Tamara McClintock Greenberg

Psychodynamic Perspectives on Aging and Illness

Second Edition

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Foreward

The second edition of *Psychodynamic Perspectives on Aging and Illness* is a timely and superb revision which offers healthcare professionals working at the mind/body interface a paradigm shift. For far too long, the wisdom of psychoanalysis as a tool to understand the suffering inherent in aging and illness has been devalued and neglected. With this update, Dr. Greenberg incontrovertibly corrects this lapse. Her integration of current scientific research, alongside a user-friendly discussion of the theory and practice of psychodynamic psychotherapy, is an important contribution to the psychology of medicine. Several topics are elaborated: the constructs of hysteria and somatization, the biology of stress, the impact of attachment history on coping with sickness as well as the experiences of trauma and grief. As with the first edition, the idea that the patient's experience of illness cannot be understood without including the subjectivity of the practitioner who provides care is considered and done so with more awareness of this complexity. Each chapter now contains a section on "Suggested Techniques" that succinctly presents a guideline for applying the ideas set forth. Other notable aspects of the book are its reflections on the culture of medicine and the insights about the influences of contemporary Western life on the manifestation and adjustment to illness. This edition is, above all, essential for those practitioners dedicated to providing collaborative and interdisciplinary healthcare which is both biologically and psychologically informed. As with the first edition, it will continue to be required reading.

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Marilyn S. Jacobs, Ph.D., A.B.P.P.

Preface

It is such a delight to produce a second edition of a book that I loved from the first moment I conceived it, several years ago. I am very grateful for this opportunity and appreciative of the efforts of Sharon Panulla and Sylvana Ruggirello at Springer, who helped me make this edition possible. This volume is expanded in a number of ways that I hope will be helpful to readers. Although it seems to be changing, there remains relatively little psychoanalytic literature as it applies to older and medically ill adults. Therefore, I hope this book can be a synthesis of the thoughtful work that has been published and provide an inclusive appreciation of both mind and body and how I have used and adapted psychoanalytic ideas in my work as a therapist in hospitals, long-term care facilities, and in my outpatient practice over the last 20 years.

I begin this edition with detailed research that not only supports the utility of psychodynamic therapy and psychoanalysis but also suggests that our more nuanced approach to understanding conscious and unconscious motives for behavior, combined with our ability to allow repressed emotions to be expressed and contained, not only allows patients to get better, but we can reach a larger portion of the population because we are particularly skilled at dealing with complex problems. Medical illness is no exception, and it has been demonstrated that our interventions reduce healthcare visits and decrease physical symptoms among those in psychodynamic treatment. Indeed, there has never been a more exciting time for clinicians who incorporate psychoanalytic principles and practices into therapy. There is a preponderance of evidence that we can effectively help a number of people with a variety of mental and physical disorders, as effectively, if not more effectively, than other treatment modalities.

One of the new things in this edition is that I now include much more information on psychodynamic technique. I provide detailed vignettes at the end of most chapters, which highlight exactly what I say to patients and the rationale for doing so. Though we all have our own individual styles in how we talk with people we try to help, I focus on things that have worked for me in engaging and getting a buy-in to therapy for even the most hesitant of patients. I realize that not everyone may be excited about these ways of talking with patients and respect the individual styles that give way to how we offer something unique and intersubjective to certain

patients. For myself, having grown up in a lower-class background, I have always found it useful to translate the complex ideas of psychoanalysis into language that anyone can understand. I actively work to be transparent in describing both theory and technique (when people ask), and the way that I speak in my writing is not different than how I talk with people who see me for help. Therefore, a reader familiar with the previous edition will find a lot more of descriptions about what I say to people and why I make such choices.

Given the historical tendency of the mental health field to focus extensively on the psychological factors that may cause or exacerbate some illnesses, I try to offer a balanced understanding regarding how some people are biologically (either through heredity or because of early life experiences or both) are simply more primed to develop some illnesses. This is the primary topic of the new fifth chapter in which I discuss "gray areas" in illness, as it does seem that some medical disorders are especially impacted by stressful life experiences. I explain how biological influences can help us to better empathize with the people we see and how we can help with the emotional confusion for those who feel indicted by their bodies and by physicians who tell them that their illnesses are "psychosomatic."

In addition to this new chapter, I expand my thinking about how to help those with a number of medical illnesses and the ways that aging vexes us to cultivate new coping mechanisms. As is consistent with my previous writing, I attempt to cull the very best of the complex and rich field of psychoanalytic theory. As someone who never could quite figure out which psychoanalytic approach is best for helping the people who see me, I am pulling from multiple ideas within psychoanalysis that help to explain human nature and conflicts, as well as how we might translate this information to those who are beleaguered by problems related to aging and medical illness. I describe the conceptualization of manic defenses and how this mode of functioning is well-suited to understanding how medicine works and how we all want to keep up our activity levels as we age and resist the uncomfortable blows we would rather ignore as our bodies seem to have an increased level of control and influence over us as a result of time passing. That said, the chapter on narcissistic injuries in aging illness—the ways that illness hits our self-esteem—has a more self and relational influence. Although ideas of grandiosity and omnipotence are things we all struggle with as we age, I have become more interested in how excessive narcissistic defenses leave some people vulnerable to a sense of emptiness or a paucity of a rich internal life and one they can rely on when the body fails or disappoints. It seems to me, now more than ever, that although many of us can manage the hits and blows of aging, and how this shakes us into a more realistic way of being, the inability to make the shift into accepting older age, or even realizing some of the incredible benefits to growing older (such as a more stable identity, increased happiness, especially beyond middle age, and more stability in relationships), has to do with a sense of lacking internal resources. I have found that for most people, in the context of a safe therapeutic relationship, one that can tolerate emotions of all kinds, ultimately what matters more than ideas of aggression is the simple fact that some people are really at a loss for knowing what is on their minds. Though aggressive thoughts and envy might fill in the gap, these ideas are often placeholders for

what is even more threatening—confusion, anxiety about the loss of a body that works, fears of being dependent, as well as existential fears about death.

I also now include more discussion on how differences between our patients and ourselves impact transference and countertransference. In particular, the chapter on transference and countertransference includes a special section on the challenges of being younger than our patients, which can be especially difficult for those new to the field. Indeed, being a therapist is one of those unique professions in which being older makes a lot of things in the work much easier. I also include race, class, and cultural differences as a factor in treatment, not just to be more explicitly inclusive, but because some oppressed racial and ethnic minorities, including immigrants, experience uniquely difficult, if not outright traumatic, experiences as children and adults, which become woven into conscious and unconscious narratives that deeply influence a basic sense of safety and create more vulnerability in the face of aging and/or illness. Class issues remain a quiet and insidious barrier in some analytic therapies, particularly because people from lower-class backgrounds feel ashamed and embarrassed about their origins. This is particularly the case when someone from a lower socioeconomic background finds their way into therapy with therapists who are frequently part of a privileged class. Whatever the difference, psychoanalytic approaches have increasingly provided guidance on how to express the tension experienced by patients who have not benefited from being a part of the dominant culture.

The rest of this volume is expanded by newer research on attachment and how this impacts the ability to cope with disease. I am including more detail on how to recognize certain medical issues (e.g., delirium) and how neurological changes in our patients may warrant collaboration or referrals to psychiatrists and physicians. I also explain new research that expands our ideas of the associations between emotional states and illness. Trauma and early childhood experiences do physiologically impact our bodies and then our emotional functioning (via pathways that impact stress hormones and inflammation), which can make a therapist's job in healing seem more daunting. That being said, it is clear now more than ever that psychotherapy, particularly psychodynamic therapy, can heal old and new wounds and that by providing a sense of security we can offer people a safe haven to deal with the most terrifying of illnesses and the most confusing of bodily states. I include a detailed section on post-traumatic growth and resilience and how some people find the resources needed not only to recover from traumatic illnesses but also to thrive in ways that alter their lives positively.

I am especially fortunate to have a number of talented minds in my life that have inspired me. Two long time colleagues, Marilyn Jacobs, Ph.D., and Mary-Joan Gerson, Ph.D., have been mentors and friends for over a decade and have provided inspiration on the ways to bridge psychoanalysis and medicine. Jon Mills, Psy.D., has been an excellent colleague and confidant regarding the challenges of writing and publishing. Marie Baca is another important writing friend; her talent and wit is matched by her loving support and encouragement. Also, the following people not only provided feedback on chapter material but also stimulated my thinking regarding a number of issues. I am grateful to Jacqueline DeLon, M.F.T.; Holly Gordon,

D.M.H.; Sam Gerson, Ph.D.; and Lee Rather, Ph.D., for always challenging my thinking about aging and illness and all things psychoanalytic. Lee Rather was especially instrumental in offering thoughts on specific chapters and keeping me on my toes regarding the use of specific psychoanalytic language. I am also grateful to the psychiatry residents at the University of California San Francisco, where I have supervised and taught for the last 15 years. The residents keep me inspired to look at new research and require me to make precise ideas that I may explain in a vague way.

Charles Spezzano, Ph.D., has also served as a most important mentor and resource. It was with him that I was able to float many ideas about this book in a way that led to the actual text I wrote, which were often co-constructed throughout my writing and thinking about this book.

Ultimately, though, it is my patients who really are the true inspiration for this book. They remind me of what is really important—not my publishing and certainly not my clever insights. At the end of the day, people who see me in my practice just want to get better, and I work hard to ensure the trust they place in me. Therefore, all cases in this book are composite cases, with information that is also additionally disguised to protect patients from being identified.

San Francisco, CA, USA Tamara McClintock Greenberg

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About the Author

Tamara McClintock Greenberg, Psy.D., M.S., is an associate clinical professor in the Department of Psychiatry at the University of California, San Francisco, where she supervises psychiatry residents. She has worked with medical and aging patients for the last 20 years in hospitals, long-term care facilities, and in her outpatient practice. Dr. Greenberg is the author of four books and a number of contributed chapters, which have encompassed both academic and popular press writing. She has written for Psychology Today online, Psych Central, and The Huffington Post. She has been a speaker to audiences and the media on topics such as aging, illness, the stresses associated with caretaking, grief, the trauma of illness, coping with aging, women's issues, and the application of psychodynamic ideas for people struggling with health problems and those who try to help them. A major focus of her writing has been on how loved ones and patients can deal with doctors and the medical system in a more empowered way while being mindful of the difficult and unique stressors physicians and medical staff face in this ever-complicated medical landscape. Dr. Greenberg lives with her husband and two pugs in San Francisco.

Chapter 1
When the Body Intrudes: Psychotherapy with Older and Medically Ill Adults

In this extraordinary age of advances in medical technology, people live longer than any other time in history. As mental health clinicians, we now treat a greater number of older and medically ill people. Being an older adult does not necessarily mandate the presence of illness; however, nearly half of adults have one or more chronic health conditions (Ward, Schiller, & Goodman, 2014). Additionally, aging itself is associated with an increasing number of limitations. Our looks change, our bodies don't work as well, and pain, even if it is minor, becomes a frequent presence in our lives. That said, naturally occurring physiological effects of aging, emotional reactions to the aging process, and the impact of medical illness vary widely from person to person. Indeed, increases in longevity mean that we are aging more diversely than before.

As psychodynamic clinicians, we are not only in the position to reduce the psychological distress that accompanies aging or illness that occurs for some, but we also have the ability to make sense of the complicated and sometimes confusing emotional states that can result in response to bodily changes and limitations. Consider the following example:

Betty is a 79-year-old female who has no cognitive difficulties beyond what would be expected of someone her age. She is in good health, though her vision has declined slightly due to mild macular degeneration. She has no history of mental health problems. However, around the same time that her vision changed, she began having anxiety and depressive symptoms, and her primary care physician observed increasingly guarded behavior. Eventually, Betty began to suspect and then complain that others were entering her apartment while she was gone and stealing her furniture. She spent increasing amounts of time checking her furniture to make sure it was not missing. As it was evident that no one was really breaking into her apartment, she developed stories to explain how her furniture had been moved or stolen and then moved back to its original position.

Although Betty's case sounds dramatic, it is not uncommon for older adults (and sometimes younger adults) to present with extreme suspiciousness in the context of

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medical problems, aging, or both. Although sometimes paranoia can be a prodrome to age-related cognitive decline and dementia, in some cases, regressed states represent a psychological collapse in response to illness, aging, awareness of mortality, and/or the fear about and realization of bodily limitations. In another brief example of this phenomenon, an acquaintance of mine, a man in his 40s, was found to have a parasite after an extended period of weight loss. Though he had been living what looked to be a completely normal life, he became obsessed with the idea that a parasite had "taken him over" and was "eating away" at him, even though he had been successfully treated by medical professionals. In addition to anxiously discussing his situation with everyone he came into contact with, he became deeply suspicious. He escalated the intensity of his emotions by screaming at friends, and eventually, his roommate, a close friend of over two decades, moved out.

The influence of illness, as well as the impact of aging, can create technical challenges for mental health clinicians who at times may expect that patients are easily able to describe emotions and thoughts related to their experience. In Betty's case, she could not articulate her fear of deteriorating vision (or other losses that eventually made themselves apparent in treatment), but began to imagine that others were stealing from her. In the case of my acquaintance, the idea that something was inside of him and causing damage made him feel perilously out of control. Although the idea of a parasite would be eerie to many of us, this man was unable to shake the feeling that something had taken control of his body. In these cases, when one develops such overwhelming fear about what is going on inside, nothing or anyone on the outside can be trusted. Even when suspiciousness is not present, however, people seeking help can appear to be "concrete," often focusing on external events with significant difficulty describing emotions.

Mainstream analysts following Freud have tended to emphasize that patients who cannot communicate symbolically are not good candidates for psychotherapy or psychoanalysis. Although many theorists since Freud have addressed some of the challenges in working with less symbolic patients, there are a number of conceptual, technical, and practical difficulties related to working with medical and aging patients. Though anyone who has difficulty with abstract thought and insight can make psychotherapy challenging, people who are ill and struggling with the impact of aging can result in therapists feeling helpless and lost, or worse, assuming that the patient is beyond help. Later in the chapter we will return to Betty's case as an illustration of how to deal with individuals who have reduced symbolic capacity.

This chapter will introduce psychotherapeutic work with medical patients, older adults, and those who are both ill and aging. Subsequent chapters will describe the variety of ways psychoanalytic ideas can help us reach our patients better and remind us why we got interested in working with older adults and those who are medically ill in the first place. Working with and helping these populations can be tremendously gratifying. Though a 75-year-old person does not have the same life ahead of them as a 35-year-old does, there is something very poignant when helping someone late in life learn new things about their thoughts and emotions, develop new relational patterns, and make the most of the rest of their lives. An additional comment I wish to make is regarding who I imagine to be the audience for this

book. I am speaking primarily to those in clinical practice who either have an interest in psychoanalytic approaches or are therapists who already identify as being broadly psychodynamic, meaning that they have an interest in dynamic unconscious processes, the presence of anxiety and defense, transference, and countertransference. More sophisticated readers who have benefited from the excellent training offered in psychoanalytic institutes and teaching programs may find some of my discussions as overly broad, but the scope of this book necessitates that I am concise. Finally, I am aware that, beginning with Freud's (1919) concern about preserving the purity of psychoanalysis, there is a somewhat contentious history within the literature concerning what is "really psychoanalytic" as well as what the actual differences are between psychoanalysis and psychoanalytic or psychodynamic therapy. Such discussions tend to revolve around matters such as frequency of sessions, use of the couch, and the relative importance of anonymity, neutrality, and abstinence, and the essential elements of the therapeutic alliance. All have been long debated, and the discussion complicated by the development of post-Freudian approaches. The pitfalls of such debates are well summarized by Rather (2008) in his remarks on analytic identity. Because the complexity of this subject is outside the scope of this book, I ask for the well-informed reader's forbearance as I take the liberty of gliding over the many distinctions that have been carefully drawn, and use the term "psychodynamic therapy" to broadly point toward certain trends which I believe characterize much of the overall ambience of psychoanalysis and psychoanalytic psychotherapy. Given this stance, I will use all of the aforementioned terms interchangeably while appreciating that each treatment has its own unique aspects.

First, I will briefly discuss why we should consider psychodynamic approaches in the first place. There is now a great deal of research indicating that this way of working is as effective if not more effective for a number of patients. I will follow this discussion by describing some of the problems that have beset the application of some psychoanalytic approaches for patients in these populations. Next, I will expand on some of the basic technical and conceptual challenges of working with medically ill and older patients and introduce some of the major dynamics we find in treating these individuals, with an emphasis on how contemporary theory and approaches can help. I will suggest that working with ill and aging patients requires us to retain some of the original ideas within mainstream psychoanalysis. However, by using contemporary psychoanalytic approaches, we can increase the chances of successfully engaging these populations in therapy. Although other therapeutic interventions outside of psychoanalytic approaches (such as cognitive–behavioral therapy, or CBT) have been suggested for working with older and medically ill patients, these methods have limitations that do not fully address many important aspects of psychological functioning, including the influence of the unconscious. Therefore, I will briefly highlight some of the shortcomings of other theoretical approaches to make a case that, despite some of the perceptions that Freudian and mainstream psychoanalysis are not useful, a modern and integrated psychodynamic orientation can be the most comprehensive approach for appreciating the complexities of the people we try to help. The chapter will conclude with the changing demographics of older and medically ill adults and will highlight the emerging need for clinicians to be prepared to deal with both chronic illness and other ramifications of aging in their patients.

Why Psychodynamic Approaches? Evidence on Efficacy

Depending on your familiarity with psychoanalytic therapy, it may or may not seem necessary to describe research that supports its efficacy. But with estimates suggesting that there may be as many as 500 different types of psychotherapeutic approaches (Lilenfeld & Arkowitz, 2012), it is important to explain how the oldest and most organized form of the "talking cure" stands up to newer treatments. While space constraints limit me from providing an exhaustive review of all of the outcome studies on psychodynamic approaches, I'll talk about some key studies and findings.

Psychodynamic therapy has been shown to be as effective as other kinds of therapy, with longer lasting benefits, especially with people who present with multiple symptoms and diagnoses. Jonathan Shedler published the most well-known review of the research on the efficacy of psychodynamic therapy in 2010. Shedler's analysis compared 74 studies of psychodynamic treatments with other research that looked at the efficacy of cognitive–behavioral therapy, general psychotherapies, and antidepressant medication. Psychodynamic approaches compared as well or better than the aforementioned treatments, with a particular benefit for people with personality disorders. These benefits occurred in both short-term and long-term dynamic therapies. A particularly intriguing study that Shedler reviewed was a meta-analysis on short-term psychodynamic therapy for people with somatic disorders. Abbass, Kisely, and Kroenke (2009) looked at 23 studies of over 1800 medically ill patients with illnesses as diverse as heart disease, musculoskeletal illnesses, and even dermatological diseases. The study found psychodynamic therapy to be effective not only for psychological symptoms but for physical symptoms as well. Incredibly, in studies that reported data on health-care utilization, there was a 77.8 % reduction in medical visits among those who had been in a psychodynamic therapy. Further, there was a 54 % greater likelihood of patients remaining in therapy when the approach was psychodynamic.

Indeed, complicated patients are well suited to psychoanalytic therapies. A recent review published in the Cochrane Library (Abbass et al., 2014) found that people with a variety of psychological diagnoses (including personality and somatoform disorders) showed greater improvement and, in many cases, longer lasting benefits when receiving short-term psychodynamic therapy as compared to patients who were not receiving other formal psychotherapy, but may have been on psychiatric medication and receiving minimal treatment as usual. Improvements reported were decreases in general psychiatric symptoms, anxiety, and depression.

Additional studies have found that when compared to CBT, short-term dynamic treatments stand up equally when treating depression (Driessen et al., 2013), social anxiety (Bögels, Wijts, Oort, & Sallaerts, 2014), generalized anxiety disorder (Leichsenring et al., 2009), anorexia (Zipfel et al., 2014), and panic disorder (Beutel et al., 2013).

Short-term psychodynamic therapy typically is defined as 40 sessions or less. And though many of us can successfully help people in this amount of time, many people often benefit from longer courses of therapy. There is data that long-term

analytic therapy and even psychoanalysis are not only beneficial, but also superior to other forms of treatment. One meta-analysis (looking at ten studies) found that long-term psychodynamic therapy, defined as therapy lasting at least a year or 50 sessions, was more beneficial than less intensive forms of therapy for people with complex psychological problems (Leichsenring & Rabung, 2011). In terms of traditional psychoanalysis, Rudolf, Manz, and Ori (1994) looked at 44 patients and found psychoanalysis to be superior to psychotherapy. This study, conducted as part of the Stockholm Outcome of Psychoanalysis and Psychotherapy Project, found that increased frequency of sessions corresponded with the most positive outcomes.

Despite all of the clear research that psychoanalytic approaches are as effective, if not more effective than other forms of therapy, those of us who practice using either long-term or short-term dynamic approaches often feel the need to justify our work. The reasons for this are incredibly complicated, and as I have argued (Greenberg, 2011) may have something to do with the ways we have described our work, as well as what we expect from patients. Also, as Jonathan Shedler (2004) has noted, our field has historically been hesitant to embrace research. Those reasons aside, when it comes to working with medical patients, as well as the general psychological patient population, CBT clinicians have done an admirable job of winning the public relations battle; they are frequently considered to be the cornerstone of "evidence-based" therapy, particularly for people with medical illnesses.

I can understand the reasons why CBT seems compelling. The first refers to the idea that "difficult" or non-adherent patients often get referred for psychological treatment. Since noncompliance is estimated to be a problem in half of all medical patients (DiMatteo, Lepper, & Crogan, 2000), these behavioral concerns naturally are often the focus of treatment by clinicians who work in medical settings. When a physician refers a patient for mental health treatment, in many cases it is for the purpose of getting a patient to do something or to stop doing something. For example, a clinician might receive a referral for a patient who has fibromyalgia; the physician may suggest that the patient needs to "cope better," which often includes a recommendation to exercise more. In such cases CBT may seem compatible; at least the approach makes intuitive sense. CBT uses techniques that encourage not only thinking differently but also addresses health-related behaviors. Ideally, for the referral described, a patient would come in with the expressed desire to exercise more and is asking us to help with that process. However, this is not often the case. The patient may not be willing to exercise and may not take the advice that a CBT approach can offer to help change their behavior and thinking about exercise, even if we (and the physician) think that this is good for them. As mental health clinicians, approaching a consultation with such an agenda risks neglecting what the patient may actually want. CBT and other directive approaches contradict the idea of free association, a core principal of psychoanalytic therapy, in which we focus on what is on the patient's mind. If the patient has ideas of what we should talk about, then we discuss those topics; it gives patients an important sense of agency and control. I am using this simple example to illustrate that if a patient is willing, with an abundance of internal resources, a CBT approach may be useful. However, many people who have these sorts of issues and problems often do not come to us for therapeutic intervention.

Instead, they use other resources in their lives to make changes related to these straightforward goals. This is not to say that we should avoid talking to patients about health behaviors (and as we will see in the case of Robert in Chapter 2, I will argue that not doing so can be detrimental); however, many medical patients or people struggling with some of the severe blows of aging don't possess the internal resources to benefit from CBT, which requires a fair amount of energy and motivation. This may explain why there are no compelling data in the literature to suggest that CBT is more helpful than other kinds of treatment for patients with complex psychological issues. A paper by Ronald Levant (2004) succinctly describes the problems with CBT research: many CBT studies include patients with only one Axis I disorder (and in some studies, those with any psychiatric disorder are *excluded*). Patients with only one Axis I disorder comprise less than 20 % of the population; comorbidity excludes more than two-thirds of the general mental health patient population. For example, major depression is a common disorder among medical patients, but rarely presents without other symptoms. Over 50 % of all depressed patients have at least one coexisting anxiety disorder (Culpepper, 2003). This does not address the number of medical patients who have Axis II symptoms, nor does it begin to address the effects of normative regression in people struggling with illness, which results in more concrete, externalized, and non-emotional thinking. My point here is that medical patients present with unique challenges that require a complex and nuanced approach. While CBT may be useful for some medical patients, the unique benefits of psychodynamic approaches may have something to do with how, even after treatment, people continue to get better because of the ways we emphasize what lies underneath symptoms. As Jonathan Shedler noted:

> Psychodynamic therapy appears to address underlying psychological patterns that affect many areas of life. This is in contrast to brief, so called 'evidence-based' treatments that define the presenting symptoms as 'the' problem, and don't necessarily address underlying psychological causes. So, the patient may show some temporary improvement, but if the underlying psychological causes are not addressed or addressed only superficially, then problems will recur. (Personal communication, September 21, 2014)

Psychodynamic interventions often have a kind of staying power because we give people tools to understand what makes them tick, both consciously and unconsciously. As we will see with Betty, I embraced a number of concrete discussions while holding in mind a number of possibilities about what unconscious processes were contributing to her paranoia. At no point was CBT an option. She would have fired me within the first few weeks had I challenged her delusions or even suggested that she might think of things differently. Working in this way requires us to tolerate a lot of ambiguity, including not knowing how we will eventually be helpful. This is in contrast to CBT and other manualized approaches, because there is really no formula we can embrace—patients, over time and in the context of a safe therapeutic relationship let us know what we need to focus on. As Shedler states:

> A hallmark of psychodynamic therapy is that we try to understand what is 'fueling' the person's anxiety or depression or whatever. We cannot know this in advance, before getting to know the person. 'Getting better' may take many forms. For one person, it may mean changes in attachment patterns; for another, enhanced capacity to regulate affect and impulses; for another, freedom from inner constraints and inhibitions; for another, a greater sense of wholeness or congruence; and so on. (Personal communication, September 21, 2014)

We have a rationale and a lot of research support for using dynamic approaches with the complicated people we see. Yet much of early psychoanalytic approaches and writing has left an unflattering legacy regarding how we are perceived to treat people today who have medical problems or who struggle with the demands of aging.

Traditional Ideas About Aging and Illness

Psychoanalysis started out as a theory of the mind that emphasized bodily reactions (hysterical illnesses) that occurred due to psychological conflicts. Freud's (1927/1961) comment relatively late in his career that "the ego is first and foremost a body ego" (p. 31) illustrates the interrelated relationship of the mind and the body. Freud's introduction of the theory began with a focus on physical symptoms in women that resulted from the influence of unconscious thoughts and feelings. For decades after Freud (with a few notable exceptions), attention to bodily symptoms and illness within the theory concentrated on the mind of the patient and not the body. There are many facets of the history of psychoanalysis and the body that do not bear repeating here, though these assumptions about physical illness have left a residue of conflict as well as concern about using psychoanalytic approaches for treating illness. I will review a few key theorists to outline how mainstream theory has treated bodily symptoms.

Many of the ideas about how psychoanalysis views illness stem not just from Freud, but also from research and writing that took place in the 1930s, 1940s, and 1950s. The maladies studied at this time were medical in nature, meaning those with organic physical causes. However, these illnesses were referred to as "psychosomatic illnesses," and psychological factors and character traits were considered underlying factors in the development of these diseases. For example, Deutsch (1939) described the term *organ neurosis* as the necessary expression of a neurotic conflict in which a specific organ is recruited to express psychological conflicts. He described a case of a woman with bladder problems as representing her "rebellion against punishment." Fenichel (1945) stated that unconscious aggression is related to heart and circulatory diseases, whereas Dunbar (1938) claimed that dependency issues were complicit in asthma.

Dunbar (1943) and Alexander (1950), who were both studying psychological factors and illness around the same time, were interested in the ability to predict the development of certain medical disorders based on personality profiles. The attempt to correlate specific psychological conflicts of particular illnesses was referred to as *specificity theory*, which postulated that certain physical symptoms are recruited to manage emotional conflicts. Alexander (1950) studied seven types of diseases and concluded that the development of many medical disorders results from repressed conflicts. These diseases included asthma, hypertension, peptic ulcer disease, and rheumatoid arthritis. Alexander developed very specific psychological pathways in which these diseases could develop. Many of these pathways suggested the influence of dependency issues, and the majority of people studied were women.