

# 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,

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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.

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