Psychodynamic Perspectives on Aging and Illness

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Preface

This book is the culmination of the teaching and writing that I have done over the last several years in which I try to speak about the value of a psychodynamic approach from a practical perspective. Although, when I was a health psychology student, I was trained as a cognitive behavioral therapist, I felt that these approaches were limited in terms of treating patients who struggle with bodily limitations. I was fortunate enough to discover psychodynamic theory in my last year of graduate school, but then had the chance to learn more from my supervisors while in internship about a more nuanced and sophisticated way of understanding the mind. It was not until I landed in San Francisco for my post-doc year, however, that I began to fully appreciate the value of a psychodynamic approach. The teachers here in the San Francisco Bay Area represent not only diverse views of contemporary thought, but also a community of talented and committed clinicians who are striving to understand the ways that they can help their patients to get better. Yet, given my training with medically ill adults, I found that some applications of psychodynamic theory, especially those that represented more traditional forms of thought, did not quite speak about the experiences of my patients who were struggling with the devastating effects of illness as well as the blows of aging. It is these gaps in the theory that have informed my writing and teaching most recently. Although contemporary theories offer the student of psychodynamic perspectives a glimpse into the incredible minds of the authors/clinicians, a common complaint is that much of this writing does not provide access to or understanding of the theory in a way that most people can comprehend. Currently, data show the limits of short-term approaches for complicated patients, which create a need for psychodynamic clinicians to make our work and our ideas more accessible, transparent, and readable.

This book attempts to bridge the best of contemporary psychodynamic theory with what I have found to be true for the patients I have treated over the years who have acute and chronic illnesses and who have wrestled with the bodily declines associated with aging. Psychoanalytic and psychodynamic theorists have been hesitant to apply their concepts to people who are aging and/or medically ill. This history will be briefly described in Chapter 1, as well as the real challenges medically ill patients and older adults face, which require us to use a different kind of approach

that sensitively and flexibly meets the needs of patients. Chapter 2 describes the dilemmas of the modern medical patient in the fast-paced culture of medicine in which technology plays an ever-increasing role in the provision of patient care. The following chapters address the common dynamics of the medically ill and aging, including the normative narcissistic injuries that occur in patients when their bodies stop working, as well as the trauma associated with being a patient with severe medical disease. I will also discuss contemporary ideas of transference and countertransference as well as the curious, but common scenario of people who do not take care of their bodies as manifested through nonadherence and lifestyle behaviors. As working with older adults with cognitive impairment is a new application of psychotherapy, a separate chapter is devoted to this issue and addresses some of the common questions that arise when working with adults with dementia.

There are currently a number of competing theories in psychodynamic psychology and modern psychoanalysis. These competing schools have made it difficult for the public to know what we have to offer. Although many forces exist which have made psychodynamic theory a less desirable approach, arguments among experts in the field itself have further plagued its ability to be accepted as a mainstream theory. In other words, if experts in the field cannot agree on what contemporary psychodynamic theory is, how can we expect anyone else to know what we are actually doing with patients? The fact that arguments occur between psychodynamic theorists is in my mind, only somewhat related to the narcissism inherent in all of us. I think that since psychoanalysis and psychodynamic therapy have been threatened, this has led to a sense of loss among many clinicians in the field. The losses are multiple, including but not limited to managed care, desires for quick fixes, and perhaps a newer generation of patients who may want to avoid the complex character understandings we can provide. I see the infighting that occurs as akin to what often results in siblings who are neglected by parents. In the face of absent parents, siblings look for intense emotional stimulation, and this is often expressed aggressively. In other words, if parents are not around, and they are being and feeling neglected, then siblings feel that they have no option but to beat each other up.

My aim in this work is to advocate pluralism within the field, as all ideas in the history of psychoanalysis have much to offer as we try to understand and help our patients. And though my stance is more modern, I see great utility in Freudian ideas, as well as ego psychology, even though these theories may not necessarily translate into the technique I use on a day-to-day basis. I am fond of the object relations theorists, self-psychologists and their predecessors who have expanded the psychodynamic literature to encompass a truer and more profound explanation of what actually happens in the psychodynamic relationships we have with our patients. That being said, my intention for this book is that I include many aspects of the rich and varied history of psychoanalysis and psychodynamic theory, as all schools can teach us how to understand and enrich the lives of our patients. Although I argue that more contemporary theories are helpful, there are a number of traditional ideas that have made their way into current ideas, even if in disguised form. Therefore, the reader will find that some chapters embrace Freud while simultaneously critique his limit in scope. Other chapters emphasize self-psychology and its great

benefits to understanding the importance of the sense of self in aging and illness, while focusing on the interpretive nature of therapy in the work of Klein and other modern clinicians. Nearly all chapters focus on the importance of the therapeutic relationship, the impact of the here-and-now aspects of relational functioning, and provide suggestions for how to talk with patients using the concepts described.

This book is geared toward therapists who are interested in psychodynamic theory, but may have encountered difficulties in graduate school in learning a more nuanced psychodynamic approach. Experienced clinicians will also find this book useful as it strives to provide an applied understanding of many concepts in psychodynamic theory, which have not yet comprehensively focused these concepts on older adults and medical patients. Additionally, patients with illnesses may also find solace in this book, as I strive to make the ideas in the field accessible and transparent to people who want to understand themselves in relation to their bodies.

My work in the field has evolved over the years, but has included the privilege of being on the faculty of the University of California, San Francisco, in the Department of Psychiatry. This position has allowed me to learn from medical students and psychiatry residents as well as the cutting-edge aspects of medical education that UCSF offers. Much of the time, however, I am in private practice and I also visit a number of nursing homes each week to see patients.

I am grateful and fortunate to have a large number of talented colleagues in the Bay Area who have generously donated their time and energy to comment on ideas in this book as well as to critique specific chapters. Thanks to Heather Bornfeld, Ph.D., Peter Carnochan, Ph.D., Holly Gordon, D.M.H., Scott Lines, Ph.D., Bart Magee, Ph.D., Anne O'Crowley, Ph.D., Steve Purcell, M.D., Owen Renik, M.D., Robert Wallerstein, M.D., and Deborah Weisinger, Psy.D. for generously taking the time to comment on aspects of this work. I also owe a debt of gratitude to the volunteers I spoke to who offered their experiences regarding their ongoing challenges with medical illness. As many of these volunteers were themselves therapists, they helped me to understand how far the field has come from the days of blaming patients for their illnesses, but also how much farther we have to go in order to create a respectful understanding of those who are beleaguered by bodies that do not function as they should.

I am also indebted to my teachers and mentors, who over the years influenced my thinking and understanding of how the mind and body work. These people have affected me in ways that they are likely unaware of, but without them I would be unable to integrate the many ideas I have learned. These clinicians include Victor Bonfillio, Ph.D., Marilyn Jacobs, Ph.D., Mary-Joan Gerson, Ph.D., Toni Vaughn Heineman, D.M.H., Maureen Murphy, Ph.D., Wendy Stern, D.M.H., and Steve Purcell, M.D. Also, a special thanks to Michael Zimmerman, Ph.D., who is responsible for my falling in love with the poetry of T.S. Elliot. The young poet as reflected in the imagined (and likely felt) experience of the old man, Prufrock, has spoken to me in ways that surpass any brilliant psychoanalytic paper. Zimmerman's teaching serves to acknowledge that psychoanalytic theory is one of many ways of understanding human suffering and the unconscious, as literature and poetry has been

trying to teach us all along about the vicissitudes of aging and human suffering in relation to the sadness in life and the inevitability of death.

I am especially grateful for the help of Stephen Brown, my psychology editor, who patiently and competently made my writing more readable. Stephen was an invaluable asset to this project and it was a pleasure to work with him and to gain from his knowledge and expertise. Also Sharon Panulla, my Executive Editor at Springer has not only been a delight to work with, but has bestowed trust in myself as a writer and a clinician. I feel privileged again to be authoring a book with Springer, as I respect their standards and their commitment to publishing works that can enable the furthering of solid academic ideas. Also, my husband, Andrew McClintock Greenberg, M.D., Ph.D., has been a great source of support and has been patient with the demands that writing a book requires.

Finally, it is the patients I have treated who are the principal inspiration for this work. My love of work is reflected in their ongoing abilities to educate me regarding the multiple ways in which the mind and the body interact. For this reason and to protect their confidentiality, all cases as reported in this work are based on actual encounters but are disguised, often in composite form, to protect identity.

San Francisco, CA Tamara McClintock Greenberg

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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 are now treating a greater number of older and medically ill patients than ever before. These populations: aging adults, medically ill adults, and those who are both older and medically ill, are the subjects of this book. Aging and illness are not always mutually exclusive. Although aging does not necessarily imply the presence of illness, it is an independent risk factor in the development of disease. Additionally, bodily changes that accompany aging are inevitable, and as we age, we are all confronted with the limits of physical abilities. However, naturally occurring physiological effects of aging, emotional reactions to the aging process, and the impact of medical illness vary widely from person to person. Therefore, some sections of this book will address aspects of aging that are distinct from medical illness.

As psychodynamic clinicians, we are not only in the position to reduce the psychological distress that accompanies aging or illness, but also we have the unique 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 in cases of serious illness) to present with paranoid ideation in the context of medical problems, aging, or both. Although sometimes paranoia can be a prodrome to age-related cognitive decline and dementia, in some cases paranoia and other regressed states represent a psychological collapse in

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response to illness, aging, awareness of mortality, and/or the fear about and realization of bodily limitations. In many patients, the presence of illness as well as the impact of aging in those who are psychologically vulnerable creates 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. Within traditional psychoanalytic (Freudian) theory, it was thought 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 medical and aging patients. Though anyone who has difficulty with symbolization can make psychotherapy challenging, patients who are ill and some aging populations present unique challenges. 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. First, I will briefly discuss some of the problems that have beset traditional psychoanalytic theory and its application to patients in these populations. Next, I will present 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. Finally, I will suggest that working with ill and aging patients requires us to retain some of the original ideas within traditional psychoanalysis. However, by using a more flexible and modern approach, we can increase the chances of successfully engaging these populations in long-term therapy. Although other therapeutic approaches (outside psychodynamic therapy) 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 historical problems with traditional psychoanalytic theory, a modern psychodynamic orientation can be the most comprehensive approach for appreciating the complexities of medical and aging patient populations. 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 facets of aging in their patients.

Psychoanalytic Theory and the Body

Psychoanalysis[1] 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 had psychological causes. Historically, attention to bodily symptoms and illness within the theory has concentrated on psychosomatic illnesses. An illness that is "psychosomatic" suggests that psychological conflicts within patients are complicit in the origin of illness. There are many facets of the history of psychoanalysis and the body that do not bear repeating here, though the historical 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 traditional theory has treated bodily symptoms.

Many of the ideas about how psychoanalysis views illness stem not just from Freud, but from research and writing that took place in the 1930s, 1940s, and 1950s. The diseases studied at this time were medical diseases, 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 with illness was referred to as *specificity theory,* which postulated that certain physical symptoms are recruited to mange 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.

[1] For ease in delineating traditional versus contemporary thinking within the broad field of psychoanalysis, I will use the term "psychodynamic" to mean the more contemporary practice of psychoanalytic psychology and an acknowledgment of the use of any of a large number of theories that stem from this tradition by a number of contemporary clinicians, including non-analysts. Throughout the book I will use the terms "traditional theory," "classical theory," and "psychoanalysis" to refer to traditional and older theories.

Specificity theory was ultimately discredited on the grounds of being too absolute (e.g., Paulley, 1991) and because research findings did not support its claims. Other psychoanalytic theorists continued to emphasize emotional difficulties as complicit in medical illness. The term *alexithymia,* introduced by Sifneos (1973) and Nemiah (1973) in two separate papers the same year, refers to individuals who are unable to use words to describe emotions. The main qualities in those who are alexithymic include difficulties identifying and describing feelings, differentiating between emotional and physical sensations, and those who have a concrete and externally oriented cognitive style (Zackheim, 2007). People who are considered alexithymic tend to present as emotionally flat; it is difficult for others to know what they are experiencing, presumably because they themselves do not know what they are feeling. Alexithymia was originally conceptualized as a predisposing factor for psychosomatic illnesses based on the notion that if one is unable to access feelings and emotions, then these feelings and emotions would be expressed in the body through physical symptoms.

Although it is true that some medical patients have trouble accessing feelings (which is often the *result* of an illness, not the cause), the implication that people who are prone to physical illness are expressing some kind of psychic conflict remains today as a stereotype of psychoanalytic approaches to illness. For example, for this book I interviewed a number of highly educated people with medical illnesses. A constant barrier in these interviews was that when the individuals I interviewed were told that I was writing a book on psychodynamic approaches to illness, they assumed that since I identified myself as a psychodynamic clinician, I must assume that their illnesses were not real. Many of these people said that they understood both traditional and contemporary psychoanalytic/psychodynamic theory to presume that illness is "all in one's head." The persistence of these ideas has made a psychodynamic influence in modern medicine difficult and seemingly incompatible. In general, many clinicians and scientists today look upon psychodynamic approaches to illness as "vague, unnecessarily mentalistic, and therefore inimical to scientific investigation" (Duberstein & Masling, 2000, p. xv).

Classical psychoanalysis was also initially not considered a useful therapeutic intervention for older adults. Freud (1905) considered the analysis of people over 50 as inappropriate due to a lack in what he referred to as "elasticity of the mental processes" (p. 258). There are exceptions to this exclusion within psychoanalysis, however. As early as 1924, Abraham described the application of psychoanalytic work to older adults. Erikson (1950) characterized self-development occurring throughout the lifespan and discussed important conflicts that need to be resolved well into old age. More recently, there appears to be an attempt to integrate psychoanalysis and psychodynamic principles with older patients. For example, Muslin (1992) and Settlage (1996) wrote on the psychoanalytic treatments of elderly women. Cohler (1998) described the benefits and limitations of working with older adults from a psychoanalytic perspective. Sobel (1980) discussed countertransference issues with elderly patients. Additionally, a new book addresses psychodynamic approaches to both late-life depression and dementia. (Davenhill,

2007). In general, however, until recently there has been little psychoanalytic or psychodynamic literature on work with older adults. The field of geropsychology often emphasizes the use of life reviews and narrative therapy as recommended therapeutic interventions with aging populations (e.g., Haber, 2006), as opposed to contemporary psychodynamic approaches.

Although Freud discovered how psychic conflicts create physical symptoms, the patients being treated at that time were thought to have physical problems without an organic cause. Very little has been said in the literature about therapeutic approaches with patients with medical problems that are not psychosomatic – those with *real* illnesses. Traditional psychoanalysis has a long and complicated relationship with its valuation of the reality of external circumstances in a patient's life, as its theoretical approach has tended to privilege meaning via fantasies over real concerns. Conceptually, the "problem" of reality was never fully resolved within the psychoanalytic school of thought (Renik, 1998), and traditional analysts have been concerned that talking about reality in the sense of actual, concrete events and situations diminishes a patient's ability to understand their psychic life. Thus, psychoanalysis has de-emphasized real events (Goldschmidt, 1986).

The persistence within psychoanalytic theory that many medical disorders are caused by psychological and neurotic conflicts is one example of how reality has not been integrated very well into the theory. Simply put, psychoanalysis has been resistant to considering external phenomena as real, including bodily events, especially illness.

Though many events relating to illness and aging are experienced as part of a lifelong history and through a dynamic unconscious, it seems reckless to say that the events, feelings, and experiences that go along with illness and physiological changes do not have an *a priori* impact, and that there are no universal consequences to aging, illness, and the meaning of death experienced by all people. For example, research suggests that regardless of character type and prior psychopathology, a specific set of symptoms arises in many adults in response to life-threatening trauma (Boulanger, 2002). I include many serious medical illnesses in the category of adult trauma, but I also suspect that universal experiences of illness can be extended to some aspects of aging as well as nonlife-threatening illnesses. When we consider the impact of adult-onset events and take them on as important, independent (of the unconscious) facts, we venture into a different area of psychoanalytic theory. Fortunately, a modern psychodynamic approach to illness allows us to use helpful aspects of traditional theory (concepts such as transference, the process of loss and mourning, and aggression) while integrating newer and more flexible approaches to illness and aging. These approaches will be introduced in the next section and will be addressed throughout the remainder of the book.

Applying Psychodynamic Concepts to Aging and Medically Ill Patients

Classical psychoanalytic theory has avoided in-depth theoretical and technical involvement regarding medically ill and aging patients, which is understandable to some extent. Ageism, the fear of growing older, and the vulnerability associated with illness and dying are likely contributors, as all of us tend to avoid what makes us uncomfortable, a dynamic that affects both patients and clinicians. Additionally, the problem of applying psychoanalytic theory to "nontraditional" patient populations has plagued the field since its inception. Historically, psychoanalysts have treated young, white, middle- to upper-middle class adults who are most often physically healthy. Such patients, it was thought, have ample psychological resources (ego strength) to tolerate the therapeutic process and sufficient capacity for symbolization. Although within the last 50 years or so, psychoanalytic theory has addressed working with patients who are more concrete and lack symbolic capacity, these approaches have not been widely applied to work with patients who have medical problems or who are struggling due to the demands of aging. Many patients who are fraught with bodily demands present with difficulties accessing thoughts and feelings. The body is a concrete arena and individuals experiencing bodily decline tend to be more focused on the physical, rather than the psychological aspects of functioning. This can make it difficult for us to connect with them.

As an example, several years ago I was talking with a colleague about working psychotherapeutically with medically hospitalized patients. We were discussing the difficulty of engaging these patients in the psychotherapeutic process. As my colleague put it, "It seems at times if the patients weren't chained to the bed they wouldn't talk to you."[2] The point to be made is that for hospitalized medical patients, their relative captivity in the hospital makes it difficult for them to refuse a consultation with a mental health clinician. Additionally, this comment reflects the fact that many medical patients get mental health treatment at the urging of their physicians. Making this situation more difficult, patients often interpret such a referral to mean that there is something psychologically wrong with them or that their physician is concerned about some aspect of their coping or adherence to treatment. These patients are often not being overly suspicious. As I have previously described, because our mental health system is not more integrated and accessible, "difficult" patients are often overrepresented among referrals for psychological treatment in medical settings (Greenberg, 2007).

When the body stops working, the individual becomes more concrete. The term *concrete* has negative connotations within both psychiatric and psychodynamic literature. Here, however, I am using it in a more neutral way. I will discuss in further detail the ideas related to this concept in Chapter 3, particularly how trauma,

[2] I am indebted to Bram Fridhandler, Ph.D., for this portrayal of work in medical settings. Many students over the years have benefited from his apt description of the challenges of working with medical patients.

illness, and the long-held notion that traumatic events impact the ability to think abstractly. However, what I mean by concrete is that the focus on the body (in illness) pulls attention away from psychological factors. When attention is removed from the psychological, all of us become more physically oriented and, thus, psychologically concrete. We have less access to our mind's capacity for reasoning, reflection, and symbolic thought. Simply put, intense bodily demands make it difficult to think. One need only remember the last serious flu they had to recognize this issue. When the body is malfunctioning and one is suffering, it is hard to reflect in a psychological way. Attention is directed toward the body. Additionally, this somatic distraction can affect not only attention, but also concentration and other necessary neuropsychological skills, which makes access to emotional functioning difficult (Duffy, personal communication, August 13th, 2008). This can also result in normative regression in which access to thoughts and feelings is reduced. In some cases regression can become extreme, as in the case of Betty, who could not access her feelings since they were externalized through her paranoia. In other patients, however, regression may mean difficulties in working with doctors, what some physicians perceive as excessive emotionality, or difficulty following a physician's advice. Although the term *regression* carries some of the same risks as *concrete*, I also mean to use regression in a neutral way. We all depend on our physical body for day-to-day support of our normal daily living and activity, so most of us take the healthy functioning of our body for granted. When our body stops working or the use of our body is threatened, this can be "world shattering" (Gordon, personal communication, August 1st, 2008). The shattering of this world, the world of physical liveliness and ability, is threatening because we realize that without a body, there is nothing else. We all are dependent on our body to live. This dependency is a normal one that we all take for granted, as most of us are accustomed to an efficiently functioning body. However, those who lose this dependency are thrown into a world where nothing can be trusted and nothing can be depended upon. Of course this is more pronounced with people who have serious and life-threatening illnesses, but this can also be true of psychologically vulnerable individuals, even if illness is not severe. As I will discuss, these issues create a sense of an inherent lack of safety; it is this lack of safety and security that presents challenges to us as mental health clinicians.

Some of these difficulties may explain the apparent popularity of cognitive-behavioral therapy (CBT). Although in my opinion the CBT approach does not fully address the range of concerns and issues present in medical patients, I can understand the reasons why CBT is *seemingly* compelling. The first refers to the idea that "difficult" or noncompliant patients often get referred for medical treatment within health care facilities. 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 mental health 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 do something (or 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