integrated understanding of a state she experienced as fragmented across multiple specialist consultations.

Prior to seeking therapy, she had consulted a gynecologist, an internist for elevated blood pressure, a physiatrist for joint pain and "clicking," an endocrinologist, and a nutritionist for weight gain, low energy, and poor laboratory results. From various specialists she had received partial recommendations and treatment within their respective domains, but was left with the impression that no one was addressing the totality of her problem. In her experience, previous psychotherapy had also not led to change, because the themes she considered central had not been addressed: improving health, building discipline, sustaining motivation, and achieving genuine change in everyday habits.

Primary Complaints and Presenting Difficulties

Over the past six years, the client had gained approximately twelve kilograms. With the weight gain came other signs of metabolic syndrome: elevated blood pressure, a disrupted lipid profile, and then musculoskeletal manifestations - joint pain, reduced range of motion, crepitus, and frozen shoulder. Declining energy and efficiency, along with a sense of no longer being "her old self," were drawing her into anxiety; intrusive automatic thoughts arose that she was unable to dismiss, and these were disrupting her sleep. These changes had begun to affect her professional functioning, her partnership, and her experience of her own vitality.

Although on the surface her motivation might appear primarily aesthetic ("I look like a pig"), closer anamnesis revealed that the principal motivation was in fact health-related: she wished to prevent further deterioration of her condition, to reduce the risk of chronic illness, to recover a sense of strength and functional capacity, and to regain a sense of control over herself. She expressed a feeling of helplessness: "I don't have a clear plan, I don't know where to begin, I don't know what would be good for me or what would help," she repeated several times.

Previous Attempts to Address the Problem

The client reported that she had managed to follow the dietary plan given by the nutritionist for only one week, after which she gave up in disappointment. Attending the gym had been frustrating, as she had the sense that effort was being demanded of her beyond her actual capacities, with an implicit message that she needed to "endure more" if she wanted results. Her descriptions reveal a pattern of brief initial engagement and enthusiasm - resolve - followed by overwhelm, self-criticism, a sense of failure, and abandonment.

She experiences the people around her as lacking in empathy: they do not understand her, they only criticize. Her family adds to the difficulty because they "do not accept her efforts to change her eating habits and turn toward healthy lifestyles."

Anamnestic and Clinical Focus of Assessment

Following a review of existing medical documentation and laboratory findings, the conversation was organized according to the priorities the client herself had identified. Laboratory results confirmed the clinical impression that the client was under significant stress and displayed signs of sympathicotonia; accordingly, it was suggested that she consider approaches to stress regulation that encompass not only technique-based methods but also changes in nutrition and physical activity. The priority was reduction of body weight, primarily for health reasons and secondarily for aesthetic ones.

Based on prior experience, it was clear that dry recommendations alone would not take hold. The clinical assessment was that the client needed to be sufficiently informed about the significance of lifestyle change. It was not enough to remain at the level of advice about "what to eat"; the plan therefore encompassed psychodynamic understanding of her behavior. I also introduced her in greater depth to the concept of lifestyle medicine as an evidence-based medical discipline, and to the way in which each of its "pillars" was relevant to the improvement of her condition.

Given that the work was taking place within a rehabilitation centre, the client had access to certain diagnostic and therapeutic procedures directed at alleviating somatic symptoms. One significant problem was urinary urgency, which was limiting her movement, physical activity, and social contacts.

Addressing this symptom through medical and functional interventions had a multiplex effect: reduction of somatic discomfort, increased confidence in everyday functioning, and - indirectly - improved social connectedness and readiness to engage in activities outside the home (such as going to the gym or socializing with others).

This segment of the work illustrates how body-directed interventions - within medicine and functional approaches - can have direct psychological and relational effects, further affirming the need for an integrative model of practice.

Relationship with Food and Eating Situations

The assessment encompassed the following questions: whether the client distinguishes physiological hunger from the need for food in response to stress, boredom, loneliness, or the desire for a specific taste (hunger versus appetite); how much she can tolerate hunger and at what point she loses the capacity for delay; what the concrete pattern of her meals looks like - whether she eats in a calm state or in a rush, planfully or automatically, whether she prepares food or orders it; whether she recognizes satiety and the nutritional adequacy of a meal; how she feels after eating - including sensations of pleasure and enjoyment, or alternatively guilt, remorse, bloating, heartburn, and other somatic discomforts; whether there are rituals, automatisms, social pressures, or family patterns that hinder change; and what role food plays in her identity, enjoyment, sociality, self-presentation, and sense of belonging.

Her responses illustrate this dynamic: "I eat when anxiety overtakes me; some foods remind me of happy times in childhood." "Sometimes I feel angry and realize I'm actually hungry, and then there's no waiting." "I often eat while checking emails; sometimes I don't even sit down at the table." "Often after a meal I feel overfull, and on top of that I ate poorly" - after which self-reproach most commonly follows. Family patterns further complicate change: "There must be at least three meals a day, lunch isn't lunch without potatoes and schnitzel, wash it down with plenty of water, a glass of red wine after dinner is healthy, a teaspoon of honey in the morning is a must, and then coffee," and "you can only enjoy yourself once you've finished all your obligations." Food is also part of identity and belonging: "My social life revolves around restaurants," and "I receive the most compliments when I invite friends over for a lunch I've prepared myself."

Relationship with Movement and Exercise

The second priority she herself identified concerned physical activity. Here too, a similar structure of obstacles emerged: a mismatch between actual capacities and expectations, a sense of being required to meet demands beyond her means, rapid abandonment when frustration arises, vacillation between the desire for health and aversion to effort, and a weak sense of connection to long-term goals.

Family and Social Context

At home she confronts a disorganized kitchen, a lack of structure, and a family that prefers unhealthy food and does not consistently support her attempts to introduce a healthier regime. In social situations she finds it difficult to refuse food and alcohol, as she experiences this as a risk of being perceived as difficult or unpleasant, or of being symbolically "excluded from the group." This means that relational themes - belonging, assertiveness, boundaries, and fear of rejection - are directly implicated in her relationship with food.

Psychodynamic formulation of the case through basic developmental competencies of personality

Within the framework of basic developmental competencies, analysis of the clinical material revealed patterns pointing to insufficient development or unstable availability of certain capacities, particularly in situations of heightened emotional tension and the need for self-regulation.

Mentalization

A person with intact mentalization capacity recognizes, articulates, and reflects upon her own and others' mental states: feelings, motives, desires, conflicts, somatic signals, and the meaning of behavior.

In the context of eating, this would mean that the client is able to differentiate physiological hunger from emotional need, stress-induced food craving, automatized reaching for food, or the need for comfort, reward, belonging, or tension regulation.

However, the client frequently fails to understand what is happening in the moment when the urge to eat "takes hold." She feels poorly before eating, during eating, and after eating, but cannot recognize the inner sequence: what triggered the impulse, whether it is hunger, anger, disappointment, emptiness, fatigue, a need for reward, or a reaction to criticism. She has the experience that something "just happens."

Neutralization

With intact neutralization capacity, a person is able to process an impulse, affect, or tension rather than immediately discharging it into action. In other words, she can "ride out the wave," respond non-mechanically, and create a space between the urge and the behavior.

In the context of binge eating, this capacity is critical in preventing the desire for food from automatically leading to ordering, snacking, or impulsive consumption of large quantities. From a temporal perspective, neutralization is the capacity to remain in the interval - to survive the psychic space between impulse and behavior, to not skip directly from the present moment into action.

Object Wholeness

Object wholeness enables a person to simultaneously hold both the good and the bad aspects of herself and others, without splitting into the wholly idealized and the wholly devalued.

In work with this client, the deficit in this capacity becomes apparent when, following an episode of overeating, her relationship with herself becomes harsh, condemnatory, and annihilating. The sense of her own personhood is then lost: rather than recognizing that she has experienced a failure in one particular situation, she experiences herself as wholly bad, weak, or unacceptable. This further amplifies shame and increases the likelihood of new self-destructive patterns.

Object Constancy

Object constancy involves the capacity to maintain a stable experience of important relationships, goals, and values despite frustration, disappointment, criticism, or momentary emotional distance.

In the context of behavioral change, this means that the person can remain connected to her long-term reason for change even on days when she lacks motivation, when she receives criticism, or when her environment fails to support her efforts. It also provides a stable relationship with oneself.

The client shows a tendency, when she receives criticism at work, when something disrupts her, or when she does not feel well enough on a given day, to lose contact with the long-term reason for which she wanted change. The image of herself as a healthy, vital, and stable person then loses its sustainability. In other words, the current

emotional situation cancels out continuity of purpose. In Freudian terms - the unconscious does not preserve the past as an argument for the present; in Jungian terms - a bridge between yesterday's decision and today cannot be established.

Tolerance of Frustration

Tolerance of frustration is the capacity to endure the thwarting of a need, the deferral of gratification, or the reality that change requires effort, discomfort, and repetition. Without it, every instance of fatigue, hunger, boredom, tension, or obstacle easily becomes a trigger for abandonment.

Although the client displays considerable patience in general, there are situations in which her tolerance of frustration is particularly vulnerable. In her professional domain she can endure a great deal and appear persevering, but in the areas of food, drink, and self-care, the threshold for tolerating discomfort is considerably lower. Hunger, fatigue, domestic chaos, uncertainty about what to prepare, boredom, or the denial of pleasure rapidly become unbearable.

Tolerance of Ambivalence

This capacity enables a person to endure the simultaneous existence of opposing desires and their consequences. The client is torn between several legitimate needs: health versus pleasure, individual change versus family cohesion, self-respect versus the need for acceptance, discipline versus spontaneity. She finds it difficult to bear that a decision in favor of one side necessarily entails the loss of the other, which leads to her becoming stuck between "I will and I won't," resulting in abandonment.

When tolerance of ambivalence is weak, vacillation becomes blockage, and decisions are rapidly reversed. From a temporal perspective, this is also a being torn between a past way of being - which was comfortable, familiar, and identity-sustaining - and a new way that is uncertain: the person remains "frozen" between two points in time, neither here nor there.

Will

Will is not the same as current motivation. It denotes the capacity for self-support, perseverance, and maintaining orientation toward a goal even in the absence of spontaneous pleasure. In this case, will is particularly important for continuing initiated changes in nutrition, food preparation, daily organization, and movement. When change ceases to be inspiring and becomes burdensome, will collapses and rationalizations and procrastination appear. Will is, therefore, the capacity to remain in the process across time - not to resolve everything once and for all, but to repeat tomorrow, and the day after, and after failure.

Initiative

Initiative is the capacity to set activity in motion, to take the first step, to conceive a direction, and to engage actively with what matters to oneself.

In this client, the weakness of initiative manifested in the difficulty of moving from desires and attempts at change toward the organization of a realistic plan that could be carried out in daily life. Her initiative is also dependent on the need for immediate pleasure, so she is unable to contain impulse; she is moved by the need to preserve relationships, but also by narcissistic motives ("I display my culinary skill and am admired for it"), as well as by the need to create the "perfect combination of flavors" and

to master a skill. Her attempts to initiate change within the family system lack a sustainable plan, alliances, and a sense of meaning, and obstacles from the environment easily extinguish the initial momentum.

Mapping Typical Client Statements to Deficits in Basic Developmental Competencies of Personality

It is instructive to show how typical statements of the client may be mapped onto specific basic developmental competencies:

"I don't understand what happens to me when I start eating" - deficit in **mentalization**.

"When the urge overtakes me, there's no delay, I just take food" - deficit in **neutralization**.

"When I make a mistake, I feel disgusted with myself" - deficit in **object wholeness**.

"It only takes something to disrupt me and everything falls apart" - deficit in **object constancy**.

"There are things I simply cannot endure" - deficit in **tolerance of frustration**.

"I want change, but the consequences are unacceptable to me" - deficit in **tolerance of ambivalence**.

"I don't have the strength to continue when it gets hard" - deficit in **will**.

"I start a hundred times but never manage to truly begin anything" - deficit in **initiative**.

Such a map enables the therapist to respond with targeted intervention and a choice of technique that corresponds to the specific emotional difficulty.

An important insight for the client was that food does not represent merely a nutritional need but carries multiple psychological functions. It is associated with experiences of pleasure, social connectedness, aesthetic expression, and narcissistic confirmation. This insight was pivotal in understanding the role of food in her life and in differentiating behaviors that on the surface appear similar but have distinct psychological foundations. Understanding the center of initiative enabled her to recognize when her behavior originates from somatic need, the need to regulate affect, the need for belonging, or the need for self-affirmation.

Therapeutic goals and interventions

Therapeutic Goals

The following goals were defined for the work:

Developing clearer differentiation between physiological and emotional hunger.

Reducing impulsive eating through the development of neutralization and mentalization.

Strengthening a more compassionate and realistic relationship with oneself following setbacks.

Maintaining contact with health-related goals even when motivation fluctuates.

Increasing tolerance of frustration and the capacity to defer gratification.

Working through ambivalence around changing habits, pleasure, sociality, and belonging.

Strengthening will through small, repeatable, and realistic tasks.

Developing initiative and organizing the environment in a way that supports the goal.

Learning assertive communication in family and social contexts.

Connecting behavioral changes to a sense of meaning, health, and self-care.

Interventions

Psychoeducation and Normalization of the Perimenopausal Experience

The first step was to link her somatic and emotional experiences to the perimenopausal period rather than to personal failure or lack of discipline. We discussed how hormonal changes can affect sleep, mood, fat distribution, energy, hunger perception, recovery, cardiovascular function, bone density, and musculature. This served to reduce her tendency toward self-criticism and opened space for understanding change as a demanding but achievable process.

Interventions Directed Toward Mentalization

Questions were used that slow down automatism and introduce reflective function: What happened within you immediately before you reached for food? Was your body seeking energy, or were you seeking comfort, respite, reward, or rebellion? How would you articulate that need if it were not "speaking through food"? In which situations can you tolerate hunger without panic, and in which can you not?

The aim of these interventions was not only insight but the creation of a language through which the client could think about herself, rather than simply attacking herself or automatically discharging impulse.

Interventions Directed Toward Neutralization

We worked on introducing a small space between urge and action: a brief delay, a change of location, a glass of water, three questions to oneself before ordering food, naming the feeling, brief breathing, or agreed-upon "micro-routines" (for example, putting down cutlery between bites until swallowing). The aim was not total control but an increase in the capacity to tolerate the urge without requiring its immediate execution.

Work on Object Wholeness and the Relationship with Oneself

Particular attention was paid to the self-punitive inner voice. The interventions aimed to help the client learn that a failure in one situation does not mean she is "wholly bad," nor does one difficult day cancel the entire process. We worked on accepting that she can simultaneously wish to be healthy and occasionally stumble, be valuable even when not ideal, and be responsible even when things are difficult.

Work on Object Constancy

When the goal was to maintain connection to the long-term meaning of change, formulations such as the following were used: "What is it that made you set out on the path of change in the first place?" "What does your healthier self look like when you are not measuring it by today's mood?" "What sentence would you say to preserve your connection to the version of yourself you are working toward?" In this way, the focus shifted from a perfectionistic outcome to continuity in the relationship with both the current and the changing self.

Work on Tolerance of Frustration

The work emphasized that changing habits necessarily involves hunger, waiting, planning, relinquishing immediate comfort, and accepting that the body and the psyche do not receive everything at once. Rather than a rigid diet, the work moved toward a gradual increase in the capacity to endure discomfort ("delay the first meal by ten minutes") without impulsive discharge.

Work on Tolerance of Ambivalence

Ambivalence was not treated as an obstacle to be "eliminated" but as a reality that needed to be recognized and borne. The losses that change entails were explored: less spontaneous hedonism, possible disagreements with the family, reduced social comfort, letting go of the image of herself through food and restaurants. Simultaneously, what the client stood to gain was considered: health, energy, less pain, greater autonomy, self-respect, and long-term freedom.

In this process, "psychological accounting," or emotional bookkeeping, was used: the client gradually came to view the balance between the gains and losses of existing patterns and potential changes. This approach was not directed toward "rational resolution" of the dilemma but toward increasing the capacity to simultaneously hold both the positive and negative aspects of choice.

Work on Will and Initiative

Rather than large and unsustainable resolutions, the plan was built through small, concrete, repeatable steps. The emphasis was not on "everything different from tomorrow" but on identifying the first possible step she could realistically initiate and repeat. In this way, will is relieved of grandiose demands, and initiative gains direction.

Behavioral Interventions

Practical structures were introduced that reduce reliance on spontaneous inspiration:

- a pre-prepared list of quick, simple, and nutritionally acceptable options for breakfast, lunch, dinner, and snacks;

a weekly shopping list;

- pre-defined "safe" options for when the kitchen is in disarray or the client is exhausted;

- gradual adjustment of movement and exercise to actual capacities, without frustrating pressure;

- planning for a "good enough" rather than a perfect day.

Assertiveness and Emotional Intelligence

Since food and drink in this client are strongly associated with belonging, an important part of the work concerned assertive communication. Sentences for social situations were rehearsed: how to refuse additional food or drink without guilt, how to request support from the family, how to speak about her own needs without feeling she must choose between her health and belonging. This was directly connected to her profile of basic developmental competencies: weaker tolerance of ambivalence, a need for confirmation, and difficulty tolerating the potential displeasure of others, alongside fears of abandonment and inadequacy.

Techniques from Other Therapeutic Approaches in the Service of Developing Basic Developmental Competencies

In order to develop specific basic developmental competencies, techniques from other therapeutic approaches were also employed: Gestalt techniques in work on object wholeness, particularly through exercises that enable the simultaneous holding of "good" and "bad" aspects of the self, thereby reducing splitting and self-criticism following setbacks; Gendlin's focusing, used to develop the connection between somatic sensations and emotional states, which was particularly important in differentiating physiological hunger from emotional need for food; and elements of rational emotive behavior therapy, applied in work on irrational beliefs, particularly in relation to rigid rules such as "I have the right to rest only when I have finished all my obligations," which in practice was unattainable and was leading to a chronic sense of deprivation.

Work on these beliefs opened space for the development of a capacity for mature hedonism - the capacity to integrate pleasure, rest, and self-care into everyday life without guilt and without the need to "earn" them.

Course of the therapeutic process

The course of work with the client was not linear but was marked by phases of initial enthusiasm, followed by the emergence of resistance and ambivalence, and by the gradual establishment of more stable patterns of self-regulation.

In the early phases of the work, a need for rapid solutions predominated, along with an expectation that change would come through clear directives and structure. As the work progressed, it became apparent that the key obstacles were connected to emotional capacities rather than to a lack of information.

In the middle phase of the work, more pronounced resistance emerged, particularly at moments when changes began to require relinquishment and confrontation with loss. During this period the client more frequently abandoned agreed-upon steps, accompanied by heightened self-criticism and a sense of failure.

With further work came the gradual strengthening of mentalization capacity and tolerance of frustration, enabling a more flexible relationship with setbacks and a reduction of the rigid "all or nothing" patterns.

In the later phases of the work, greater stability in everyday habits became apparent, alongside more realistic expectations and a reduction in the self-punitive relationship with herself, together with a greater capacity to integrate concern for health with the need for pleasure and social contact.

Transference, Resistance, and Defense Mechanisms

In the course of the work, elements of transference reactions, resistance, and defense mechanisms also became apparent, which further illuminated the difficulties in behavioral change.

In the transference relationship, the client at times experienced the therapist as a figure who evaluates, expects, and potentially disagrees - in keeping with her earlier experiences with authority figures and significant others. In such moments there was heightened self-criticism, a need to "be good," or, conversely, withdrawal and abandonment.

Resistance manifested through ambivalence toward change ("I will and I won't"), procrastination in implementing agreed-upon steps, and through rationalization and minimization of the significance of particular interventions. Changing life habits carried not only gains but also an experience of loss - "even that little bit of pleasure,"

spontaneity, belonging - which further amplified resistance.

At the level of defense mechanisms, a tendency toward introjection and identification with critical objects is observed: external criticism is rapidly internalized and experienced as one's own inner voice ("I am lazy and undisciplined," "I am worthless"). This dynamic contributes to the loss of object wholeness and intensifies the self-punitive relationship with oneself.

Furthermore, in certain situations an element of projection may be observed: the experience of inadequacy or failure is attributed to external sources ("my family doesn't support me, others are sabotaging me"), which simultaneously protects against the sense of personal inadequacy and guilt while also impeding the assumption of personal responsibility for change.

Understanding these processes was crucial to the choice of interventions, as it enabled resistance to be seen as a psychological reaction to inner conflicts and fears related to change.

These mechanisms are directly connected to deficits in basic developmental competencies, particularly in the domains of object wholeness and constancy, as well as tolerance of ambivalence.

Examples of Basic Developmental Competency Deficits in Relation to Physical Activity

As in the domain of eating, a similar logic applies to physical activity:

Mentalization: "Am I avoiding exercise because I am tired, ashamed, angry, discouraged, or because the plan is unrealistic?"

Neutralization: "Can I endure the initial aversion to effort without immediately giving up?"

Object wholeness: "If I did not exercise today, does that mean I am a failed person?"

Object constancy: "Can I remain connected to my goal even when today has not been a good day?"

Tolerance of frustration: "Can I accept that results will not come quickly?"

Tolerance of ambivalence: "Can I accept that I want both comfort and health, while not always being able to maximize both?"

Will: "Can I do the minimum of what the plan requires even when I don't feel like it?"

Initiative: "Can I myself conceive of a sustainable form of movement that suits me?"

Outcomes

Although the primary aim of the work was not exclusively reduction of body weight but the establishment of sustainable patterns of self-regulation and reduction of anxiety, positive shifts were noted across multiple levels during the process.

The client reports improved regulation of eating behavior, a reduction in impulsive eating episodes, and a greater capacity to differentiate physiological from emotional need for food. She also notes increased tolerance of discomfort and a reduced tendency to abandon efforts following setbacks.

On the somatic level, there has been subjective improvement in energy and functional capacity, as well as greater engagement in physical activity. Particularly significant is the reduction of limitations in everyday functioning arising from somatic symptoms,

which has also enabled better social inclusion.

On the psychological level, a gentler inner dialogue is apparent, along with a reduction in self-criticism and a greater capacity to integrate different aspects of herself, pointing to the development of certain basic developmental competencies.

Discussion

This case illustrates several important points for work with women in perimenopause, particularly when considered through the lens of time.

First, somatic symptoms, weight change, and failure in behavioral change cannot be adequately understood without the context of developmental phase, hormonal change, and overall life organization. Perimenopause is a neuroendocrine transition and a period of redefining identity, somatic experience, self-confidence, priorities, and relationships. The Jungian metaphor of the midday of life here acquires its clinical weight: the woman who comes to therapy is not merely seeking resolution of symptoms - she is passing through a crisis of continuity between a past and a future self, between what she knew of herself and what has not yet become clear.

Second, advisory and medical approaches often remain at the level of recommendation, while an assessment of the emotional capacities required to implement the recommendation is absent. A person may know what she "ought" to do and yet be unable to do it when she encounters frustration, loneliness, a conflict of loyalties, or a narcissistic injury.

Third, OLI IPP formulation through basic developmental competencies enables symptoms to be translated into developmental and therapeutic language. This renders the work more precise: rather than working on general motivation, the specific capacity that is lacking for a given behavior to become possible and sustainable is developed.

Fourth, in cases such as this, the integration of psychodynamic and behavioral interventions is particularly important. Interpretation alone, without concrete anchors in everyday life, may prove insufficient; while behavioral structure alone, without understanding inner conflicts, often proves short-lived. It is precisely the combination of reflection, emotional work, micro-planning, assertiveness, and psychoeducation that offers the greatest probability of sustainable change.

Conclusion

The presented case demonstrates that difficulties in changing life habits during perimenopause cannot be adequately explained solely by a lack of discipline or motivation. They require an understanding of emotional processing, self-regulation, inner conflicts, and the patterns that maintain the existing state.

The OLI IPP approach enabled the problems in eating, movement, and self-relationship to be viewed through basic developmental competencies, as well as through counter-skills, secondary gain, and resistance to change. In this way, the focus of the work was not only on what the client needed to change, but on how she might develop the capacities needed to sustain change.

The central shift was not only in behavior, but in a greater capacity to recognize inner states, defer impulse, endure frustration and ambivalence, and establish a less self-punitive relationship with herself.

This case affirms the significance of psychodynamic assessment in perimenopause, and also demonstrates that medical, behavioral, and lifestyle interventions achieve their

full effect only when they are connected to an understanding of psychodynamic processes and the development of emotional capacities - and, as is the subject of this paper, to an understanding of how the person lives in time. The therapeutic achievement was not only in behavior, but in the acceptance that change is not an event that occurs once and is concluded, but a process that unfolds in time, requiring repetition, return, and perseverance. In Jung's words: accepting that midday has passed does not mean that all is lost - it means that a different journey is beginning.

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