

Individual Supportive Psychotherapy in Multiple Sclerosis: A Single-Case Study

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Abstract

This individual case study follows a 47-year-old woman who was directed by her treating physicians to individual psychotherapy after being diagnosed with Multiple Sclerosis (MS). The main methods our study was based on were clinical observations and neuropsychological assessments. The patient's concerns revolved around her self-care and her inability to set boundaries in her interpersonal relationships. During her first sessions, she demonstrated symptoms of anxiety, depression, and self-destructive behavior. Due to these facts, psycho-supportive medication was deemed essential. The main purpose of this case study was to investigate whether supportive psychotherapy may be of additional help to patients with MS. In this individual case, we will present how effective supportive psychotherapy can be for the patient, which is part of the treatment for a personalized holistic intervention programme. Given the lack of relevant research in Greece, this study can help expand the knowledge and deepen the understanding in this field. Moreover, this study may reinforce the importance the care of MS patients to be carried out in a holistic intervention program. After one year of individual psychotherapy, the patient demonstrated significant improvement. Psychotherapeutic and supportive interventions, combined with MS medication, have been proved to be a more appropriate treatment for coping with and managing this chronic disease.

Keywords: Individual psychotherapy; Multiple sclerosis; Case study; Chronic disease; Intervention program

1. Introduction

A chronic illness is characterized as a state of health with persistent symptoms for more than three months, with alternating periods of exacerbations and remissions, on a basis of a prolonged clinical course. Such an illness can

show progressive development over the years and can have multifactorial causes. The lack of any definitive treatment leads to the need for continuous monitoring, control and management [1]. MS is a chronic inflammatory demyelinating disease of the central nervous system with autoimmune parameters and multiple lesions that present "a dispersion in space and time" and is characterized by periods of relapses and remissions [2]. It presents with a variety of symptoms and effects on the patients' life. The areas that can be affected could be their family, personal and social relationships, their self-esteem and their work. The decline in their mental ability, depression, anxiety, fear of the uncertain progression of the disease and the physical health problems, as well as their reduced mobility, social isolation and lack of support and understanding from their environment, are all important issues that people with MS often have to deal with [3].

The psychological effects, the mental deficits and the psychosocial problems that may stem from this chronic disease have been studied several times and most of these studies have deemed it essential to also provide psychosocial support to people living with MS [4, 5]. According to the National Institute for Health and Care Excellence providing psychological support is considered a necessary complement to intervention programs for the management and treatment of the disease [5, 6]. Adapting treatment to a chronic illness is an ongoing, personalized and challenging process.

There are many studies that show that stress and depression worsen over the course of the disease [7]. Thus, a non-pharmaceutical treatment often proves to at least as important, if not more so, than a solely pharmaceutical treatment [7]. Supportive psychotherapy, provided by mental health professionals, aims to strengthened the individual's efforts to live normally and process the stress and complications caused by MS [8]. The patient has an absolute need for support and aid in order to be able to prioritize his needs, and the psychotherapeutic intervention from the very first diagnosis of the disease greatly aids in this [7]. For a person to be able to live with MS, he would need essential coping tools, such as information, guidance and support. With the aid of supportive psychotherapy, individuals receive answers to their questions, a better understanding of their reactions, they are able to speak openly about their feelings and to adopt new communication tactics and strategies. Psychotherapy sessions can also help in periods of high intensity, the arrival of new symptoms and unavoidable changes in the patient's daily activities [8].

2. Ethical Standards

In order to protect her identity, the name used in this study, "Stella", was randomly selected and does not correspond to the real name of the patient. Moreover, special care was taken not to reveal any information that could jeopardize her anonymity, without this impeding the understanding of the case and the applied therapeutic procedures. Written consent was requested and obtained by the patient, after thoroughly informing her of the objectives of the research, the procedure and the safeguarding of her personal privacy.

3. Methods

Stella's first referral took place on April 2019 by the head of the MS team of the AHEPA Hospital 1st Neurological Clinic. Her face-to-face sessions were performed on a weekly basis, each lasting about 50 minutes. These sessions, during the composition of this study, have not yet been concluded, and she is currently in her 30th session.

The main methodological tools that were used for this study were clinical observations and neuropsychological assessments, with the therapist keeping weekly therapy and supervision notes. The patient's evaluation, using psychometric tools, was carried out before the beginning of the first session. These tools, and their corresponding results, were: the Mini Mental State Examination (MMSE): 28, the Montreal Cognitive Assessment (MOCA): 16, the Functional and Cognitive Assessment Scale (FUCAS): 46, and the Geriatric Depression Scale, (GDS): 5. The results were indicative of a decrease in Stella's mental functions and they hinted at emotional disorder.

4. Case Presentation

4.1 Demographics

Stella is a 47-year-old woman, married with three children, a 21-year-old girl and two boys, aged 25 and 10. She was born and raised in Thessaloniki, Greece. She lives with her children and husband. She has completed high school and has not been working in recent years. Stella had never seen a mental health professional before her referral to our clinic.

4.2 Health history

When she was 19, she was diagnosed with Type I diabetes, for which she is being treated with insulin injections. She reported to have lost her first child to diabetes. There have been cases in the past where she fell into a coma from hypoglycemia or hyperglycemia because she did not properly manage her insulin intake. Also, at the age of 19, she was diagnosed with hypothyroidism, for which she claimed not to have been re-examined since, yet she was still receiving medication for it. In November of 2018, she was hospitalized at the 1st Neurological Clinic of AHEPA hospital, where she was diagnosed with MS, presenting with vision impairment, one of the common symptoms of MS. Stella had lost her sight in one eye. She has reported that 10 years prior she had lost part of her sight again for three months, when her children were 14 15 years old. Back then, she went through a period of intense anxiety, and extreme concern for the wellbeing of her children. At that time, she did not consult a specialist for her symptoms. Ever since her MS diagnosis, she has been receiving her medical treatment regularly.

4.3 Psychiatric history

Stella has reported alcohol abuse in recent years. Especially during family gatherings, she admitted to increased alcohol use to the point of her doing "stupid things" that she could not later recall. Her spouse was making fun of her and she was very ashamed at that time. Even if she claimed not to harbor any suicidal thoughts, she was referred to a psychiatrist by the head of the MS team because of her clinical picture. She promised to visit the psychiatrist and

was informed, during her very first sessions, about the privacy protections in place. She also agreed to report any suicidal thoughts she might have in the future. In June of 2019, she was diagnosed by a psychiatrist at the AHEPA hospital with anxiety depression and she is receiving regularly SSRI antidepressants.

4.4 Family history

While discussing her family history, she avoided giving information about her parents, claiming that she had no memories, and everything felt like a "vague dream". She mentioned that she has an older brother, with whom her relationship is "formal", that they were never close as children and that their relationship retained the same status during adulthood.

In subsequent investigative sessions, she revealed that her father had died of cancer 4 years prior. The shock was great for her as "he was the only person who ever loved her". She had a fondness for him because she felt that he was willing to listen to her and caved in to her demands. On the other hand, she described him as old-fashioned and behind the current times. For example, he did not allow her mother to work, and when she did find a job, Stella was forced to "cover" for her mother, undertaking all the housework, so that her mother would not be accused of neglecting their household.

Her mother she described as oppressive, critical and intrusive. She always felt that she was being treated as incompetent and useless by her. She believes that her mother never supported her and did not teach her to protect herself from others. She feels that she never loved her. She believes that both of her parents were overprotective and that is why she was forbidden to do anything on her own. She kept feeling that she was being constantly interrogated and oppressed. As a child, she stated she felt ugly and had low self-esteem. She said she never believed in herself and her strengths, because no one ever believed in her. When she was 19, she met her husband (10 years older) whom she married in less than six months. Their marriage was her only way out of her family.

4.5 Psychotherapy goals

Her request during the intake concerned her self-care and her inability to set boundaries in her interpersonal relationships: "I want to take care of myself, my health and my diet", "I want to start prioritizing myself", "I want to be able to deal with people when they are angry with me", "I want to be able to put them in their place".

4.6 Present situation

Currently, Stella feels very angry with herself and thinks that she has wasted her life, stating: "I am 46 years old and all I have managed to have is multiple sclerosis, thyroid, juvenile diabetes and sick children". At the same time, she presents self-destructive behaviors. More specifically, she does not eat enough when she is stressed or forgets to eat altogether, which, combined with her inability to properly inject her insulin, several times has led her to hypoglycemic episodes. She also constantly feels tired and cannot stand it: "Maybe if I die I can rest", "If I drink 8

coffees a day I don't get tired", "Nobody helps me, I do all the housework myself, I cook 2 meals a day, I pay the children's expenses, I wash the dishes, I can't take it anymore, and I'm tired ". She also feels terrified of the progression of her health condition: "I have three deadly diseases and from time to time I may die," "If I go completely blind, I will not be able to take care of my children." She feels shame for herself and for the deterioration of her health for which she considers herself to be responsible. She expresses intense guilt and self-blame: *"I am a fool, stupid, dumb, ugly, uneducated, and useless, I have no money, I can't do nothing in my life anymore", "Everyone walked all over me, and I have no life anymore".*

As for her relationship with her husband, she claims that he constantly disdains her, that he has cheated on her and, thus, she no longer trusts him. She presents him as an emotionally absent father and husband. She believes that he contributes very little to the financial needs of their household. They have no sexual relations at all and, generally, only minimal communication. She regrets her decision to marry him and considers him to be responsible for the condition their relationship is currently at. She claims to never have been in love with him and that the only reason she married him was because she saw the marriage as an escape from oppressive her paternal home.

Regarding her relationship with her children, she professes that she feels them to be angry and frustrated with her, as they have accused her of being responsible for the condition of her health, whereas she rejects any help or advice from them. She regrets the freedom of choice she had given them as children and believes she can no longer contain and modify their behavior. She is constantly arguing with her daughter, who is "threatening" her to leave their house. Her eldest son recently moved out, which has caused her a lot of distress, as, she claims, him being the only one in the family to show any support to her. Her youngest son often takes care of her during hypoglycemic episodes, prepares food for her, helps her go to bed, tidies up the house and sometimes accompanies her to the hospital. Overall, she is emotionally distant from her children and her husband. During our first sessions she was very stressed and nervous (as demonstrated by nervous movements of the limbs, as well as taking rapidly and at a high volume). Her clothes were dirty, and she would often sit on the hospital floor and wait for 2 or 3 hours before the scheduled time of her appointment.

5. Results

5.1 Treatment plan

Stella, as mentioned above, at the time of treatment, was in a psychological maladjustment, which is the result of the individual falsifying important experiences or denying their existence and, consequently, failing to symbolize and organize these experiences into the gestalt of their self-structure. When this situation exists, there is incongruence between one's self and experiences, so the person becomes vulnerable and feels threatened [9]. At the other end of this, there can be mental balance and psychological adjustment, when there is complete agreement between self and experience or an absolute acceptance of all experiences [9].

Stella's problems are pervasive and are related either to herself or to her relationship with others (husband or children). More specifically, she is unable to take care of herself and her behaviors are self-destructive (alcohol abuse, malnutrition, lack of compliance to her medication regiment). She presents deep-rooted perceptions of defectiveness and inferiority, which are due to the starvation of her basic emotional needs during her childhood.

Her diagnosis and her lack of knowledge and understanding of her disease, create intense fear and uncertainty for her future. She feels helpless, isolated and alone. Any disease, regardless of the diagnosis, is a threat to humans in various ways, with the initial human reaction being usually fear. Fear of the unknown, of the unexpected, of death, of the present as well as the future, of the deprivations and sacrifices that may be required and of the fear of the disability itself [10]. Many times, a disease forces a person to withdraw from their usual activities and then they become egocentric, stressful and demanding [10]. And this is especially true for life-long progressive degenerative diseases, such as MS [11].

As Stella's personal history shows, there have been no support networks available to her, and her relationships with significant others have been conflicting and characterized by vague boundaries and ill-defined roles. These issues were pre-existing but were triggered during the summer of 2018, when she discovered that her husband had been cheated on her and she was later diagnosed with MS.

In the first couple of sessions, she was ambivalent about the changes she was willing to make: on one hand, she was desperately asking for our help, and on the other, she was rejecting every effort of ours to support, guide and care for her. This constant conflict between her self-perception and reality is the cause of contradictory behavior, which is sometimes determined by the former and sometimes by the later tendency [12]. When she believes that she is unworthy of love, care and the emotional support of others (during her childhood her parents deprived her of the emotional care and understanding a child requires) and yet she feels that she is experiencing a condition where she is "safe" and cared for and receives attention, acceptance, empathy and guidance, then she is in a state of incongruence, internal conflict and contradictions. The same pattern of behavior seems to be repeated in other relationships of hers.

Here are some examples: While Stella wants to be close to her children and communicate with them, she avoids talking to them and "doesn't care". Any close interpersonal relationships she perceives as threatening. She believes that if she shows genuine interest in others, she automatically fears that they might think this behavior of hers to be controlling. One of her cardinal fears is that she might become like her mother, who was reportedly extremely controlling, but this has led her to the other extreme, making her indifferent to her own children and unable to impose boundaries to their behavior. She also says she wants to break up with her husband, while, on the other hand, she "wants a man in the house", as Stella believes she is weak and unable to handle daily responsibilities, solve everyday problems and function independently, precipitating this schema of dependence to her husband.

Her thinking is polarized, seeing herself and others in terms of "all or nothing", without appreciating the range of possibilities between these two extremes. Things are "*either good or bad*", there are "*successes or failures*", "*superior or inferior people*", "*beautiful or ugly*", "*sick or healthy*". This way of thinking leads her to completely describe herself as "*inferior, ugly, sick, useless*" and generally describing herself using harsh and humiliating terms. Self-blaming, according to the theory, can be very undermining, even more than if a significant criticism originated from someone else [13].

In the initial phase, it was deemed necessary to identify, address and manage her self-destructive behavior. Stella had not been aware of her desire for change and that is why the treatment process was initially based on finding an incentive that would motivate her into action. Her need for regarding positively her youngest son, and by extension, other family members as well, was her first motivation for action: "*I want to see him grow up, complete his military service, start a family, and when they ask about his mom I want him to tell people what I've taught him and how I've helped him. He has told me I have taught him kindness*". Subsequently, the goals of the treatment then focused on recognizing and regulating her emotions, and on improving Stella's sense of despair. The interventions used were aimed at reducing the intensity of the uncomfortable feelings she experiences with the goal of relieving, securing and empowering her.

5.2 Description and evaluation of the therapy process

Stage 1: The importance of the therapeutic relationship: In the first stage of her treatment, Stella did not recognize or accept her feelings and their personal meaning. She appeared to be rigid in personality and rather remote, cut off from her emotions and from other people as well. She was unaware of her desire to change and personally develop, but, at the same time, she was lacking the energy, she was mired in apathy, and insisted on withdrawing from reality, through hypoglycemic episodes, and all this made the therapeutic procedure difficult. At this point, the chances of a patient seeking help are small, and the chances of actual improvement to be established smaller still. The appearance of anxiety and tension are the implications of the incongruence between one's self and experiences, which should be understood as a "cry for help" and as an expression of a desire to understand [9]. When the person begins to realize this need, as mental pain intensifies and he seeks help, if it is offered, it is only then that the prerequisites for change are established [9].

Individuals have vast resources for self-understanding and changing their perceptions, basic attitudes, and self-directed behavior [14]. This tendency can be buried deeply and covered under many layers and psychological defenses. The above resources can be tapped into, if there is a definable climate of facilitative psychological attitudes [14]. According to the person-centered approach, there are three conditions that must be fulfilled for this growth-promoting climate to be achieved.

The first condition is **authenticity**; this means that the psychotherapist distinguishes the patient's experiences and feelings clearly and can, when and if this is considered useful and appropriate, convey them honestly to him, and, thus, the therapist becomes transparent in the therapeutic relationship [15]. In this way there is a close correlation or congruence, between what is experienced in the depths of the patient's psyche and what is consciously perceived and what is expressed [16].

The second condition is the **unconditional positive regard** of the patient. When the therapist is experiencing a positive acceptance towards anything the patient currently is a therapeutic movement is more likely to occur. The therapist should be willing to allow the patient to behave based on whatever emotion they are experiencing at the time – be it confusion, resentment, fear, anger, shame, love, courage or pride. This attitude is not possessive, as the therapist rewards the patient in an absolute way and without conditions of worth [16]. Its importance for psychotherapy can be more readily understood, if one considers that the need for unconditional acceptance and positive recognition is one of the basic human needs [15]. This acceptance, in addition to allowing the generation of a positive environment, helps the patient express his feelings and more readily accept them. So, gradually he learns to accept himself, acquire a positive self-regard, and increase his self-esteem and appreciation. Self-esteem is shaped by the way others behave towards a person, by whether that person has felt respected, appreciated, and accepted, and whether he has been shown emotional affection and care by others. thus, unconditional positive acceptance enables the patient to reduce their fears and lower their defenses and start to express their genuine feelings [15].

The third facilitative aspect of the relationship is **empathic understanding**. This means that the therapist senses accurately the feelings and personal meanings that the patient is experiencing and communicates this understanding back to the patient. So, the therapist listens with sensitivity and objective understanding, examines the patient's perceptions accurately, and enters his inner world as a trusted guide and companion. The therapist can then point out the possible meanings in the flow of the patient's experience, helps his focus on them and transcend beyond them [15]. In this environment, as the patient gets accepted and rewarded, he tends to develop an attitude of heightened self-care. As the patient is empathically understood, it becomes possible for himself to understand more accurately the flow of his own personal experiences, and when he understands and rewards themselves, he will become more in tune with his experiences. This gradually renders the person more real and authentic. These tendencies, and the reciprocity of the therapist's attitudes, make the patient capable of being a more effective lever to initiate his own developmental ascension [17].

In such a psychotherapeutic environment, Stella confronted her feelings of loss the first time and started to realize the extent of her problems. The psychological burden of diabetes, combined with her diagnosis of MS, can have an impact equivalent to mourning. The person laments their image of their former self, when they were completely healthy and whole [18]. The feeling of having lost a significant amount of time causes stress and sadness to chronic sufferers [19]. According to Shontz (1975) the way people react after a serious illness can be summarized in the

following sequence: a) the initial shock, during which the patient feels and behaves automatically, as an observer of their own life, if removed from reality; b) the controversy, which is characterized by disorganization of thought and a sense of extreme loss, deep grief and even despair; c) the retreat, during which the individual tends to be in denial in order to be able to cope with the new reality, which reality gradually yet inevitably settles into the patient's life and transforms it [20]. Gradually the patient realizes what is happening and begins to adapt. Obviously, the above progression does not have to apply to everyone, as each person may react differently; nevertheless, it seems to apply to most [20]. That is the reason why Stella required the right environment to be able to recognize, accept and express her feelings and her perception of her new reality, before setting off on the path of composing the process of rediscovering meaning in her life.

Stella had to confront an unfamiliar and quite threatening term for her: "Multiple Sclerosis". When her situation changed, she was already trying to manage a major challenge, and she was called upon to manage a new serious illness, her feelings and her environment, all by herself. For these reasons, the first phase of the interventions focused on her psychological reeducation: they were aimed on Stella's training on the situation she was facing, regarding her regaining a sense of control and, thus, reducing her stress levels [21]. Psychoeducational intervention assumes that the most positive results and empowerment occur when there is an optimal level of patient information [22]. Also, applying psychoeducation to patients with depression has been reported to lead to an improvement of their clinical course and psychosocial functionality, as well as an amelioration of their observance of their treatment [23].

The main points we focused on with Stella were, first, to provide information about her disease to her, explaining what MS is, what it means to have a chronic illness that is not imminently lethal (as she feared). We discussed her MS symptoms, such as fatigue, in order to learn to recognize and accept them. We also talked about the importance of communicating with the head of the MS team and how essential it was for her to adhere to her medication regimen. At the same time, after she had been diagnosed by the AHEPA hospital psychiatrist with anxiety depression, we educated her about her diagnosis, discussed her feelings and explained in detail her medication instructions. These interventions proved to be very effective. Initially Stella became reassured as she was able to understand that her fears of the unknown disease and potential looming death were simply stemming from her lack of information about her condition. Subsequently, by being able to comply with her MS and anxiety depression medication regimens, her depression was alleviated and our therapeutic alliance was enhanced.

Stage 2: The loss of her old life: During the second stage, Stella gradually began to externalize, to express herself, and to allow herself to experience the feelings of loss. When she came to realize that for so many years, she failed to set boundaries in her relationships with others, that she ignored her needs, her desires and allowed them to be pushed, at best, in second place, she collapsed. This initial shock led to grief. Her crying was a good sign in our sessions, as it showed that she feels enough emotional security in our therapeutic relationship, and, at the same

time, she managed thoroughly experience her grief, externalize it and come to grips with it. She said: *"I feel like I've been buried in the ground for so long and now for the first time I'm digging with all my might to get out, I see the sky but I'm still so far away."* Then came the anger.

Her anger was directed first towards herself and then towards others. The expression of her anger helped us to understand its origins. It sprang from all that she had been deprived off for so many years and all her unsatisfied needs, which she could now recognize. Interventions that focus on emotions are more effective in cases where the stress inducer is less under the control of the patient, and, thus, the patient has little influence on its existence and progression and, therefore, needs to learn to cope with its effects - as is in the case of MS [24]. The mobilization and processing of the disease-related emotions helped Stella to change the way her disease was perceived, as well as to understand that it was not her "fault". She characteristically said: *"MS helped me wake up and understand what was going on around me and what I want, and not what others want"*, and: *"If it weren't for MS, I would still be asleep in the pit"*. Positive reappraisal is defined as the conscious and repetitive use of information about the beneficial effects of a stressful situation. It refers to the active effort to reinterpret negative facts as experiences that promote positive changes in the individual and is, therefore, considered a coping strategy [25].

Stage 3: Redefining life: During the last stage, where we currently are, Stella feels more stable and confident about herself and she has started to recognize her needs and the benefits of our sessions. In her own words: *"It's like a book that we read over and over and every time we understand something else, and learn so much more about me"*, and: *"I feel important when we are together, you don't underestimate me, you help me and you support me"*.

The therapeutic relationship and the safe environment that we have created both contribute towards establishing and maintaining the three therapeutic conditions mentioned above, provide the suitable substrate for acceptance and appreciation of all aspects of the patient's human existence. This emancipation of the individual from possible limitations allows him to discover more respect for his needs and to consider that what he desires has intrinsic value. During this process the patient can choose how he behaves, assume responsibilities and make decisions [26]. In our case, Stella began to understand the importance of adherence to her medication regiment and, as a result, the occurrence of her hypoglycemic episodes decreased. She commented: *"Today the diabetologist found me in excellent shape because I was consistent in everything he told me to do"*. Moreover, after many years, she decided to visit a specialist doctor and have her thyroid, for the first time taking responsibility for her health, but not in the way she had done up to then: *"I know that it is me who is responsible for my health and I cannot expect others to look after me"*. Additionally, she began to appear to our sessions well-groomed, with clean clothes and generally taking care of her hygiene. She started babysitting her neighbor's child, as a way to earn a small income. Stella also began experimenting with boundaries for the first time, saying "no" when she did not agree with what others were asking her to do. For example, when another neighbor of hers asked her to take care of her dog while she was away on vacation, and her initial tendency was to concede, she "broke" her automated behavior and politely declined as she

did not have time to do it. A behavioral modification she was very happy with. We took the time to recognize and reward the steps she had taken in order to strengthen her resolve, as she finds it very difficult to focus on her efforts and, at the same time, evaluate them positively. These interventions encouraged her, strengthened our therapeutic relationship and increased her confidence in the psychotherapy process.

At this stage, Stella is gradually taking responsibility for her problems, tries to set boundaries on the other people in her life, and prioritizes her needs. Psychotherapy at this point is focused on her training in assertive behavior in order to reduce family conflicts and create more meaningful interpersonal relationships, which are based on effective communication and understanding of and by others. It also aims to strengthen her alertness, so that she can protect herself from exploitation, safeguard her individual rights, encourage her decision making and improve the choices she makes regarding her life. Relapse management is an additional therapeutic goal, that, at this point, is a necessary skill to develop. Psychotherapeutic work was initially adapted to manage emotions with the aim of emotionally discharging and redefining life priorities. It is now focused on problem-solving management, with the aim of developing active cognitive and behavioral strategies [27].

6. Conclusions

Chronically ill people are faced with very serious physiological, psychological, socioeconomic and occupational effects, which they are called to deal and cope with [1]. The symptoms of their disease and the intense stressful situations they experience, both impede their adaptation to the "new" life. Acceptance by the patient of the changes required in his lifestyle is easier once he has fully understood the nature of his illness, the severity of his condition and the role that his proper cooperation with health professionals plays [20]. The patient must work on the acceptance of the disease make targeted efforts to incorporate the demands of his disease into his own reality. As a result, he is to seek opportunities and accept new life directions that will allow him to experience real change and development [28].

There are many reasons why psychotherapy is so important during the treatment of chronic physical illness. Apparently, there is are links between physical illness, mental distress, depression, anxiety and stress reactions. These latter are not only common effects of serious physical illnesses and they not only affect the quality of life - but can also accentuate the negative effects of a physical illness [27]. Thus, the stress and depression that accompany chronic physical illnesses tend to reinforce behaviors that undermine health, such as alcohol abuse or smoking and disrupt the patient's compliance with his recovery regimes, such as medication, exercise, diet, nutrition and stress reduction. Quite often, the diagnosis of depression in people with MS is overlooked. This is considered to be a critical element before initiating any medicinal schema, as the treatment of depression can provide a new strategy with which to modify the very course of the disease [29].

It is also important to remember the social stigma and, thus, psychological burden associated with many physical ailments. At a time when patients are in dire need of social support, the shame and stigma of the disease can socially isolate them, a development that exacerbates their stress [27]. Physical illness makes people aware of our mortal limitations and the fact that we are fundamentally vulnerable [27]. Physical illness can also extend its effects to the patient's family members and can spread feelings of unhappiness, anxiety, anger and guilt [30]. Very often, partners find it difficult to deal with this new reality and this often results in estrangement from their spouses or even divorce, especially when the patient is a woman [11]. Children, particularly, can feel marginalized or guilty because they may believe that they are responsible for the onset of the disease [30]. Psychotherapy, be it individual or in groups (often involving the patient's family), can indeed be an invaluable tool for the patient to learn how to cope and adapt to his chronic disease.

In the case we are presenting here, we cannot know with absolute certainty whether the provided individual psychotherapy has been solely responsible for the resulting improvements. However, this study gave us the opportunity to examine each parameter more carefully and acquire a deeper understanding of how important it is to provide a personalized and holistic intervention program in the management of a chronic disease such as MS. Based on her clinical observation, the individual supportive psychotherapy Stella received, in combination with her pharmacotherapy, seems to have contributed to her impressive improvement in her interpersonal competence. Very importantly, the psychotherapeutic work, so far, has also helped her in the management of her disease. We can see coping as the medium and adaptation to a chronic disease as the goal [27]. Providing emotional support, positive reinforcement, and recognition, whereas encouraging expression, and acceptance of the emotions that accompanied the diagnosis, all increased the patient's sense of control and reduced the previously severe mental suffering. Our patient was also able to cope more effectively with her medical condition, which increased her compliance with her medication regime. Through the therapeutic process, her hope for the future was mobilized and maintained, and her priorities were positively redirected.

Our concluding understanding is that the early diagnosis of the disease and the psychological problems it is accompanied with, as well as their treatment by the medical team should always be guided by the special needs of each individual and aim at their global support. This comprehensive approach can significantly improve the MS patient's quality of life and lead to more effective long-term MS management. For this to be achieved, we deem necessary for neurologists to work together with psychotherapists and to jointly formulate a holistic treatment strategy, with repeated testing during the individual supportive psychotherapy offering the opportunity to identify the therapeutic results more accurately and in greater depth. Such an approach would make it possible to track the links between the therapeutic process and its effect on the patient. It is very important to assess our findings by putting them to the test of a large number of patients and we welcome all feedback.

Conflicts of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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