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A Self-Psychological Exploration of Multiple Sclerosis in its Biopsychosocial Context

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Running Head: SELF PSYCHOLOGICAL CONTEXT OF MS

A Self-Psychological Exploration
of Multiple Sclerosis in its Biopsychosocial Context

by

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**A SELF-PSYCHOLOGICAL EXPLORATION OF MULTIPLE SCLEROSIS
IN ITS BIOPSYCHOSOCIAL CONTEXT**

presented on June 20, 2011

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Dedication

To Rob

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Abstract

This theoretical dissertation constructs a new frame of reference for understanding relapsing-remitting multiple sclerosis (RRMS) using self psychology to develop a biopsychosocial formulation of the illness in order to better inform the medical treatment of patients. After conducting a critical exploration of MS in its historical context and providing a brief overview of the etiology of MS, this paper examines the phenomenology of the illness using the concepts of self psychology to further develop the theory of Engel's (1977) biopsychosocial model. The relationship among biological, intrapsychic, and social factors and coherent conceptualization and medical treatment of multiple sclerosis is addressed. This project examines the ways that experiencing the symptoms of MS, undergoing diagnosis, and seeking treatment for the illness disrupt individuals' sense of self. In particular, it considers the role and impact of the doctor-patient relationship as it relates to the patient's experience of wholeness. Patient accounts illustrate and humanize the theoretical concepts as they are presented. Through a self psychology-elaborated biopsychosocial lens, this paper also explores the ways that mainstream medical treatment can inadvertently strain patients. Finally, with this new frame of reference, this project suggests approaches to better supporting patients' psychological needs through a self-psychology informed approach.

keywords: self psychology, biopsychosocial model, multiple sclerosis,
doctor-patient relationship

This paper is an integration of several ideas. First, multiple sclerosis (MS) is presented as a serious neurological disease that broadly and unpredictably impacts patients' physical health. In addition, MS is examined as an illness that affects individuals' experience of themselves, their relationships with others, and their place in the social world. The biomedical historical context for conceptualizing the lived experience of MS is also examined. The impact of MS will be described broadly from the perspectives of the biopsychosocial model and self psychology.

Multiple Sclerosis is a serious neurological disease that affects an estimated 400,000 individuals in the United States. It is a chronic illness in the sense that once the disease process begins, it never completely abates. Symptoms of the disease vary widely, however, and may remit for long periods of time. Though it is rarely permanently disabling and usually does not affect life expectancy (National Multiple Sclerosis Society, 2010), the unpredictability and inconsistency of this illness have a unique way of testing the limits of modern medicine, human resiliency, and the doctor-patient relationship (Kalb, 2007).

The purpose of this paper is to construct a new frame of reference for understanding MS using self psychology to develop a clearly articulated biopsychosocial formulation of the illness. After conducting a critical exploration of MS in its historical context and providing a brief overview of the etiology of MS, this paper examines the phenomenology of the illness using the concepts of self psychology to further develop the theory of Engel's (1977) biopsychosocial model. The relationship among biological, intrapsychic, and social factors and coherent conceptualization and medical treatment of multiple sclerosis are addressed.

This paper concentrates on the ways that experiencing the symptoms of MS, undergoing diagnosis, and seeking treatment for the illness disrupt individuals' sense of self. In particular, it examines the role and impact of the doctor-patient relationship as it relates to the patient's

experience of wholeness. Physicians occupy a primary role in shaping patients' perceptions of their illness and its treatment (Weng, 2008). By relating a theory of the impact of MS on self experience and the doctor–patient relationship, this paper addresses the psychological aspects necessary to build a foundation for “realizing the full individuation and flourishing of the patient” (Kachuck, 2011, p. 206) in the context of a very challenging illness.

Through a self psychology-elaborated biopsychosocial lens, this paper will also explore the ways that mainstream medical treatment can inadvertently strain patients, and how, through a self-psychology informed approach, physicians may avoid the pitfall of causing iatrogenic effects.

Phenomenology of Multiple Sclerosis

Multiple sclerosis is a chronic neurological illness that affects the central nervous system (the brain, the spinal cord, and the optic nerves) through an autoimmune process in which the body erodes away sections of its own myelin, the substance that insulates nerve fibers. Nerve fibers transmit sensory information throughout the body and myelin serves to increase the speed and accuracy of these messages. The loss or misinterpretation of electrical message is apparent in MS patients through a variety of neurological symptoms, among them loss of coordination and fine motor control, gait problems, visual disturbances, bowel and bladder dysfunction, sexual dysfunction, numbness in the limbs, cognitive changes, and paralysis. Symptoms are unpredictable and vary depending on the precise location and extent of nerve damage. Most people with MS do not become severely disabled and life expectancy is not typically affected. The disease is not contagious or directly inherited. Although there is no cure for MS, a variety of medications are available to treat the disease (National Multiple Sclerosis Society, 2010).

MS symptoms tend to follow one of four broad patterns, or courses, over time: relapsing-remitting, primary-progressive, secondary-progressive, or progressive-relapsing. Of the four, relapsing-remitting multiple sclerosis (RRMS), the focus of this paper due to its prevalence and characteristic course, is the most common initial diagnosis, affecting 85% of patients. This form of MS is characterized by attacks of worsening neurologic functioning followed by periods of remission during which individuals recover from their symptoms completely or in part (National Multiple Sclerosis Society, 2010).

Living with RRMS is an exercise in the tolerance of ambiguity, particularly as individuals first experience symptoms, seek treatment, receive a diagnosis, and begin to adapt to this illness. It is not unusual for this period of heightened uncertainty to last years or even decades. MS is a neurological illness that typically develops in early adulthood, often with the sudden onset of non-specific symptoms that disappear after a period of days or weeks. It occurs most commonly among people living in northern latitudes. Like other autoimmune diseases, twice as many women as men are affected (National Multiple Sclerosis Society, 2010).

Diagnosis is a complex process that often requires sustained neurological testing, examination, and observation. Although treatments—abortive, preventative, and palliative—are available, there is no cure for MS. The varied symptoms that may result from neurological dysfunction occur intermittently and unpredictably. It is difficult to speculate about, let alone predict, the course of MS. Given the uncertainties of life with RRMS, coming to terms with the illness psychologically—a process referred to as illness acceptance—presents formidable challenges (Kalb, 2007).

While adapting to diagnosis may seem to be the primary psychological task of coping with any chronic illness, in the case of MS, diagnosis itself often requires individuals to

surmount numerous obstacles. For a host of reasons, patients are often referred to multiple physicians before their suffering is confirmed to have a neurological basis. As Campbell, DeJong, and Haerer (2005) observe, “MS is often initially diagnosed as hysteria, malingering, depression, anxiety, neurasthenia, or some other “functional” disorder” (p. 640). Often patients report a history of misguided treatments, including psychiatric care, as well as shameful encounters with skeptical or even demeaning physicians (Rosner & Ross, 1992). “Diagnostic delay” is the term used to describe the interval between the onset of symptoms and diagnosis. Recent analysis of a self-report registry of 18,000 MS patients found a mean diagnostic delay of approximately seven years (Marrie et al., 2009).

Even under the best circumstances, diagnosis is time consuming, uncomfortable, and often disorienting. The diagnostic criteria are complicated and several sources of data, including clinical presentation, histological evidence, and magnetic resonance imagery (MRI) are required (Compston & Coles, 2002). More importantly, the onset of symptoms is often insidious or vague. Even dramatic symptoms, such as paralysis, may spontaneously remit. MRI technology may be a boon to neurodiagnostics but to many patients, the notion of undergoing a “brain scan” raises considerable anxiety. Patients typically receive the diagnosis of MS in the company of unfamiliar physicians and imposing diagnostic equipment (Miller, McDonald, & Smith, 2005).

MS treatment requires monitoring and active management. Approximately six injectable medications, known as disease-modifying agents, have demonstrated the ability to decrease the likelihood that a patient will experience periods of acute disability (also known as relapses, exacerbations, or attacks) since becoming available, initially only by lottery, in the mid-1990s. Although these medications are critically important in stabilizing MS, they present significant costs, discomforts, and risks (Noseworthy, Miller, & Compston, 2005c). Other medications are

effective in aborting a relapse (Noseworthy, Miller, & Compston, 2005a) once it has begun or in treating more chronic, low-grade aspects of the illness, such as fatigue, restless legs, and spasticity (Noseworthy, Miller, & Compston, 2005b). At present, the standard of care includes treatment with a disease-modifying agent (National Multiple Sclerosis Society, 2007) as well as abortive and palliative agents as needed. Due to the complexity, risk, and various efficacy rates of treatment, patients must be willing and able to engage in a trusting relationship with their physician (Kachuck, 2011).

It is worth noting that this dissertation focuses exclusively on the lived experience of RRMS within mainstream medical contexts. MS tends to be a disease of Westerners, particularly people of northern latitudes (Compston & Confavreux, 2005). No longstanding tradition for conceptualizing and treating MS has emerged from the non-Western cultures from which most alternative therapies originate. With the exception of evening primrose oil, complementary therapies for MS tend to be nonspecific and palliative. They include approaches such as exercise, massage therapy, marijuana, and acupuncture. Although it is likely that the psychological experience of diagnosis, adjustment, and treatment would be very different in contexts other than hospitals and neurology clinics, circumventing the dominant system is not an option for American patients seeking a confirmed diagnosis at this time. Therefore, this project has assumed exposure to mainstream medical procedures in its exploration of patients' experiences (Bowling, 2006).

A Historical Perspective on Multiple Sclerosis

The concept of multiple sclerosis emerged in the early 19th century through the work of the German clinician and pathologist, Friedrich Theodor von Frerichs; the Viennese physician, Ludwig Türck; and the Bohemian pathologist and psychiatrist, Carl Rokitansky, among others

(Murray, 2005). Jean-Martin Charcot, the legendary French neurologist, is credited for initially naming the disease, describing it clearly, and widely educating the medical community about it. Charcot first lectured on “sclérose en plaque disséminée,” as it was originally called, in 1866; two years later he published the first formal and comprehensive description of the disease (Charcot, 1868; Goetz, Bonduelle, & Gelfand, 1995; Murray, 2005). Yet the true origins of MS are unclear. It may be a relatively new disease, originating just several hundred years ago. Or, it may have existed, un- or misdiagnosed, for a longer time, perhaps at its current rate of prevalence. Murray describes published cases that meet current diagnostic criteria for MS dating back to the 17th century. Cases were conceptualized according to the medical science of their time and typically attributed to “chronic lameness,” “palsy,” or “some action of the patient herself” (Murray, 2005, pp. 16-17).

One particularly intriguing case was published in *The Lancet* in 1864. It chronicled the illness of Margaret Gatty, a Victorian novelist. In retrospect, hers was almost certainly a case of MS. Her physician, Thomas King Chambers, went to great lengths to attempt to treat Mrs. Gatty effectively. Indeed, he consulted with other physicians and published her case in the leading medical journal of his day. Ultimately, his treatment was unsuccessful and Mrs. Gatty’s health steadily declined. Dr. Chambers concluded that the cause of his patient’s illness was “gardening excessively and using tools in the manner of a man” (Murray, 2005, p. 17).

Such misdiagnosis of multiple sclerosis was exceedingly common well into the 20th century. Even with the growth of texts addressing the differential diagnosis of MS, many cases were determined “only to exhibit characteristic changes of MS at autopsy.” As Murray (2005) observes, “One sees what one looks for, and often clinicians assessing a patient with complex and multiple neurological symptoms considered neurosyphilis, hysteria, or some other

neurological disorder first” (p. 206).

Though Charcot’s study of MS, published in 1868, just a few years after the publication of the Gatty case, encouraged the medical community to reevaluate their diagnostic assumptions, MS continued to present formidable challenges to diagnosis. In 1890, Dr. Thomas Buzzard, then President of the Neurological Society of London, gave a speech entitled, “Simulation of hysteria by organic disease of the nervous system” (later published in *The Lancet*). He concluded artfully, “The figure of Hysteria shrinks in proportion as the various forms of organic disease acquire greater solidity and sharper definition” (p. 285). Seven years later, in a chapter titled, “Diseases of the Brain,” the prominent neurologist Dr. Joseph Collins (1897) acknowledged the difficulties faced by his peers.

The statement by Buzzard that of all organic diseases of the nervous system, disseminated [multiple] sclerosis in its early stages is that which is most commonly mistaken for hysteria, will be agreed to by every one who has seen much of the former disease. Both of these diseases show themselves most frequently before or during early adult life, and the development of each may often be traced to some physical or psychical trauma. (p. 169)

Indeed, although MS is now understood to affect women at least twice as often as men, MS was widely believed to be a men’s disease until at least 1960. Historians speculate that this discrepancy was due, in large part, to the fact that men with probable MS were more likely to be given an organic diagnosis, while women were more likely to be diagnosed with hysteria or functional impairments under the same circumstances (Murray, 2005).

Improved recognition of MS and better conceptualization of the disease and its course did not simplify the diagnostic landscape, however. In the 20th century, physicians became both

better able and less willing to diagnose MS. In an attempt to preserve patients' sense of hope, physicians withheld the diagnosis of MS from patients, only informing spouses or other family members as necessary. It was common for spouses to be informed of the diagnosis and be instructed to keep it secret from the patient (Burnfield, 1984). As Murray (2005) writes, "Neurologists had such a negative view of the disease that they were reluctant to give any patient 'the death sentence;' they recognized no form of therapy altered the eventual outcome of the disease" (p. 517). Physicians feared that the patient's knowledge of his diagnosis would have an iatrogenic effect and therefore they routinely withheld diagnostic information from patients themselves.

When the term "iatrogenic" first appeared in a psychiatry textbook in 1924, it referred to patients' mainly psychological reactions to physicians' medical diagnoses. The term reflected a 19th and early 20th century attentiveness to the impact of physician communication on the physical and emotional well being of patients (Sharpe & Faden, 1998). As Francis Peabody warned young medical students in his 1927 treatise, *The care of the patient*, "You will find that physicians, by ill-considered statements, are responsible for many a wrecked life, and you will discover that it is much easier to make a diagnosis than it is to unmake it" (p. 881). As medical science advanced, use of term "iatrogenic" shifted, however. By 1956, "iatrogenic illnesses" were understood to be "diseases resulting from the development of potent new therapeutic agents and improved surgical procedures" (Sharpe & Faden, 1998, p. 63). In contemporary medicine, the term "iatrogenic illness" tends to refer to problems like nosocomial infections and adverse events related to medication use and diagnostic procedures (Steel, Gertman, Crescenzi, & Anderson, 2004). In social science circles, an iatrogenic effect is more broadly defined as "the unintentional harmful effects of medical intervention or advice"

(<http://www.preventionaction.org/node/801>, downloaded August 28, 2010).

In this paper, the term ‘iatrogenic effect’ refers to the unintentional harmful intrapsychic effects of medical intervention or advice. This paper explores iatrogenic experiences in order to better understand the challenges faced by individuals living with MS and threats to the effective medical treatment of this illness.

As recently as 1985 and 1990, editions of the authoritative text, *McAlpine’s Multiple Sclerosis* warned against directly informing a patient of his diagnosis. The authors acknowledged that because the disease had attracted public attention from the media and groups like the National Multiple Sclerosis Society, it was advisable to provide patients with “a rational explanation” such as “a disorder of the nervous system, which might clear up with adequate rest” (Murray, 2005, p. 517). If a patient pressed for more detail, the physician might share the diagnosis, “along with a warning not to believe everything printed about the disease” (p. 517). In all cases, physicians attempted to instill “good habits” (p. 517), particularly rest, communicate with “the relations, not the patient” (p. 517), and leave hope undisturbed.

The Biopsychosocial Model and the Theory of Self Psychology

Historically, the origins of MS have often been explained from a psychological or social point of view as much as from a biological or medical perspective. Indeed, the psychosocial aspects of this illness have played an integral role in the medical field’s understanding of it. In contemporary medical practice, one way to address the broad impact of MS is by conceptualizing the illness using the biopsychosocial model.

The Biopsychosocial Model

This project begins by applying the biopsychosocial model to multiple sclerosis. The biopsychosocial model is a well established, familiar, and generally well-regarded way for

physicians to acknowledge that the lived experience of an illness is much larger than the physiological process of a disease (Engel, 1977; Ghaemi, 2009). As Frankel, Quill, and McDaniel explain (2003), the biopsychosocial model:

provides a broader understanding of disease processes as simultaneously encompassing multiple levels of functioning, including the effect of the physician–patient relationship.

This means that a comprehensive understanding of every aspect of care from diagnosis to treatment depends upon an appreciation of both linear and nonlinear processes associated with disease and illness” (p. 24)

This model is important because it invites the patient’s personality as well as a vast array of others into the exam room: family, supervisor, colleagues, friends and lovers. It even welcomes the patient’s encounters with strangers on the bus, dilemmas regarding yet unborn children, and difficulties adjusting to social norms and expectations. In the absence of the biopsychosocial model (i.e., the biomedical model), physicians and patients risk neglecting the importance of the patient’s internal experience as well as the impact of encounters with the society in general. All of the experiences of being sick might be too quickly reduced to the biological imperative of demyelination and autoimmune dysfunction (Frankel et al., 2003).

The biopsychosocial model has become commonplace within American medical circles since it was first introduced in 1965 by Roy Grinker, M.D. Grinker, an analyst of Freud (and perhaps his last living patient), was trained as a neurologist, worked in the field of psychiatry and embraced eclecticism and General Systems Theory in strong opposition to psychoanalysis (Ghaemi, 2009; Grinker, 1965). His role in coining the term “bio-psycho-social” (Grinker, 1964, p. 229) is often unacknowledged (Ghaemi, 2009).

The biopsychosocial model was popularized by George Engel, M.D., who studied

internal medicine at Johns Hopkins University Medical School in the 1930s and devoted most of his clinical career to the treatment of gastrointestinal maladies. Engel subsequently received psychoanalytic training for five years in the 1950s at the Institute for Psychoanalysis in Chicago. Although his allegiance to psychoanalysis seems to have been forgotten, Engel's mission was to bridge the gap between psychoanalysis and internal medicine (Ghaemi, 2009).

In contemporary health settings the biopsychosocial model has become a dominant “common sense” approach to considering the broad impact of individual, family, and systems-level dynamics as well as the interplay of biology, psychology, and social factors (Ghaemi, 2009). Perhaps because of its wide acceptance, writers such as Ghaemi and Epstein, Borrell, and Carrio (2005) have criticized physicians, and especially psychiatrists, for their complacency with a model that has drifted towards an eclecticism verging on solipsism. A serious failing of such an approach, and one that this project seeks to remedy, is the potential for a popular, apparently sensible model to be practiced in an unreflective manner that neglects the deeper, but possibly quieter, aspects of human interaction.

This project elaborates Engel's (1977) biopsychosocial model with the concepts of self psychology. Integrating the biopsychosocial model with self psychology offers a more holistic understanding of the lived experience of multiple sclerosis and the important role of the doctor-patient relationship. By regarding the biopsychosocial model of MS through the lens of self psychology model, this paper seeks to better articulate the dynamics and processes whereby intrapsychic and relational experiences influence chronic illness and one another.

The Theory of Self Psychology

Self psychology is a psychoanalytic theory that was founded in the 1970s by Heinz Kohut. According to self psychology, the primary psychological aim of human existence is the

“cohesion and fulfillment of the self” (Wolitzky, 2005, p. 25) The self is understood to be the internal, psychological structure that provides a felt sense of cohesion, continuity, and enduring organization to self-experience over the lifetime (Socarides & Stolorow, 1984). Individuals gain this sense of cohesion, or wholeness, by developing, and then maintaining, a healthy self that exists in relationship with others (Wolf, 1980).

The theory of self psychology offers a means for understanding individuals’ experience of intrapsychic and interpersonal stress in the context of multiple sclerosis. This section discusses several relevant theoretical aspects of self psychology in an effort to provide a lens from which to understand the disruption of self that is inherent in MS.

Theory of selfobjects. A key concept to understanding the foundation of self psychology is the theory of *selfobjects*, “those persons or objects that are experienced as part of the self or which are used in the service of the self to provide a function for the self” (St. Clair, 1986, p. 149). Kohut theorized that individuals need others to engage them with a sufficient degree of attuned responsiveness in order to feel cohesive, or, in ordinary terms, human. According to Kohut, this need for attuned responsiveness emerges in infancy and is met by empathic caregivers. Kohut referred to the experience of increased self-cohesion in the context of attuned responsiveness as a selfobject function. He theorized that individuals internalize selfobject functions in order to restore their sense of cohesion during periods of distress. In other words, a selfobject is an internalized experience that functions to maintain one’s healthy sense of self (Kohut 1971, 1977; Wolf, 1988).

Kohut argued that selfobject experiences play an enduring role in maintaining and energizing the self throughout life. The characteristic form of these experiences shifts to meet the developmental needs of the individual (Kohut, 1971, 1977). In addition, selfobject experiences

do not always take the form of interpersonal relationships. For example, a child may reach for a favorite stuffed animal when he is tucked in at bedtime in order to soothe his fears of being alone in a darkened room. The comfort imparted by this non-human object exists in relation to the child's constellation of attuned, responsive relationships with important caregivers, thus evoking the necessary selfobject experience to calm and comfort the child.

Kohut (1971, 1977) believed that the self could not be experienced as cohesive in isolation from its selfobjects. He also asserted that the expression and intensity of selfobject needs in adulthood is directly related to the positive and negative aspects of one's early relationship with primary caregivers.

The bipolar self. According to Kohut, the healthy self is a consolidated product of two primitive components otherwise known as *the bipolar self*. The first component is the *grandiose, exhibitionistic self*, which contains the individual's fantasy of omnipotence and perfection. The second component is the *idealized parental imago*, which is the projection of one's imagined omnipotence and perfection onto another person. Over time, and through the process of normal development, these primitive components are refined. They transform into the mature capacity for ambition, pride, ideals, and goals. In this manner, healthy adults become capable of expressing capacities for self-awareness, emotional regulation, conflict resolution, and the maintenance of self-esteem (Kohut, 1971).

Kohut regarded the determining factors of psychological development to be the inborn potential of the child and the quality of the empathic relationship between the parent and child (St. Clair, 1986, p. 151). He did not believe that children were born with a self. Rather, because parents treat children as if their selves are present, the cohesive self gradually forms through a process of inclusion, exclusion, and strengthening of boundaries. Over time, the potential for

fragmentation decreases. Childhood grandiosity, channeled into ambition, initiative, and self-esteem, fuels realistic endeavors and creates feelings of satisfaction. The idealized parental imago is introjected as the superego (Kohut 1968, 1971; St. Clair, 1986).

Optimal frustration. One key concept of the Kohut's formulation of self psychology is *optimal frustration*. Kohut (1971) theorized that in order to establish internal psychological structures to soothe and tolerate tension in the self, individuals must experience "tolerable disappointments" (p. 64) in relationship with a primary caregiver. According to Kohut, every time an infant encounters, and survives, an optimal frustration, his need for the parent's perfect functioning and permanent presence diminishes. The infant internalizes omnipotent objects during periods of optimal frustration by providing soothing functions to himself. In other words, the experience of optimal frustration prompts the infant to internalize the primary caregiver's capacity to calm the self during periods of stress (Kohut, 1972).

Transmuting internalization. Kohut defined optimal frustration as the primary mechanism by which psychic structure is built and psychoanalysis cures patients. He described a process of internalization whereby characteristics of selfobjects are internalized into the self structure. That is, as children experience many brief reminders that their primary caregivers cannot maintain an experience of perfect equilibrium for them, they gradually "microinternalize" realistic aspects of the parent's image, such as calm and patience, into their own "psychological equipment" (Kohut, 1977, p. 32). The painstaking construction of self structure by means of optimal frustration forms the core of the therapeutic process, as well. Kohut named this process *transmuting internalization* to describe "the depersonalizing shift from the personality of the object, which performs the function, to the function itself" (St. Clair, 1986, p. 150).

In addition to containing an individual's enduring personality organization and managing internal states of distress, the self also generates the desire to find and attract others. An individual's relationships with others fall into two broad categories, mirroring Kohut's bipolar structure of the self. One category represents the need to experience others as ideal, special, and more powerful than the self. This category of individuals is experienced as unlike the self. A second broad category of relationships represents the need to experience others as like-minded or similar in talents, abilities, and perspective (St. Clair, 1986; Socarides & Stolorow, 1985).

The theory of self psychology suggests that a psychologically healthy person has six positive personality capacities, “. . .enduring sense of personal agency, continuity through time and space, stable self-esteem and sense of well being, unitary mind and body vitality, functional soothing and regulatory capacities, and the ability to seek out meaningful others . . .” (Geist, 2008, p. 130). Despite their general stability, these qualities are vulnerable to damage. In other words, when psychological connection with either ideal or like-minded selfobjects is disrupted, self capacities may become impaired. (Ornstein, 1998).

Empathy. One of Kohut's (1959, 1980, 1982) most important contributions to self psychology was his formulation of the role of empathy in human development and his development of the concept of *vicarious introspection*, a form of empathy-oriented data collection in psychoanalysis. Kohut regarded empathy as a developmentally necessary aspect of good caregiving and he described several critical selfobject transferences concerning the adequate communication of empathy throughout the lifespan. Kohut applied empathy to psychoanalysis, coining the term *vicarious introspection*. In this sense, Kohut regarded empathy as an intentional, disciplined, and focused “immersion” in the self experience of another person. In the context of an empathic listening perspective, attunement to the fluctuating self states of the

other becomes possible. With accurate empathic attunement, a person may experience a deep feeling of being known and understood. From the perspective of self psychology theory, empathic attunement is a vital aspect of accurately understanding states of depletion and suffering as well as restoring a sense of cohesion to a person in the throes of self fragmentation and depletion.

Although Kohut's theory did not directly address the relationship between empathy and iatrogenic effects, he makes an interesting note in his 1979 clinical paper, *The Two Analyses of Mr. Z.* The paper comments upon two courses of analysis with the same patient, the first a classical analysis and the second a self psychology analysis. Kohut describes the analyst's behavior during the first treatment as heavily interpretive and rather distant from the analysand's own experience. For a year and a half, the analysand's rage dominated treatment (1979, p. 5). At that point, the analyst offered a powerfully validating comment and the analysand's stance shifted dramatically. During the second treatment, the analyst supplemented his interpretive work with a firm commitment to vicarious introspection. Kohut describes a dramatic shift in the analysand and concludes that the rage that predominated the first analysis was "a burdensome iatrogenic artifact" (p. 12) of the classical psychoanalysis. In other words, Kohut's conceptualization of the analyst seems to indicate that in the absence of empathy, experience-distant, interpretation-oriented analysis is quite capable of causing iatrogenic harm.

Essential selfobject functions. Kohut articulated three essential selfobject functions for healthy psychological development: mirroring, idealizing, and twinship (Kohut, 1984).

Mirroring. Mirroring concerns the need to experience affirming responsiveness from others. In mirroring, an empathic selfobject empathically responds to the grandiose-exhibitionistic self of the child (St. Clair, 1986). It is noteworthy that as his writing

progressed, Kohut expanded the concept of mirroring to include “all of the transactions characterizing the mother-child relationship, including not only reflections of grandiosity but also constancy, nurturance, a general empathy, and respect” (Greenberg & Mitchell, 1983, p. 355).

Children seek validation, a slightly more sophisticated form of the mirroring function (Stark, 2002), in various ways throughout normal development. For example, a child who has just learned to ride a bicycle will seek her parents’ admiration and approval of the accomplishment by demonstrating her new skill for them. When mirroring needs are frustrated, affirming responsiveness may be inadequate or missing. The girl on the bicycle may encounter a parent who expresses anxiety regarding her newfound skill, rather than pride, for instance. In this case, the individual may feel psychologically injured. Internally, such injury may take the form of feelings of arrogance, rage, shame, or depreciation of the self (Kohut 1971; Wolitzky, 1997).

Idealization. Idealization is a second essential selfobject function. In idealization, the child experiences the parent as calming, strong, trustworthy, and safe while also feeling a part of that object. Again, as his writing progressed, Kohut, “writing about the compensatory value of relations with the father” expanded the concept of idealization to include “intimacy, empathy, sharing, and other dimensions of a good relationship” (Greenberg & Mitchell, 1983, p. 355). Idealization is present when an infant cries and wishes to merge with the responsive parent. In that moment, the infant believes he controls the parent with his crying, and he idealizes the power of the parent to soothe him and restore his sense of wellbeing (Geist, 2008; Kohut 1971).

Twinship. Twinship is a third essential selfobject function that concerns the experience of feeling like other people and part of a human community. In twinship, the child experiences oneself and another as possessing shared talents and capabilities. There may be an unconscious

fantasy of being perfectly understood by the other, even without communicating verbally. Baker and Baker (1987) offer an example of the twinship selfobject function in the case of a young boy pretending to shave, using a bladeless razor, along side his father. Adolescent peer groups frequently exhibit twinship selfobject functions, as well. At this age, the closeness of the twinship may be dramatic, with strict rules about standards of dress and behavior. Over time, mature adults develop collegial experiences of closeness that meet twinship functions while remaining tolerant of individual differences. This sense of alikeness, shared experience, and companionship emerges later in childhood than the previous two selfobject functions and is an essential stepping stone to healthy adult relationships (Baker & Baker, 1987; Kohut, 1971).

Trauma. Mirroring, idealization, and twinship are essential aspects of healthy psychological development within self psychology theory. In the absence of healthy selfobject experiences, the self becomes fragmented. Self-fragmentation, within this theory, is the harbinger of psychopathology. Individuals will go to great lengths to avoid experiencing fragmentation and maintain a sense of wholeness and connectedness to others.

In the realm of self psychology, trauma occurs when selfobject experiences are inadequate. When the selfobject milieu of early life is adequately responsive or is frankly antipathetic, the developing self may be missing requisite structure and/or become vulnerable to self-fragmentation. This outcome can also result from trauma that occurs “in later life when selfobject experiences are unavailable, unreliable, or inconsistent” (Ornstein, 1998, p. 207) because, as previously noted, selfobject relations and needs extend into adulthood, albeit less urgently (Wolf, 1980). The development of the healthy self is then arrested (Socarides & Stolorow, 1984; Ulman & Paul, 2006), or, in the case of adult trauma, the functioning self regresses.

The lived experience of selfobject failure at a traumatic level may be extremely distressing at any age. Caregivers or critical others, expected to provide key selfobject experiences, may be chaotically overstimulating to the individual or may leave his survival at risk. The extent of harm may be mitigated by quick, appropriate soothing responses that help the individual consolidate his sense of self (Schoe, 2002).

Primary defects and compensatory and defensive structures. From the perspective of self psychology, psychopathology represents a misguided effort to restore a sense of self cohesion and protect individuals from engaging in situations where they anticipate selfobject failure (Ornstein, 1991, 2009). Kohut (1977) described primary defects and compensatory and defensive psychological structures. A defensive structure simply hides a primary defect in the self whereas a compensatory structure both hides and compensates for a defect in the self. Ornstein (2009) elaborates on Kohut's comments by noting that defensive structures may occur on any scale from the perspective of self psychology. Affects may be used for self-protective functions, as may complex personality features. These patterns, whether simple or complex, tend to become organized in childhood, in order to both preserve the child's attachment to the caregiver and protect the vulnerable self. Because self psychology prioritizes the cohesion of the self over the uncovering of truth, for instance, therapeutic work with defenses in this modality remains focused on maintaining empathic attunement and tending to patients "healthy strivings" (Ornstein, 2009, p. 468).

The Biopsychosocial Model and Self Psychology in the Context of MS

Elaborating the biopsychosocial model with the theory of self psychology offers a novel approach to understanding the lived experience of multiple sclerosis. Curiously, each modality seems to reach for the other. Engel's biopsychosocial model is an approach that seeks to

integrate biological with psychological and social sources of data. The biopsychosocial approach welcomes diverse sources of information yet is challenging to apply in clinical settings (Baker & Baker, 1996). Self psychology has been intently focused on implementation since its inception but not popularly disseminated like the biopsychosocial model. It is remarkable that Kohut (1973) himself strongly believed that the insights of self psychology should be applied to a broad range of contemporary problems in society.

Indeed, Kohut was originally trained as a neurologist (Strozier, 2001) and therefore, most certainly was familiar with MS. With specific regard to conceptualizing selfobject relations, Kohut recognized his and others' (e.g., Wolf, 2002) represented only a portion of the conceptual work of self psychology. As he wrote in 1984:

...we need investigations of the special selfobject needs of adolescents and the elderly, for example, along with investigations of the selfobject needs that accompany specific life tasks including those shifts to a new cultural milieu that deprive a person of his 'cultural selfobjects' during his mature years or when he has to deal with a debilitating illness, or the confrontation with death. (p. 194)

Methodological Approach

This project integrates a critical exploration of historical perspectives on MS and the phenomenology of RRMS. It considers MS from the biopsychosocial (Engel, 1977) perspective, that is, from a perspective that addresses the effect of the illness on individuals' physical, psychological, and social experience of self. The methodology will use self psychology as a conceptual tool for making sense of the history of MS and for understanding how those who are affected by it directly experience MS.

Baker and Baker's (1996) paper served as an exemplar for this project. These authors

demonstrate the integration of self psychology and the biopsychosocial model in the context of attention deficit/hyperactivity disorder (AD/HD) with the dual purpose of engaging in a coherent discussion of etiologic factors for that illness while also presenting AD/HD as a paradigm of the integration of those theories.

This project applies Baker and Baker's (1996) approach to RRMS in order to develop a theory that captures the effect of a medical problem—multiple sclerosis—on the interaction of individuals: patients, doctors, and society as a whole. A biopsychosocial approach to MS facilitates the acknowledgment of the complex physical, psychological, and social effects of the illness on those who are affected by it. However, the biopsychosocial model may be considered under theorized from the perspective of depth psychology. By adding self psychology to the biopsychosocial model, the experience of MS patients may be more accurately described, theorized and fully understood (Baker & Baker, 1996).

The methodology uses self psychology to understand individuals' experiences of fragmentation in terms of physical functioning, internal functioning, and interpersonal functioning, specifically the doctor-patient relationship. The concept of MS as traumatic disruption to self cohesion is described. The potential for positive and negative selfobject experiences is explored. Various transferences (mirroring, idealizing, twinship) are investigated in the broad context of RRMS. The dissertation concludes with a discussion of treatment considerations.

Patient Accounts

Patient accounts are interspersed throughout the dissertation's thematic contents. These accounts are intended to convey the lived experience of MS and illustrate the theory as it evolves. They are not intended to provide scientific data for empirical analysis. The sources of

the patient accounts are published memoirs as well as transcribed interviews collected for a qualitative research study conducted by this writer in 1994 and 1995. These accounts were first collected, explored, reported, and discussed in this author's unpublished undergraduate anthropology honors thesis titled, *Illness Narrative Among Multiple Sclerosis Patients: The Cultural, Social, and Semiotic Phenomena of Diagnosis, Adaptation, and the Doctor-Patient Relationship* (Smith, 1995a). The following section describes the circumstances under which the unpublished patient accounts used in this paper were originally collected.

From June–August 1994 and December 1994–January 1995, supported by the Claire Garber Goodman Fund at Dartmouth College, this writer conducted interviews with adults who had been diagnosed with relapsing-remitting MS. The groups were asymmetrical with respect to race, gender, age, class, geographic location, and treatment profile. Interviews were conducted with rural New Englanders recruited through a multiple sclerosis support group facilitated by registered nurses, Virginia Kilpack and Mary Ellen Shulock, at the Dartmouth Hitchcock Medical Center in Lebanon, New Hampshire. Six women were recruited through this group. The interviews referenced in this paper took place at the informants' homes over nine weeks during the summer of 1994. Each informant was interviewed on between four and eight different occasions. Signed informed consent was obtained for these audio-recorded interviews, which lasted one to two hours each.

The consent process made explicit the terms of the undergraduate thesis research: participation was voluntary, the data could be used at any time for publication, and confidentiality was assured through anonymity and the alteration of significant identifying details. This writer made notes about the interview itself immediately after each session. Audio-recordings were transcribed verbatim. The Committee for the Protection of Human Subjects at

Dartmouth College prospectively designated this study exempt from IRB review. Signed consent forms and audio-recordings were destroyed in 2003. No individually identifiable information has been retained.

The patient accounts collected by this writer in 1994 and 1995 examine the socially, culturally, and psychologically complicated phenomena of chronic disease as it is experienced through diagnosis and adjustment, compliance and adaptation, and the changing understanding of the doctor–patient relationship in the late 20th century. Data from transcribed interviews exhibit such themes as stages of adaptation, explanatory models of chronic illness, and strategies of coping as MS is incorporated into the personal identity of the patient. The structure and specific nature of this writer’s study were entirely original.

Multiple Sclerosis and Self Disruption

Baker and Baker (1996) theorize that the degree to which an individual experiences his self as coherent depends upon: (a) his stress level, at any given moment; (b) the health of his intrapsychic self-structure; and (c) “the empathic quality of [his] current object relationships that offer or refuse the opportunity to generate self-object experiences” (p. 230). Furthermore, Baker and Baker point out, “[a]ny biological factor can intensify or diminish stress, facilitate or impede development, and impact the generation of self-object experiences” (p. 230).

The self disruptive features of RRMS dovetail with Baker and Baker’s (1996) model. Although the effects of RRMS are variable and unpredictable, the literature on RRMS generally agrees that the effects of this disease disrupt selfobject experience. Superimposing RRMS symptomatology on Baker and Baker’s (1996) model yields the following observations:

1. Stress: The disease process causes symptoms that are disabling and stressful.

Individuals may experience loss of vision, debilitating fatigue, mobility problems, bladder and

bowel dysfunction, and cognitive changes, including depression, even early in the course of the illness (Compston & Confavreux, 2005; Multiple Sclerosis Society, 2010; Baker & Baker, 1996).

In addition, adapting to the diagnosis of MS necessitates the major life change of redefining oneself as an individual with a chronic illness facing an uncertain future. Experiencing a relapse “is always considered a ‘crisis’ that disrupts the status quo for both patient and family....

Because these symptoms may have a profound impact on life at home and at work for long periods of time—with no predictable outcome—relapses elicit strong reactions in those affected by them” (Kalb, 2007, p. S29). Reactions to a diagnosis of MS or to relapses commonly include anxiety, anger, guilt, grief, hopelessness, self-doubt, and indecision (Kalb, 2007).

2. Intrapyschic self-structure: The disease process impedes the construction and maintenance of coherent self-structure. Physical symptoms arise unpredictably and individuals living with MS discover that they are sometimes perfectly well and other times completely debilitated (Smith, 1995a). MS functions as a traumatic disruption to self cohesion.

3. Selfobject needs: The disease process hinders the ability to meet selfobject needs over the course of the lifespan. MS often impairs one’s ability to function as an employee, friend, spouse, or parent in a consistently healthy manner. Work performance, relational intimacy, and sexual performance may all be significantly affected and selfobject experiences suffer.

Individuals coping with MS are vulnerable to loss of self-consolidation and yet they may be less able to access supportive experiences (Baker & Baker, 1996).

In summary, a self-psychological approach suggests that the disease process of RRMS: (a) creates a traumatic disruption which in turn impairs intrapsychic self structure, creating identity confusion and loss of self consolidation; (b) strains selfobject relationships; (c) obstructs

selfobject experiences; and (d) hinders the optimal integration of available selfobject experiences (Baker & Baker, 1996; Smith, 1995).

The effect of this selfobject disturbance is self-fragmentation (Baker & Baker, 1996). Such states place MS patients at higher risk for exacerbations (Mei-Tal, Meyerowitz & Engel, 1970). Baker and Baker observe, in their analysis of similar dynamics among adults with ADHD, that, “a vicious cycle ensues, with distorted and arrested development that both increases the need for and disrupts the empathic responsiveness necessary to maintain self-cohesion” (p. 231). Among individuals with MS, early developmental concerns are not likely to be the primary concern. The illness tends to become apparent long after basic psychological development has been accomplished. Nonetheless, MS may trigger a “vicious cycle” of frustrated selfobject needs.

MS impacts each aspect of the biopsychosocial model. Each aspect also interacts with the others. For instance, unpredictable neurological impairment increases with stress. Stress threatens psychological wellbeing, weakens the self structure, and increases the need for social interactions that could be used to generate essential selfobject experiences. However, neurological impairment may simultaneously disrupt the quality or opportunity for these types of social, empathic interchanges. For individuals with MS, it may be difficult to feel connected to others. As experiences of empathy, mirroring, and twinship decrease, the potential for loss of self cohesion increases. Any subsequent reduction in self cohesion seems to increase the frequency and intensity of biological MS symptoms (Baker & Baker, 1996; Mei-Tal, Meyerowitz & Engel, 1970). MS not only attacks the self, but it assaults the individual’s ability to experience like-mindedness with others, the very experience that is needed to heal the self.

Disruption of the Body Self

Kohut (1971) conceived of the body as an integral part of the psychological self. He viewed “the body self,” that is, the intrapsychic relationship to the physical body, as the primary mechanism for the expression of exhibitionist and self-esteem needs. This experience of the self in relationship to the body is rooted in infancy and has several layers of meaning. First, the child’s experience of the grandiose self is through a body self grounded in the psyche. Second, an infant’s first experience of empathy is mediated through the body in infancy by means of physical contact, such as holding, rocking, and nursing. This original experience of receiving care is theorized by Kohut to be a rather magical time when the infant feels fused with the caregiver. It is this experience of fusion to which the individual will return during moments of connection with others in body, mind, and spirit throughout the lifetime. In its most simple form, self-cohesion is experienced, that is, grounded, through the physical body. Because the body is the individual’s first context for experiencing physical and psychological reality, the well being of the physical body was, in Kohut’s eyes, an integral aspect of body self cohesion.

The body self is also the locus of the paradox of multiple sclerosis. Like other autoimmune illnesses, MS not only threatens the physiological and psychological self, but it acts through a terrible malfunction of the immune system, a mechanism that normally works to stabilize and protect the life of the body and the self (Cohen and Abramowitz, 1990). In this sense, relapsing-remitting MS may disturb an individual’s ability to maintain a stable, cohesive sense of self. McWilliams (1994) writes that an “integrated sense of their own identity” (p. 54) is a necessary component of psychological wellbeing. The absence of specific symptoms and a circumscribed course of illness deprive the patient of a clear physical source of distress through which he can organize his sense of self in relation to MS.

Disruption of Expectations of Self

As Compston and Coles (2002) observe, “for the patient, multiple sclerosis threatens an apparently infinite variety of symptoms but with certain recurring themes and an unpredictable course” (p. 1221). The implication of the physical presentation this illness is that individuals living with relapsing-remitting MS are sometimes debilitated and other times quite well. However, (in reality, at least) they can never identify themselves as wholly one way or the other; furthermore, they cannot predict the course of their illness (Smith, 1995). The body self can be experienced as out of control and unreliable. Kohut (1971) theorized that individuals affected by vague and diffuse symptoms are particularly vulnerable to fragmentation. Wolf’s (2002) general definition of fragmentation in self psychology evokes the lived experience of multiple sclerosis: “Fragmentation means regression of the self toward lessened cohesion, more permeable boundaries, diminished energy and vitality, and disturbed and disharmonious balance” (p. 30).

Disruption, Loss and Grieving

This paper focuses on the disruption of selfobject experience during diagnosis and the early stages of treatment because these periods tend to present novel stressors. Although MS may traumatically disrupt selfobject experience throughout the lifetime, early periods of the illness tend to present the most intense psychological challenges. This is likely because they coincide with the early stages of the grief process. Like other situations that interfere with important aspects of life, developing a chronic illness triggers a grief response (Kalb, 2007).

What is grief from the perspective of self psychology and in the context of RRMS?

Cohen and Abramowitz (1990) address the first part of this question.

The affective experience of grief brings with it wrenching psychic pain; it involves the deepest sadness known to human experience. The death of a loved one, who provided

vital self-sustaining functions for the bereaved, can traumatically threaten the bereaved's most basic sense of self cohesion. A feeling that one is "falling apart" or is "lost and adrift" accompanies grief and reflects a profound sense of fragmentation.... Expressed in self psychological terms, whereas grief is the affective expression of the self traumatically disrupted by loss, the grief process involves mechanisms that may begin to restore self cohesion in two ways: by intrapsychically maintaining the selfobject bond with the deceased and by bolstering and reaffirming selfobject ties with the living. (p. 161)

One way of applying Cohen and Abramowitz's conceptualization of grief to the context of RRMS is to formulate the self as both fragmented and split. In RRMS, the "loved one" that has died is the healthy self, that individual that existed prior to the onset of the disease. The "bereaved" is the ill self, that individual that has developed some constellation of neurological signs and symptoms. Because the loved one and the bereaved are actually contained in one person, the self is split. Additionally, the self is fragmented by grief, the disruption of multiple selfobject bonds, and the physical realities of RRMS.

Experiencing the loss of prior functioning due to RRMS is similar to the course of the illness itself. The meaning of the illness, and thus the loss it inflicts, does not become apparent immediately. This complicates the grieving process. It is difficult to know what or how to grieve if it is unclear what will be lost or how the losses will occur. A few general comments can be made, however. The losses of MS are wide-ranging. As it is a disease that tends to strike healthy adults in the third or fourth decade of life, it is often a direct blow to peak parenting and professional years. As a result, regardless of its actual expression, MS threatens the ways in which adults express healthy narcissism, ambition, and ideals: profession, income, family role,

and physical health, among others (Cohen & Abramowitz, 1990). In this way, MS triggers a grief response that may have an ongoing impact on the lived experience of the illness.

In the early and middle stages of the grief process, individuals may be deeply affected by denial, anger, sadness, guilt, and anxiety. Just as the need for enhanced selfobject experiences grows, the reliability of existing selfobjects wavers. Contact with selfobjects, through the communities of daily life, is interrupted by illness. The ill individual may no longer feel a sense of fit with like-minded others who formerly shared a sense of professional collegiality, supporting mature, adult selfobject needs for twinship. The difference between the circumstances of the ill individual and those of her circle of friends, family, coworkers, and daily contacts may seem glaringly obvious. Idealized others, such as physicians and other important figures, may fail to fulfill their selfobject needs as individuals move through the process of recognizing worrisome symptoms, seeking medical help, and, ultimately, obtaining a diagnosis. Altogether, the ill individual is acutely vulnerable to a traumatic disruption of self (Charmaz, 1993; Cohen & Abramowitz, 1990).

This acute vulnerability to traumatic disruption of self experience changes over time. Even under difficult circumstances, individuals' relationships with others tend to become more stable and predictable over time. In this way, selfobject experiences may become more constant, dependable, or gratifying. Although one's objective health status may be more impaired several decades after the diagnosis of RRMS has been made, the patient's experience of the illness is likely to be more socially and psychologically stable than it was immediately following diagnosis. This gradually increasing awareness and accommodation of the illness is known as illness acceptance (Charmaz, 1993; Smith 1995a).

Disruption throughout the Biopsychosocial Spectrum

What follows is an exploration of several central phases of RRMS—first noticing symptoms, learning of the diagnosis, making decisions about treatment, and adjusting to life with the illness—from the perspective of self psychology and the biopsychosocial model. The core underlying themes of selfobject disruption and grief are discussed on an ongoing basis alongside these phases of illness.

Symptom onset. An individual's first exposure to symptoms is often confusion, disorientation, and shock. Regardless of whether a patient seeks medical care and receives an accurate diagnosis at this point in time, it is unlikely that she is able to fully appreciate her prognosis. Later, in the process, as she experiences a second attack, receives a diagnosis of clinically definite MS, and faces decisions about beginning disease-modifying agents and other treatments, she will encounter many additional challenges (Charmaz, 1993; Kalb, 2007).

A period of diagnostic uncertainty typically lasts years. In a sophisticated neurology practice, it is possible for individuals to be diagnosed with new-onset MS rapidly, thanks to modern neurodiagnostics and clinical advances. However, it is also routine, in these same practice settings, to meet scores of MS patients who report that they lived with symptoms for years, sometimes decades, before being accurately diagnosed (Marrie, 2009). From a self psychological perspective, this delay in diagnosis suggests that many patients may spend long periods of time without a reliable physical "locus" around which the psychological self can be organized (Cohen & Abramowitz, 1990, p. 159). As Kohut (1971) acknowledged, physical illnesses with vague symptoms increase one's vulnerability to self-fragmentation.

Initial encounters with MS may trigger self-fragmentation by a variety of mechanisms. First symptoms, such as rapid-onset vision loss, paralysis, or loss of coordination or motor

control, may be startling, cause embarrassment, and dramatically impact one's basic sense of trust in oneself. Others' confidence in the afflicted individual's wellbeing and competence to perform daily tasks, such as driving a car, caring for children, and carrying out work-related tasks, may also be affected. Such symptoms interrupt mirroring selfobject functions, as one's experience of feeling competent and admired diminishes.

This sense of diminishing competency may be internally driven. An individual's initial awareness of the illness may be characterized by heightened awareness, diffuse anxiety and confusion. As one patient described,

I couldn't understand what was going on, I was beginning to, to doubt my sanity a bit. Um, I thought maybe I was hiding something from myself in a major case of denial; it was very strange, because I'd always been very coordinated and very athletic, um, and all of a sudden I just would go through periods where I couldn't hold onto things, and I would drop things, and, and I would be terribly fatigued. I could sleep and sleep and sleep, and then I'd be fine. Um, so I kept thinking, alright, what is it that subconsciously is bothering me that I'm going into these deep periods of depression that I'm not aware of why I'm depressed. (Smith, 1995a, p. 48)

This patient's memory of her initial encounter with MS highlights the way that her symptoms contradicted her sense of invulnerability (i.e., "athleticism," "sanity"). In addition, like Dr. Buzzard's peers in London in 1890, she initially mistakes her symptoms for something like hysteria.

In contrast, some individuals find refuge from internally driven anxiety through defensive denial. Individuals who are convinced they are not impaired may not be immune from the

disruption of mirroring selfobjects. They are likely to encounter others' concern for their health.

Cohen (2005) recalls his experience with this process in his memoir, *Blindsided*,

My minor symptoms had become too big a deal, I thought. Doctors were supposed to be cautious, but they seemed to be rushing to a verdict before the evidence was in. Concern was out of proportion. "No," I calmly explained to my family and friends and doctors.

"This is a mistake."... Nobody was buying my explanation, least of all my neurologist.

"We will see" was about all he would say. The doctor did use a word that was unfamiliar to me in the context of illness: *denial*. (p. 13)

Denial in response to potentially serious illness may signal the emergence of the grandiose self in an effort to stave off further decompensation (Tasman, 1982).

From the onset of symptoms to diagnosis, there is, necessarily, a gap in the ability of selfobjects to adequately meet one's twinship needs. In other words, ill individuals may begin to sense, or even explicitly articulate, that they have become different from the healthy people that previously met their twinship needs. Sue, a woman with MS whose narrative (Campling, 1981) appears in the Disability Archive UK, describes her initial experience of the illness:

MS came suddenly, dream-like. On my usual walk down the lane which marks my country home, legs became heavy, the unconscious movement became conscious. I fell among the grasses and wild flowers, no real alarm yet, wondering. The strange consciousness of movement receded, I continued, but days later it reappeared. I went to the doctor. 'Er, Doctor, I-um-don't seem to be able to walk properly' - embarrassed, conscious of sounding silly.

This experience of difference separates them from the others that helped them feel part of a cohesive group, can lead to feeling fragmented, and reduce resilience to psychopathology.

Simply stated, individuals beginning to experience MS begin to feel different from the people they are closest to, and this feeling of difference and accompanying selfobject loss, may fragment the self, which leads to psychological suffering (Charmaz, 1993; Cohen & Abramowitz, 1990).

Notably, during this period of diagnostic uncertainty the post-diagnostic grief process cannot yet move forward. Individuals cannot accept the mantle of the “MS role,” as fragmented as that may be, and embrace the social support and possibilities for twinship experiences inherent in that role. And yet they may be well aware that they are not truly like others in some important but vague way. Support groups, which may play an important role later in meeting twinship needs, are not yet an option as the ill individual has no name for, let alone any sense of acceptance of, the illness (Charmaz, 1993). The situation is especially difficult as symptoms of MS spontaneously remit, only to relapse again later. At this point in the illness, individuals have no way to organize their experience or perceive it as an enduring presence.

Disruption of idealizing selfobject functions. When patients seek medical help for their symptoms, they hope to find people who can allay their anxiety as well as their physical suffering. From a self psychological perspective, the patient is prompted to seek medical care by some conscious recognition that self fragmentation is occurring in response to symptoms of illness. Through exchanges with an idealizable physician, the patient wishes to regain a sense of calm and security. In addition, the patient expects the physician to meet mirroring selfobject needs. As Cohen & Abramowitz (1990) observe, “the seriously ill person yearns, like a vulnerable child, for omniscient and omnipotent figures to merge with: thus, physicians, nurses, therapists, and other caregivers are sought to fulfill idealized selfobject functions” (p. 164).

Patients may recall this desire and articulate the need they felt very clearly. In the following patient account, a woman with RRMS recalls her first encounter with an idealizable physician.

[When I was younger...] the doctors used to make house calls. But I think here we were blessed with exceptionally good medical care... And doctors were much more attuned to people and what was new. But my very earliest memory of a doctor was old Dr. X. who went around with a horse and buggy and I remember the house that my parents built was being finished and I remember his coming down and sitting on a crate and he said, "I brought you something!" and I remember this and I would think, a present! And he brings me—his wife had pureed vegetables from their garden for me because my mother would be busy moving and all, so I remember his sitting and feeding me. And he was rather unusual because he had trained in, I think it was Harvard, I'm not just dead sure, but then he had gone to—I think it was Germany or someplace and gotten all where at that time they were ahead of us really in child medicine and so he fed me because I had been allergic to my mother's milk and so I had been fed on somebody's barley and vegetables and things like that way before children were eating at that time. It's amazing. But that's why I'm a vegetable person, I always say. There was never one that I didn't like! (Smith, 1995b)

Of course, in the case of MS, medical providers do not have all the answers, even in the best of circumstances. Under typical circumstances, the ill individual enters a lengthy period of uncertainty, during which she may seek care and reassurance from a variety of caregivers. This period of uncertainty often involves a gap in the fulfillment of idealizing selfobject needs, meaning that just as an individual's idealizing selfobject needs are mobilized by the illness, the opportunity for meeting these needs is lost and there is a resulting retraumatization. The ill

individual feels strained and possibly fragmented by the mysterious appearance of symptoms just as caregivers may doubt the clinical relevance of patients' presenting complaints or struggle to weave together the details of the clinical picture into a meaningful narrative. Often, caregivers are unable to step in to provide safety, calmness, and healing.

Physicians empathically fail patients at this point in the illness experience for a number of reasons. Misdiagnosis certainly frustrates selfobject needs for mirroring and idealization. However, even in the context of perfect interpersonal attunement, this situation—confronting the early phase of RRMS—is a setup for empathic failure. Before they develop symptoms of the illness, individuals' relationship with their body self is idealized. As symptoms develop and persist in a worrisome way, doubt arises and medical expertise is sought. The physician enters this idealized relationship between the psyche and the body self. At this point, an intricate process to solve the mystery begins. Inevitably, the physician disrupts the idealization of the body self by the psyche (personal communication, C. Smith, March 1, 2010), a process that may begin long before diagnosis and extend indefinitely.

The idealization of the body is nearly palpable in the opening of the account of Sue, the English patient quoted above, who first encounters MS, “dreamlike... among the grasses and wild flowers” (Campling, 1981). Relapsing and remitting symptoms persist and she consults a physician. Her story proceeds, describing a doctor–patient interaction in stark contrast to the happy, well-fed infant of the previous excerpt:

He eyed me bleakly and handed me some tranquillisers. I went home and threw them away. Symptoms continued and varied. I visited the medical profession again. This time he was not amused - look Mrs. Housewife you are depressed/isolated/neurotic/female. Are you taking the pills? No? Exasperated, take *these* pills. I take the pills, symptoms

persist. I go back to the overworked doctor. Repeat my story. He tries psychological approach (after all, he's on duty at the local 'mental hospital' sometimes, he has an interest in psychology). 'Do you find walking easier when you are not with your husband?' 'No.' I am not being helpful. 'Do you find it more difficult out of doors?'. 'Yes, I keep feeling like I'm going to fall over (and there's no furniture to hang on to).' Ah hah—his face brightens up, he's got it—agoraphobia. I'm not at all convinced, I ask for an examination. Smile fades, he refuses, says it's not necessary—I am agoraphobic. I don't feel any better, but I have a label. I go home and report that I am an agoraphobic. There follow months when I nearly kill myself, forcing painful legs on long walks, bike rides, in an effort to de-agoraphobic myself, combined with amateur psychiatry nights of 'where did I go wrong'. I couldn't get the feel of being an agoraphobic. I go back to the doctor; this time he's had enough. I am a hypochondriac - heated words - the patient answers back. I'm shown hastily out of the surgery shouting, 'Next time I see you I'll be in a bloody wheelchair.' Prophetic words. The next day I collapse, an embarrassed doctor (but covering up well with professional ethos) orders an ambulance (Campling, 1981).

Another illustration of such empathic failure comes from the following patient account. After consulting a psychologist and a gynecologist about her symptoms (the latter pressured her to undergo exploratory abdominal surgery), this patient finally saw a neurologist.

So I went to a neurologist 'cause a friend of mine who had MS was saying, "You know, I think you may have it." And I thought, "Nah, nah, not me, I don't have that, that's an incurable disease, I don't have that." So, I did go to a neurologist and he asked me what my social life was like, and I sort of looked at him, and I said I wasn't dating anybody at the time, and he asked me why I moved from the city out to the country, and I said, well,

because a relationship had ended, the lease was up, and all sorts of things were coming to an end, I wanted to get a fresh start . . . So he decided that I was very upset and I was really under stress, and what I really needed was a psychiatrist to talk to, 'cause obviously I needed a better social life, because he said, well, how often do you date [laughter]? I said, well, it's sort of hard to say, exactly, I'm not seeing anybody, I wasn't seeing anybody steadily at that point, and uh, you know . . . So he said, well, obviously, you're lonely and distraught, and you need a better social life, and a psychiatrist, and that was before he even examined me, and I was having some, looking back on it now, I definitely had some fine motor problems, and a little bit of some gross motor problems, so the neurologist tests, of your nose, and touch the finger, and that sort of thing and matching up. I realize now that, I had, never having done it before, it's like, this is a little awkward. But, not thinking at the time that it wasn't because I hadn't done it before, it was because there was a neurological problem there, and he was in, he was in denial of that, so he wrote a letter back to the referring physician saying that, based, I think he actually used the word neurotic in the, in the letter back to uh, the referring doctor.

(Smith, 1995a, pp. 50-51)

These last two examples recapitulate 19th century notions of hysteria, gender, and power within contemporary neurological practice, demonstrating a complex interaction between doctor and patient in their historical and biopsychosocial context. More specifically, examples such as these point to the serious disruption of selfobject ties that such an interaction may threaten for an individual patient. This felt disruption may recapitulate themes of its own, specifically, the ill individual's own preexisting self issues. In other words, the broader context of MS in society informs the doctor-patient interaction, which in turn conjures up the patient's internalized

selfobject milieu (Cohen and Abramowitz, 1990). Although the form of self disruption will vary, the lack of empathy and mirroring that patients encounter affects their relationships with physicians. They may find that their preexisting idealization and trust in physicians is dented or shattered (Scovern, 1999).

Diagnosis. Diagnosis is a fundamental aspect of medical practice; it is the process of discerning a problem through examination (Kleinman, 1988). In American culture, it is Western biomedicine that has identified multiple sclerosis as a disease and has determined methods for finding evidence of the disease. Especially in recent years, the American medical establishment has developed treatments for this disorder (Bowling, 2006). In this culture, diagnosis creates order and meaning out of the vague, distressing symptoms of multiple sclerosis. Doctors diagnose in an attempt to create certainty, meaning, and some semblance of control and, as Freud observed, to alleviate the caregiver's anxiety (Freud, 1913; Kalb, 2007; Kleinman, 1988).

Multiple sclerosis can frustrate both doctors and patients in their search for meaning and mastery. Especially in the days before effective disease-modifying treatment was available, diagnosis created as much uncertainty as it alleviated. The moment of diagnosis is recalled as an emotional crisis by many patients (Kalb, 2007; Smith 1995a).

From a self psychological point of view, diagnosis is a double-edged sword that may initially present a serious threat to self-cohesion while also offering the possibility for redemption at a later time. Initially, diagnosis attacks the cohesion of the body self. Notably, it is the physician both controls diagnostic information, executes the diagnosis, and works to heal the patient. Though he or she may have occupied an idealizing selfobject function, in the moment of diagnosis, the physician breaks the patient's fusion with the body self (C. Smith, personal communication, March 1, 2010). This is a moment that can be expected to trigger feelings of

fragmentation. In the following patient account, a woman with RRMS recalls her own experience of learning that she has MS:

I remember I was still in the hospital. Actually I didn't get the diag-- Dr. G. came to say, "We need some more physical tests" and so on and, "Well," he said, "You know, I'll teach you how to use a cane." I hadn't even used a cane at all and I was shattered at that idea, that I was going to have to use a cane because how on earth was I going to take care of my husband and how was I going to take care of the house and how was I going to mow the lawn and how was I going to do this and that and shovel the drive, and you know all these things that were going through my mind. Dr. H. came to see me shortly afterwards in the room and I told him I felt terrible. I said, "I feel gloomy." And he said, "Oh, what's the matter?" I told him and he said, "We shouldn't have said anything. I hadn't told you yet." So he sat down and explained it and I said, "Well, what's going to happen?" And he said, "I don't know." (Smith, 1995b)

This patient recalls her "shattered" sense of self with a caring physician, who meets the patient's request for mirroring. In this interaction, the physician seems to acknowledge fears of iatrogenic harm and a wish to protect his patient, at least temporarily, from the reality of the diagnosis. Nevertheless, he expresses concern about her feelings and ultimately conveys his sense of powerlessness and uncertainty with her. This may be an example of a physician maintaining an idealizing selfobject function by expressing and demonstrating his desire to protect and soothe the patient, despite his lack of omnipotent control in this situation.

Another patient describes her diagnosis experience as profoundly disorienting. This patient vividly depicts the antipathetic aspects of hospitalization and treatment by a cold physician as well as her awareness of her own empathy towards her doctor's predicament.

I had started reading about MS, so I knew a little bit about it, but I was reading it more because this person that I knew had it, and I... wanted to know, um, so I did, I got my people to take their things, and friends brought me up to the hospital so that they could leave my car there and worry about driving back. And, Monday, Sunday they started some tests, and Monday morning they did evoked potentials and a spinal tap and a mimogram, and then I had to lay flat for 24 hours, and while I was still laying flat, Tuesday morning he came in and said, "The initial results are back, and the spinal tap, and although you don't have the normal readings for the [unintelligible] of what it is, it looks like you have MS, from the history that you've told me." And I just lay there, knowing, I can't get up or else I'm going to get a migraine. Um, so I laid there [unintelligible] I had to go to the bathroom and I could not use the bed pan. Yes, I ended up begging to be catheterized. I never thought I'd beg for that but I did, um, and much to my relief they finally did come in and offer me the service, provide me with that service after I begged for it, but I just remember laying there, tears rolling down, and the poor doctor—he was a very nice man, very quiet, very very [unintelligible], and he was not the type of doctor—he was a very good neurologist, and I know that he did care—but he wasn't the type to reach out physically at all, and he also couldn't even reach out really emotionally. It just, I think it hurt him too much, quite honestly, to have to give that kind of news, and at that moment I was aware of his pain, but I was also really aware of mine. That, what is this going to mean? And we talked for a little bit, and I'm not sure whether he said then or a little bit later, but it certainly was in that first week or so, that he said, "You know, you're not going to be able to do what you're doing right now." It's like, do I really need to get all of this at once? You know, I said, gee, does my life really have to

change, you know, with about a dozen 360s and a couple of 180s, and I don't know what direction I'm headed in at this point. (Smith, 1995a, pp. 51-52)

The following patient account, from a published memoir, expresses an existential sense of "uncertainty" and lack of self that may be present for many patients at this stage of illness, yet accessible to reflection only after a period of time. Webster (1989), a patient with MS, describes the turmoil of early illness in her autobiography:

This new uncertainty arises from the site of this disease. I stumble, limp, drop things, but there is nothing wrong with my arms or legs as such. The disease process and the resulting damage is in my brain. This fact raises questions for me that, while imperative, are also unanswerable.... What is my self? What are its boundaries and where is it to be found? What is it that makes me who I am and what of that is essential? Will I know if I cease to be who I am? It seems unlikely because I would no longer be there to know it. How does my self know itself? (Webster, p. 87)

Diagnosis ushers in the possibility of adjustment and acceptance. Just like early encounters with the illness, acceptance of RRMS requires grieving. It is at this stage that the longer-term ramifications of the illness on one's "way of life" (Charmaz, 1993, p. 35) are evaluated. Indeed, it seems that the threat—or anticipation—of loss is at the root reactions to the diagnosis of chronic illness. Various and complex reactions may arise, including fear and anxiety, anger, depression, guilt, and attempts to regain control (Falvo, 2005). Within the self psychology framework, these reactions are conceptualized as defensive responses that attempt to restore cohesion to the traumatized self by demanding adequate selfobject functioning or shielding the self from unempathic encounters with others (Ornstein, 1991).

Alternatively, such reactions may be symptoms of intrapsychic dynamics. For instance, ongoing denial may indicate the reinvigoration of the grandiose self in an effort to mobilize a sense of invincibility and omnipotence. The presence of anger may suggest that denial has failed, and the patient is feeling frustrated by a feeling of powerlessness and helplessness. Depression may emerge after multiple attempts to establish self-cohesion have failed or may signal a prolonged sense of selfobject loss and anticipatory grief (Tasman, 1982).

During this period following diagnosis the patient with RRMS may (or may not) be medically stable yet encounter enormous turbulence in the social world. Selfobject crises develop as loved ones learn of the illness and exact their own demands on the ill individual. One patient recounted her sudden abandonment by her fiancé when she disclosed her illness as the two took a walk on the beach. Another patient account describes the period immediately following her diagnosis this way:

Actually I was so busy keeping my husband and my grand—my my my stepson in one piece that I didn't have time to fall apart myself and I knew and then uh uh by the next day things got a little bit worse but I think that was partly because probably because of stress and strain but then maybe it was just that I was it was just sort of like an exacerbation and um I really didn't have time to be depressed about it. (Smith, 1995a, p. 68)

Medical treatment. One aspect of adjusting to, and eventually accepting RRMS, is medical treatment. Optimal MS treatment involves a long-term, trusting relationship with a neurologist (Kachuck, 2011). The disease is unpredictable as is each individual's response to any given treatment. Disease monitoring and medication management is a complex task that must be customized to each patient. Over the past 17 years, a variety of new medications have become

available to prevent exacerbations and halt the progression of the disease. These medications offer significant benefits and treatment guidelines recommend that patients receive them indefinitely (National Multiple Sclerosis Society, 2007). However, their use is often fraught with aversive side effects and serious, albeit rare, medical risks, including death and cancer. Under such circumstances, continuity of care, honesty, and adherence to treatment become critical aspects of treatment (National Multiple Sclerosis Society, 2010). Treating MS is now a subspecialty within neurology (Kachuck, 2011).

Patients in treatment may present to physicians with a variety of often silent psychological needs coupled with a host of dramatic somatic complaints. Individuals may be dismayed to learn that ongoing, often intensive, treatment is necessary after they have just emerged from a lengthy, sometimes adversarial struggle to identify their problem (Smith, 1995a).

Individuals' choices about pursuing or not pursuing optimal treatment often relates to the fulfillment, or traumatic rejection, of selfobject needs in medical settings. Seeking medical care in a psychologically vulnerable state, ill individuals look to fulfill idealizing selfobject needs. In other words, the patient feels a deep need to be confident in the doctor's expertise, value the doctor's input, and experience safety and calm in the doctor's presence. Over time, if the patient begins to feel psychologically stronger and more capable, she may engage the physician to fulfill twinship selfobject needs. That is, rather than seeking care and soothing through medical care, the patient may move towards a collaborative relationship. Once this shift has occurred, the doctor and patient may together establish a mutual conceptualization of the patient's illness and the treatment approach (personal communication, C. Smith, March 1, 2010).

From a self psychological viewpoint, one may theorize that neglecting the selfobject functions of the doctor results in poor treatment adherence and increases stress. In the following excerpt, a woman with RRMS addresses her willingness to seek medical care:

Interviewer:

So are you still in touch with doctors?

Participant:

I guess I try to avoid them as much as possible.... I'll see another female doctor. I'm more female oriented than male oriented. I've had too much male. They don't understand people—women, especially women. So I thought if I see a female doctor maybe she'll have more touch with me....

Interviewer:

What made you decide to see her [this female doctor]?

Participant:

Because I'm sick of males.... So all I can do is get in touch with females. And see female doctors.

Interviewer:

But you feel like it's time to see a doctor?

Participant:

Right. I haven't seen anybody... that I can count on.... And my doctor that I told in '91 what, he was a male, one of the number one, he didn't understand female problems and stuff like that. He needed a female, is what I think.... (Smith, 1995a, p. 70)

This participant's explanation of her needs in the doctor–patient relationship is rich, despite its halting, disorganized delivery. Her description of the physician she saw in 1991 reveals a conflict between his status and her evaluation of him. The phrase, “he was a male, one of the number one,” refers to his position as one of the top doctors in his department. Despite his status, this participant characterizes him as unempathic: “he didn't understand female problems

and stuff like that.” Her final statement, “He needed a female” recommends that the physician “find his female (i.e., caring) side” while stressing the participant’s voice, “is what I think.” Although the physician was idealized, his status served to only intensify the trauma of his misattunement. Notably, when the interviewer asked this participant about medication use she reported taking antidepressants and other drugs, but was most optimistic about vitamins that had been recommended by a prestigious male MS specialist from a different institution. When she said that she only saw him once, the interviewer followed up on her reasons for discontinuing care, “I liked him a lot. He’s an older person. I have more faith in older people than in anybody else.” She continued, “I was comfortable with him, but I want some female” (Smith, 1995a, p. 70). Her clarification suggests that this patient is not simply prejudiced against male doctors, but is adamant in her demand for a health care provider that will empathize with her, earn her idealization, and support her own voice.

Treatment Implications

The contributions of self psychology may extend to health psychology as to any other aspect of the human experience. They are particularly salient, perhaps, in the case of chronic relapsing–remitting multiple sclerosis, because this condition threatens the cohesion of the self through somatic symptoms that affect the psychological experience of self cohesion. Because self psychology seeks to understand, illuminate, and nurture self cohesion, it suits the medical treatment of an illness that causes life to be fragmented into periods of normality and disability like relapsing-remitting multiple sclerosis does. This section uses a self psychologically-informed treatment approach in the consideration of physicians working with individuals who may be, or have been, diagnosed with RRMS. In doing so, it highlights how a self psychology-informed model could augment the standard of care.

The Role of Physicians

In the context of RRMS, physicians may provide a central role in restoring and sustaining patients' self cohesion. Such a key role may effect important changes in patients' attitude, stress level, social relationships, and physical wellbeing (Charmaz, 1993; Mei-Tal, Meyerowitz & Engel, 1970; Scovern, 1999; Tasman, 1982). Physicians' intention to support patients' psychological and social needs is critical in chronic illness, as are their capacities to function in mirroring, idealizing, and twinship functions. Patients living with the threat of psychologically disrupting illnesses benefit from ongoing and predictable caring relationships with physicians. Neurologists providing care to such patients must align with these individuals in order to meet selfobjects needs for reassurance and basic security in addition to the mirroring, idealizing, and twinship selfobject needs already discussed (Cohen & Abrmamowitz, 1990).

Although the language of selfobject transferences may not be familiar to the heavily biomedical culture of mainstream neurology, introducing an elaborated biopsychosocial model to resuscitate contemporary medical practice may be a real possibility. Kachuck (2011), a neurologist, concludes a very recent piece on medical decision-making with MS patients with the following entreaty to his colleagues:

Good medical judgment requires not simply considering the obvious health risks attendant to a particular course of therapy, but also coming to understand one's own, and the patient's, values, goals, and unique personal and cultural circumstances brought to that therapy as its crucible.... It follows that doctors need to listen to patients, to acknowledge the power of the patient's narrative, and doctors must realize the consequences of the biopsychosocial aspects of medical care.... But once the physician is doing these things, and even doing them well, there may still be a gaping discrepant

chasm between doctor and patient, unless that information is processed in some way that brings into the equation your sense of who you are... and those same traits of the patient, together. This capacity to be confidently vulnerable as you engage with empathy allows the two of you to cross over the divide.... (p. 206)

Kachuck's invitation to supplement "the biopsychosocial aspects of medical care" with a "capacity to be confidently vulnerable as you engage with empathy" suggests that enriching biopsychosocial practice may be desired by some MS specialists.

Empathy. As Kachuck (2011) seems to recognize, empathy may be the most critical ingredient to working with patients at risk for a high degree of self disruption. Kohut (1959, 1980) presented empathy as an intentional, disciplined, and focused "immersion" in the self experience of the patient for the purpose of both collecting clinical data and facilitating self integration and cohesion. From Kohut's perspective, empathy is an essential informant of appropriate intervention (Kohut, 1981). In the absence of empathy, one may theorize that the psychological and social aspects of medical intervention are likely to become rote and uninformed from the patient's perspective, no matter how carefully crafted and medically sophisticated they may be from the biomedical perspective. To borrow Grinker's (1964) terms, one may consider that once the physician empathically acknowledges the self disruption inherent in multiple sclerosis, treatment inevitably must "[expand] above its medical roots to contain a peculiar bio-psycho-social admixture" (p. 229; Kohut, 1981).

Within a single doctor-patient visit, there are a multitude of opportunities for empathy. The most fundamental example of empathy is the physician's internal experience of stepping into the patient's shoes and seeing the world from that perspective. This experience, which occurs in the presence of the physician's awareness, would then inform the physician's behavior

towards the patient in some meaningful way. In other words, empathy is a fundamental relational tool utilized in a variety of settings, including mirroring, idealizing, and twinship transferences (Kohut, 1959, 1980).

Mirroring. Mirroring and validation are experiences of selfobject life that, when successful, are derived from moments of accurate empathic attunement. In other words, a person experiences someone from their perspective, gains new knowledge of the lived experience of that individual, and then chooses to act in a manner that helps that person restore a sense of completeness and cohesion (Kohut 1959, 1980). For seriously ill patients, an ongoing relationship with a reliable, caring physician assuages archaic fears of abandonment and isolation that may have developed in response to the disruption of other mirroring selfobject functions. In other words, doctor–patient relationships may help establish the basic safety in which patients can maintain a sense of hope and connectedness (Cohen & Abramowitz, 1990).

Physicians engage in mirroring constantly, in both small scale and large scale interactions with their patients. On the small scale, a physician may engage in mirroring by matching the patient’s slow rhythm of speaking, for instance. A patient who feels overwhelmed by the amount and intensity of new information he is receiving may start to slow down and withdraw during a discussion of diagnosis. Through empathic attunement, the physician may recognize the patient’s experience of being flooded and his desire to control the stream of information he is receiving. In an effort to remain empathically connected to his patient, the physician may slow down his speech and simplify his narrative. An antiempathic or anti-mirroring stance in this example would be insisting that the patient accept the diagnosis and all the medical information that should be provided at this time and refusing to match the client’s processing speed.

On a larger scale, patients experience mirroring in the physician relationship when their concerns are taken seriously and they feel recognized for their unique circumstances, experiences, and desires. In contrast to optimal fulfillment of mirroring needs, Kachuck (2011) identifies the “pseudo-objectification of evidence-based care” as a component of “the fiduciary and biopsychosocial contretemps of the doctor and patient” (p. 197). According to Kachuck, an overreliance on standards of care diminishes the humanity of patients and reduces the vitality of the doctor–patient relationship. Although mirroring selfobject functions may seem simple and fundamental to the model presented here, it is clear that meeting such needs is both valued by physicians and challenging to accomplish in contemporary medical practice.

From a biopsychosocial perspective, physicians may also facilitate mirroring selfobject functions in the larger psychosocial realm. Physicians may meet with the family members of their patient, for instance, in order to help those related individuals better understand the experience, prognosis, and risks of MS and its medical treatment. This type of consultation meets family members’ needs for mirroring while also preparing the family to better meet the mirroring selfobject functions of the ill individual (personal communication, D. Junno, June 9, 2011).

Idealization. Idealization is another component of healthy selfobject experience. In medical settings, and particularly when patients are gravely ill, feel helpless in their disability, or are struggling with great uncertainty, physicians offer wisdom, strength, and the great potential to soothe fear, pain, and confusion. These professionals may be the first individuals to whom ill patients can tell the truth about their situation. Physicians support patients’ idealization needs by embracing their roles as healers and scientific experts. They may also do so by being honest about their limitations, for example admitting that they do not have a clear answer. Physicians often encounter their roles as idealized healers long into the treatment relationship, as they make

recommendations for treatment and encounter success as well as failure in this endeavor (Geist, 2008).

In the case of MS, physicians may need to begin the treatment relationship by empathically addressing the patient's past experiences with the medical establishment. Patients may harbor disappointment towards former providers who caused iatrogenic harm or otherwise failed to provide for their idealized selfobject needs in the past (Cohen & Abramowitz, 1990). They may be recovering from disruptions to idealized selfobject bonds that occurred in settings that were peripheral to the doctor–patient relationship, such as distress related to diagnostic procedures like magnetic resonance imaging, lumbar punctures, and evoked potential testing. Patients may also need assistance regaining trust in treatment after a medication has failed to help them, caused problematic side effects, or, perhaps worst of all, both helped greatly and seriously threatened toxic effects.

In all of these cases, the caring physician may find an opportunity to heal an empathic rupture and thus restore stability to the idealizing selfobject function of the doctor–patient relationship. Indeed, this role is central to the patient's wellbeing throughout the biopsychosocial spectrum. As Abramowitz and Cohen (1990) acknowledge, “the curative power of the physician and treatments may be partially founded on their idealizability; thus restoration of these selfobject bonds is vital” (p. 169).

Twinship. Twinship is the selfobject function that concerns the human need to be in the company of connected, like-minded others who share one's capabilities and values (Geist, 2008). The twinship transference is a prominent aspect of joint physician–patient decision-making. In contemporary MS treatment, many difficult choices need to be made regarding medication and the management of medical risk. The twinship selfobject function may serve as a pathway

through which patients learn about treatment options, make informed choices, and then follow through by using medications as indicated. In the absence of a twinship selfobject function, one may hypothesize that patients would more likely feel isolated in making tough decisions, become overwhelmed with risk profiles and costs, or struggle with treatment nonadherence.

Physicians are also frequently in the position of facilitating the twinship ties among patients and past or potential future selfobjects. Spouses, children, and friends of patients often comprise the social component of the biopsychosocial sphere encountered by the health care system. Because MS heavily taxes patients' source of familial and social support, strengthening the patient's connection to others, and establishing a connection between the health care provider and the patient may provide much-needed stability to the illness or perhaps the self-concept of patients (Cohen & Abamowitz, 1990).

Physicians may also already support twinship selfobject functions by simply providing a waiting room where patients with a similar diagnosis gather on a routine basis and encounter magazines and other materials geared towards people with their problem. For instance, in a typical neurology office it is not unusual to materials from the Multiple Sclerosis Society, promotional materials for National Multiple Sclerosis Society fundraisers, and other books. Many hospitals and agencies that treat significant populations of MS patients offer a weekly support group for patients. Any opportunity for patients to come together and express their experience of being ill, whether it is with other patients, their physician, or the health care team, has the potential to support their need to feel connected to like-minded others and grieve the loss of their life before multiple sclerosis.

World MS Day, Walk MS, and Bike MS, movements to raise awareness and funding for MS research and serve important twinship functions to individuals with MS as well as the

myriad others who support them and struggle alongside them. Events such as these unite patients, caregivers, and allies, while drawing public attention to the experience of living with MS and the goal of curing this disease (Cohen & Abramowitz, 1990). These events combat disability, isolation, and hopelessness by bringing people together in an active, organized, purposeful way.

In MS, empathy, mirroring, idealization, and twinship are all vehicles for the restoration of selfobject disruption. Over time, in the company of empathically-attuned others, ill individuals have the opportunity to make sense of their illness, despite its ambiguity, and find acceptance.

Conclusion

Multiple sclerosis is a wide-ranging, unpredictable neurological illness that challenges individuals' physical wellbeing, roles in the world, relationships with others, and interactions with physicians. Though modern biomedicine is beginning to solve some mysteries of multiple sclerosis, a great deal remains unknown. As a result, multiple sclerosis taxes patients' internal sense of cohesion and stability.

Physicians occupy a critical presence in their patients' lives. By nature of their position as healers, physicians and other such providers are uniquely poised, through their attunement, to help patients regain a sense of cohesion and wholeness in the midst of serious illness. This project set out to explore the dynamics of self cohesion and disruption in multiple sclerosis, and in the doctor-patient relationship, in particular, in order to shine light on the potential for this relationship to better facilitate healing.

Limitations of the theory. There are limitations to the proposed elaboration of the biopsychosocial model with the theory of self psychology. This paper neglects the physician's experience within the context of contemporary medical practice. In addition, this paper does not

address the impact of neurological disease, such as MS, on patients' capacity to reliably establish and maintain selfobject transferences. The emerging field of neuropsychanalysis is bringing together diverse perspectives to construct a "developmental neurobiology of the selfobject relationship" (Schoore, 2002, pp. 437-438). The author suspects that there is a relationship between the pathological processes of MS and the neurobiology of the selfobject relationship that individuals with MS establish, but additional research is needed to investigate this relationship.

Additional research recommendations. While this self psychology theory provides one new way of looking at the complicated lived experience of RRMS, additional exploration and research would likely benefit patients and physicians in their joint pursuit of health. Research on physicians' capacity to meet patients' selfobject needs would be particularly relevant to the implementation of the theory presented here. In particular, future research might investigate the feasibility of the physician-patient relationship given the time and resource demands of contemporary medical practice. It would also be fascinating to turn this project around to examine the gratification of physicians' selfobject needs in the professional context of work generally and the doctor-patient relationship, specifically. Further exploration of the training of medical students and ways to enhance growth through collaboration between physicians and psychologists is another avenue for investigation, as is the intersection between medical ethics patient decision-making, and the role of the doctor-patient relationship.

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