Brian C. McSHARRY
Erzsebet F. TOTH

»Chronic physical invisible illness denial«: self-loathing, iatrotheology and supporting rationalizations

»Zanikanje kronične nevidne telesne bolezni«: samozaničevanje, iatroteologija in podpirajoče racionalizacije

POVZETEK

Interakcija kompleksnih biopsihosocialnih dejavnikov lahko včasih ovira pravočasno diagnosticiranje kroničnih nevidnih bolezni. V nedavno objavljenem članku v tej reviji smo razvili empirični in procesni model, s pomočjo katerega je možno razumeti pojav »zanikanja kronične nevidne telesne bolezni« (McSharry, Toth & Koch, 2018). V tem članku pa prikažemo koherentno teoretično utemeljitev, ki olajšuje razumevanje procesnega modela. Če smo v prejšnjem članku podali razlago, *kako* zanikanje nevidne telesne bolezni izgleda, se v tem članku osredotočamo na to, *zakaj* ta pojav sploh obstaja. Namen obeh člankov pa je enak: osvetliti izkušnjo ljudi, ki so doživeli zanikanje kronične nevidne telesne bolezni. Upamo, da bomo z ozaveščanjem psihoterapevtov in zdravnikov o razlogih za njihovo nezavedno nagnjenost k napačnemu vrednotenju simptomov tovrstnih bolezni zmanjšali število dolgotrajno nediagnosticiranih primerov.

KLJUČNE BESEDE

Nevidne bolezni, moralizacija, psihologizacija, iatroteologija, projektivna deifikacija

ABSTRACT

The interaction of complex biopsychosocial factors may sometimes militate against the timely diagnosis of chronic physical invisible illnesses. In a recent article, also published in this journal, we developed an empirical and process-driven model through which the phenomenon of »chronic physical invisible illness denial« could be understood (McSharry, Toth & Koch, 2018). In this article we develop a coherent theoretical lens which facilitates a more substantive understanding of the process-driven model. While the earlier article explains *how* invisible illness denial can find expression, this article focusses on *why* the phenomenon exists at all. The aim of both articles is the same, however: to cast some light on the biopsychosocial lived experience of chronic invisible

BRIAN C. MCSHARRY, MA, JD, PHD (PENDING DEFENCE, SFU, VIENNA), MCSHARRY2@GMAIL.COM.

ERZSEBET F. TOTH, PHD, SIGMUND FREUD UNIVERSITY IN VIENNA, COORDINATOR OF THE INTERNATIONAL PHD PROGRAM, ERZSEBET.TOTH@SFU.AC.AT.

illness denial. By making psychotherapists and physicians more aware of the reasons behind their own potential unconscious biases against validating the symptomology of genuine cases of chronic physical invisible illnesses, it is hoped that the occurrence of cases of long-term undiagnosed chronic physical invisible illness may be reduced.

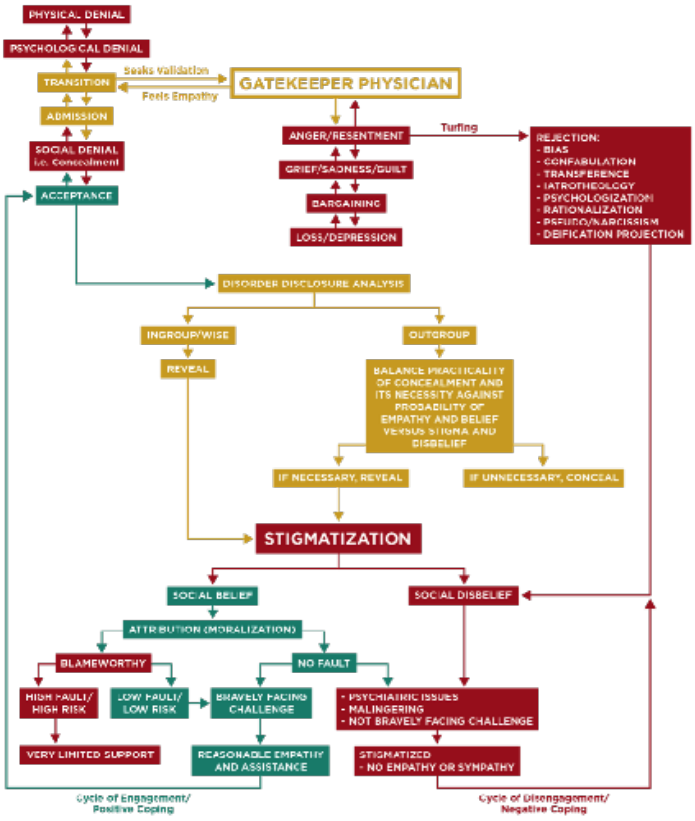
KEYWORDS

Invisible illnesses; moralization; psychologization; iatrotheology; deification projection.

Introduction: The denial of chronic physical invisible illnesses

There can be a social tendency towards denying the legitimacy of invisible illness symptomology. This tendency can even be accompanied by the stigmatization and marginalization of those who develop such conditions. Within this context, as demonstrated by Figure 1, the physician in today's society plays the crucial role of gatekeeper (McSharry, Toth & Koch, 2018).

Figure 1: The Biopsychosocial Invisible Disorder Process Analysis Chart



As can be seen from Figure 1, if the gatekeeper validates the symptomology of an invisible illness and provides a physical diagnosis, the door may be opened for the affected person to receive the social support necessary to enter a cycle of positive engagement coping (Werner & Malterud, 2003). If, on the other hand, the gatekeeper physician does not validate a particular person's genuine invisible illness symptomology and instead applies the psychiatric label, this may lead to the affected person being socially stigmatized and entering a cycle of negative disengagement coping (Strating, Suurmeijer & Van Schuu, 2006).

The question examined by this paper is: Why may otherwise valid and legitimate cases of chronic physical invisible illness sometimes be psychologized, and the sufferers of such conditions socially marginalized? As we shall see, the answer is a complex biopsychosocial one, related to the unconscious terror of death and the mythologization of medicine into a transference object.

Theory

The fight or flight response, survival and the terror of death

According to Becker (1997), the state of nature is a Hobbesian state of »all against all,« where life is »cold, short and brutish.« Within this context, all lifeforms, even those as basic as the amoeba, have evolved thanks to a survival instinct. Indeed, without such an instinct, life would be short, indeed.

Thus, as Banja (2005) notes, when threatened with pain or injury the primitive animal brain experiences an acute adrenalin rush which initially engenders an experience of fear and shock, thereby dulling the pain normally associated with injury. As the body goes into its emergency mode, chemicals which encourage resistance to, or flight from, the threat are immediately released. In this way, the animal brain is biochemically programmed to encounter and defeat that which threatens it, or to run and flee. Such a survival instinct is a useful trait, for in a natural world where the weak are constantly culled, animals benefit from the ability to stand and fight or run and hide.

The survival instinct, the denial of death, and self-loathing

However, as Becker (1997) notes, when humanity evolved a symbolic consciousness, the survival instinct created an inherently contradictory self-loathing and disgust with the embodied human life it was designed to protect. This occurred because when humanity became self-reflective it saw that the world it inhabited was infinitely full of possibilities for death and injury. The awareness of the ever-present threats of death, in turn, triggered the survival instinct's fight or flight instinct. But, there was nowhere to run, and no concrete enemy to flee. The only enemy was conscious life itself, for it was the mere act of living as a conscious being that brought with it recognition of the possibility of individual extinction. Thus, when it became symbolically conscious, humanity's instinctual urges simultaneously threatened to reduce it to a perpetually impotent bundle of chemically-fuelled terrified aggression.

As Anna Freud (1993) and Elisabeth Kubler-Ross (2014) both note, when humanity is faced with terror, the defence of denial is the normal reaction. Not surprisingly, therefore, humanity seized upon the defence of denial as a way to resolve the tension caused by the unsatisfiable and constant urge to fight, or flee from, the ever-present threats which its own consciousness revealed to it. By deploying the defence of denial in this way, humanity attempted to cope with the anxiety existence caused by simply ignoring the ever-present reality of death. However, as Becker (1997) notes, this had existential consequences.

In order to effectively deny death, humanity came to split its self into physical and mental aspects, attributing issues of sickness and death to the physical component, while attributing immortality to the intellectual aspect. Within this paradigm, humanity came to convince itself that when death does occur, it only occurs to the *physical* body, but the *symbolic* self lives forever. The survival instinct thus resulted in a connection being made between the physical self and death, and the symbolic self and eternal life. Within this context, because of the survival instinct, the body is unconsciously reduced to a useless appendage that is found to be loathsome, and something which must be avoided.

We can find confirmation of Becker's thought on humanity's unconscious self-loathing in the empirical work done by Haidt, McCauley and Rozin (1993), who have found that human beings have seven core disgusts. Three of these core disgusts are driven by the biological urge to survive, while the remaining four disgusts are caused by the evolution of the symbolic self on top of the animal consciousness.

In terms of the biological instinct for survival, humanity feels revulsion at spoiled food, excrement, and certain animals and insects, such as rats and roaches. These are things which can represent putrefaction, and putrefaction can bring death through ingestion. As such, animal instinct demands that such things be avoided.

The remaining four core disgusts, on the other hand, are psychological add-ons. These add-ons represent a fundamental disgust when exposed to sex, the stench of bodily excreta, blood and guts, and, finally, illness and death. The fact that humanity feels disgust at these things—things which are necessary for human existence itself—confirms that the survival instinct has turned humanity's symbolic self against its embodied form, something which, in turn, reveals significant unconscious internal tensions.

The denial of death, society and mythology

A defence of the magnitude of the denial of death does not occur in a vacuum. It requires social support and the deployment of various buttressing supplemental unconscious rationalizations. Indeed, as a biopsychosocial phenomenon such denial has traditionally occurred as part of a group activity and been made part of myth or religion.

Viewing the collective denial of death project in terms of social constructionist scholarship, social denial occurs through a cultural process of »social fact« creation, in which symbolic selves fabricate a mutual understanding of various phenomena within a given culture (Gelo, Vilei, Maddux & Gennaro, 2015; Gelo, Ziglio, Armenio, Fattori & Pozzi, 2016). Very large »social facts« are what Campbell (1989) would call myths.

Used in this sense, the word »myth« is not to be taken as a comment on truth or falsity; it simply relates to a social belief system.

In *Totem and Taboo* (1919), Freud identified the three »world systems« or mythologies, of animism, religion and science. Humanity has historically used these world systems as what Becker would call »transference objects.« Specifically, in *The Future of an Illusion* (2010, p. 17) Freud noted that mythologies function so as to »exorcize the terrors of nature, … reconcile men to the cruelty of Fate, particularly … death, and … compensate them for the sufferings and privations which a civilized life … has imposed on them.«

It may seem somewhat odd to speak of science as being a mythology or medical science a transference object, and technically speaking science is not designed to function as a belief system. Instead, science is simply a method which allows for attempting to understand the world with the use of reason. However, even science can be—and has been—mythologized into a transference object. As will be seen, when used as mythologies, animism, religion and science each foster a »just world« mentality pursuant to which the believer convinces him or herself that everything happens for a reason.

By encouraging this just world mentality, the animistic magical belief system rid the ancient world of the need to fear unpredictable events, such as disease, illness and death (Eliade, 1954). Within this context, Eliade shows that each animistic culture interpreted illness as being a punishment visited upon the sufferer for having deviated from a given social norm. In such circumstances, when one became ill one was expected to offer a public confession of one's guilt and an admission of one's entitlement to punishment. In more serious cases of illness, a blood sacrifice was required. In such a system, medical cures were not developed and progress was not made, but in light of the unconscious need to deny the ever-present reality of arbitrary illness and death, such a system was infinitely preferable to a world where death and unexplained illnesses could simply occur without justification.

According to Sontag (1991), the unconscious connection between illness, social norm violation, guilt and expiation are also found in the second of Freud's world systems, religion. Within Judaism, conduct related to the seven core disgusts is highly regulated by the Pentateuch. Food hygiene, unclean animals, blood and contagion, sexual contact, and coming into contact with certain illnesses and death is regulated by the law (Sprinkle, 2000). Moreover, when someone does become impure due to a violation of the law, such impurity has social implications. In some cases, indeed, such as coming into contact with lepers, people were ostracized unless and until they returned to a state of cleanliness by undergoing a particular cleansing ritual. Under the cleansing laws, much like their animistic predecessors, expiation, and sometimes even a blood sacrifice, through the use of birds and scapegoats, was required to wash away the sinfulness attached to illness.

Similarly, according to Sontag, Eliade and Bultmann (1961), Christianity shares much with Judaism and animism. Within Christianity, Adam and Eve fell from grace by eating from the tree of knowledge, and the price paid for this sin was death. Within this context, Christianity teaches that everyone is sinful and deserves death, but through the sacrificial blood of Christ those who confess their sinfulness will secure eternal life.

Thus, sinfulness is connected to death and eternal life is connected to cleanliness and expiation.

Science as a transference object, psychologization, moralization and medical iatrotheology

As Sontag (1991) discusses, when the old mythologies began to fade and science began to ascend as a world view, science itself began to attain mythic significance. Indeed, science has become so mythologized that Kubler-Ross (2014), herself a psychiatrist, bemoaned the fact that beneath all of our technological trappings, the old magical thoughts linger, and the terror of death and the need to deny its reality is ever-present in the unconscious mind.

Perhaps due to the proximity in time between the Enlightenment and the Reformation, the scientific method was prone to confusion with certain religious beliefs. Whatever the reason, science ultimately became mythically entwined with utilitarianism and capitalism to the point that an individual's existential-metaphysical worth became identified with their economic worth (Weber, 2005). In this way, the mythic conception of sickness as an economic burden and a punishment from God was attached to the value-neutral method of science. The re-entry of the mythic conception of moralization was quite convenient in a utilitarian economic system, for it allowed for the sick to be marginalized, and the obligation to render them assistance minimized. After all, the logic goes, had God wished them to live a comfortable life, He would have not made them sick.

Of this, Sontag (1991) notes that at the time of the plague it was mythically believed that a moral person was a happy person, and that a happy person would not develop the plague. As time progressed, this notion morphed into the belief that one's state of mind could overcome, or fend off, a disease, especially with the assistance of science. In this is the early roots of what Sontag calls the psychologization of illness. Moreover, as a corollary to this, she says that it came to be commonly believed that if science could not provide a cure for a particular illness, or if science could not find the disease which ailed a person, then the sick person must in some way have been morally culpable, or psychologically defective. In this way, we can see that the buttressing rationalizations of psychologization and moralization can support both each other and the underlying unconscious denial of death defence.

Pursuant to this modern mythology of science, we see what Rieken (2015) calls iatrotheology. In this mythology, medicine is believed to be a great protector, a god-like entity that can protect all people against all things. When people become ill, especially with an invisible illness that cannot be seen or cured, then the fault must be rationalized as being with the sufferer and not with the science. In this way, we see illnesses — such as AIDS and cancer—being psychologized or moralized as being the fault of the sufferer. As always, beneath all of this is the need to believe in a »just world,« lest the terror of illness and death become overwhelming. In this manner we can see that science itself has become a transference object as noted by Becker (1997).

In connection with this, Kubler-Ross found it worth noting that many of the dying patients whom she interviewed for her study no longer attempted to bargain with God as

part of the grieving process. Instead, they bargained with science. Sometimes, she says, they even promised to give parts of or their whole body »to science« if the doctors used their knowledge of science to extend their life (Kubler-Ross, 2014, pp. 80-81). Moreover, this explains how, when Sontag developed cancer, she noted that people routinely called the disease »an evil,« »a curse,« »a punishment,« and an »embarrassment.«

These words, Sontag said, revealed a revulsion and disgust which went far beyond what a rational being would attribute to a mere physical condition. These words revealed that on an unconscious level the »curse« and »punishment« of cancer were viewed by many in society as being visited on »cancer personalities« in connection with something the sufferer themselves may have done. In other words, through such rationalizations we can see that the unconscious operation of the »just world« mentality is still operative in the species. This mentality engages in the rationalizations of blame attribution and moralization, rather than accept the reality of the fact that misfortune is indiscriminate and unpredictable.

Moreover, in the mythology of the scientific world, when someone becomes chronically ill they may be stigmatized and ostracized, just as they were in the mythologies of long ago. For, chronic and incurable diseases have the potential within them to destabilize the social order by revealing medicine's lack of omnipotence and omniscience. Thus, through stigmatization and marginalization of the chronically ill, the offending sick person may be effectively removed from society so that the risk of contagion may be unconsciously minimized, a fact noted by Sim and Madden (2008). As Sontag notes, we see this at work within the context of the social treatment of people with AIDS and cancer. In their treatment by society, we can see that humanity's internal feelings of self-loathing, guilt, blame and shame can be collectively projected onto the sick, who may then be used as a scapegoat, and ostracized.

Iatrotheology, deification projection and the bias against legitimizing invisible illness symptomology

As we have seen, the belief system that medical science is omniscient and omnipotent is called medical iatrotheology (Rieken, 2015). While operating under the »just world« mentality, which serves the denial of death project, if it is believed that science is omniscient, it can be unconsciously assumed that there must be a reason for the failure of science to cure a given person. Alternatively, if a diagnosis of an invisible illness cannot be obtained, operating within the paradigm of medical iatrotheology it is logical to assume that the person could be a psychiatric case or a malingerer fabricating their symptoms.

Within this context, even physicians may be susceptible to being affected by medical iatrotheology. Banja (2005), a medical ethicist at Emory University, notes that sick people routinely and willingly surrender their fates to physicians because of what he calls »deification projection,« the willingness of the sick and their families to consider a physician as being god-like. Moreover, Banja states that given the dominant cultural mythology in which deification projection occurs, it is no surprise that narcissists and pseudo-narcissists are drawn to the profession in higher numbers than they are to other jobs.

Banja defines narcissists as being those who possess the actual pathological disorder of narcissism. Pseudo-narcissists, on the other hand, are those who for social, or other reasons, are prone to engaging in narcissist-like behaviours and over-valuing their own worth over that of others. As such, narcissistic and pseudo-narcissistic physicians, notes Banja, can be overly-confident of the powers of science and/or their own diagnostic prowess, and they can also be unwilling to admit the fact that diagnostic error is possible. Within the context of a culture based on iatrotheology and the denial of illness, this can result in certain unfortunate outcomes, such as the delayed diagnosis of invisible illness symptomology.

In connection with this, we see the work of Skevington (1995), which provides empirical evidence for the proposition that the medical profession is prone to finding malingering or psychiatric issues in cases where the cause of a given invisible illness symptomology cannot be proven through modern diagnostic testing. That is to say, she demonstrates how the absence of evidence of a condition can be confused as being evidence of the absence of a condition. This phenomenon is, in turn, an expression of psychologization as an unconscious buttressing rationalization.

In this expression of psychologization, all symptomology displayed in conjunction with a particular physical condition may be confused with superficially similar symptomology associated with psychiatric symptomology. An example of psychologization as a phenomenon is seen in the case of the neurological illness of focal hand dystonia. In this condition, in order to avoid pain, the brain erases its map of the hand and »forgets« how to use the fingers when they are engaged in given task-specific activities, as Elbert, Candia, Altenmüller, Rau, Sterr, Rockstroh, Pantev and Taub (1998) show. Dystonia is normally associated with musicians such as concert pianists and violinists whose hands suddenly become incapable of playing the instruments in question.

For many years, the symptomology associated with the neurological damage caused by focal hand dystonia was so unusual that it was originally thought to be a neurosis. Only recently, due to advancements in medical science imaging (the PET scan), has focal hand dystonia been recognized as being a neurological problem:

> A remarkable characteristic of the presentation of many patients with focal hand dystonia is the exquisite task-specificity. Symptoms typically manifest only when patients are writing or playing an instrument and not with other manual tasks. The curious aspect of task specificity led to it being attributed to psychiatric illness in the early 1900's (sic). (Lin & Hallett, 2009, pp. 111-112)

As such, despite the fact that there was no evidence for either a physical cause or a psychiatric cause for focal hand dystonia, we can see that physicians classified it as being a psychiatric condition. This further demonstrates Skevington's findings on bias towards psychologization.

In cases of invisible illness, this tendency can be very counterproductive. Symptomology such as chronic pain and fatigue, temporomandibular joint dysfunction (»TMJ«), gastro oesophageal reflux disease (»GORD« or »GERD«), and gastrointestinal issues superficially resembling those found in cases of anorexia can be characterized as being purely psychological in aetiology. However, such conditions are not necessarily psychiatric, and these symptoms also have counterparts which are physical in aetiology.

This may explain the observation by Adib, Davies, Grahame, Woo and Murray (2005) that the most significant cases of invisible illness can sometimes be the ones which are most retarded in terms of diagnosis. In such cases, instead of being treated, the person's legitimate physical symptoms may be dismissed as being psychiatric symptoms, and the person »turfed« to a psychiatrist (Stein, 1986).

This tendency to psychologize invisible illness symptomology may cause not only unnecessarily prolonged, but additional, suffering for those with invisible illnesses such as Ehlers Danlos Syndrome (EDS):

> The lack of obvious disease and the relatively high functioning of many patients led some physicians to suggest that patients simply should quit worrying. Suggestions of psychiatric need were common. The lack of a medical diagnosis and their physicians' suspicions led many patients to have self-doubts and excessive frustration. Many patients suspected that their physicians were frustrated, embarrassed over their lack of knowledge about EDS, and defensive when the patients attempted to educate them about EDS.« (Lumley, Jordan, Rubenstein, Tsipouras & Evans, 1994, p. 151)

In terms of the psychology of turfing, we can now understand why, in an iatrotheological mythology, the gatekeeper physician is deemed to have the power to declare the legitimacy or illegitimacy of a particular person's entitlement to claim the »sick role« (Werner & Malterud, 2003). Moreover, we can understand why such a »shaman's« judgment can help determine whether a sick person is stigmatized and marginalized, or whether such a person receives a modicum of social accommodation, and healthcare treatment (Sim & Madden, 2008).

Application of theory

In looking again at Figure 1 in light of the foregoing theory and the data presented in *An Analysis of the Phenomenon of »Chronic Physical Invisible Illness Denial«* (McSharry, Toth, & Koch, 2018) we can see that in cases of chronic illness, the initial instinctual reaction is for the survival instinct to deny and overcome sickness for as long as possible. However, once pain and malfunction cannot be physically overcome, knowledge of the condition can begin to slowly seep into the mind, through a filter of shock and denial. »No, I cannot be sick. I am not like the others,« the mind says (Kubler-Ross, 2014, pp. 40-41).

When the reality of illness starts to win its battle with the mind, the person begins to enter the transitionary phase of Knafl and Gillis (2002). This is a tumultuous phase of anger, self-blame, a desire for punishment, and bargaining. In this phase, as a product of their culture, the person may still conceive of the universe as a just place, where things do not happen accidentally. An internal battle may rage between the self that is, and the self as it was imagined to be, a self that lived in a »just world« where illness and death were only visited upon those who deserved them.

As acceptance and equilibrium are sought, anger lashes forth, forgiveness for whatever imaginary sleight which may have upset the gods is sought, and in return a cure is bargained for. Of this desire, Shania tells us that post-diagnosis she attempted to engage

in bargaining her condition away, but when this did not work she moved towards acceptance:

> I worked on my diet and lost 30 pounds and cut out inflammatory foods. To my disappointment at 118 pounds, I still felt pain. * * * I definitely had Ehlers Danlos hypermobile Type III. I was someone shocked and in somewhat disbelief. I was also disappointed that there was no »fix« for me. I couldn't change my diet or do anything to necessarily stop the effects of EDS… Regardless it has been an up and down journey... A little over a year later, I now have accepted the diagnosis [and] studied Ehlers Danlos...

According to Kubler-Ross, bargaining comes after frustration and anger, because the logic is: »if God has decided to take us from this earth and he did not respond to my angry pleas, he may be more favourable if I ask nicely« (2014, p. 79).

Simultaneously with this internal battle, an external battle may begin to rage. Given that illness is a biopsychosocial phenomenon, tell-tale signs may begin to emerge which separate the affected individual from the masses, just as a lame animal drifts from the herd. Upon noticing this drift, and while functioning in the dominant denial of illness mythological paradigm, friends and loved ones may initially convey the inherently psychologized message to the sick person that pain itself is not real and is merely a figment of the imagination. At this stage of illness, socially projected guilt and force of will may even be used in a misguided effort to compel »wellness«. This may also be an expression of the affection-fuelled desire to protect the affected person from stigmatization for as long as possible. In this phase Susan notes that she kept quiet about her symptoms because she did not want to be considered a »moaner.« Moreover, she says, »I doubted my symptoms and kept them to myself so as not to make an issue out of it.«

Similarly, Sally says that the expectation was to keep going and tough it out. And, Jane says, »I thought it was a normal part of growing up. But, then again, now you look back at things and you think about how much sense it all makes.« However, as Cheryl points out, there comes a time when one can no longer simply believe that illness is normal and in one's head.

If handled appropriately by a gifted gatekeeping medical and psychology team, however, acceptance of the rift involved in being pulled from the dominant mythological framework can result in »normalization,« including the minimization of stigmatization. In this way, the chronically ill person can move away from dreading what they believe will be a radically altered future with limited opportunities, towards acceptance (Knafl & Gilliss, 2002).

However, as Murray, Yashar, Uhlmann, Clauw and Petty (2013) note, individuals with chronic pain conditions can suffer extreme frustration when the gatekeeper disbelieves and psychologizes their symptomology. In such situations, the gatekeeper's disbelief of chronic physical invisible illness symptomology can result in stigmatization and scapegoating. This can, in turn, result in disengagement coping on the part of the sufferer, including anger and depression (Castori, 2012)

In connection with this, we can see the effects of medical iatrotheology and its supporting rationalizations in the lives of all of our study participants. Indeed, Susan says:

> A couple of doctors made me think it was all in my head. They would say things like »Oh you again, why are you here?« And they would make me feel like I was just moaning. I wasn't trying. They couldn't understand where it was all coming from.

Marie states that when she was younger, vomiting and not putting on weight due to her EDS, she was sent to a counsellor. Her TMJ and eating problems were dismissed as being anorexia and stress-related issues. She was told that she just »wanted attention« and was prescribed tricyclic antidepressants. However, she was ultimately diagnosed with an underlying EDS-related physical condition that could cause these issues.

From the foregoing we can see that the denial of chronic physical invisible illnesses is an extremely complex biopsychosocial phenomenon. Through it we see that the survival instinct can create a terror of death and chronic illness which may be denied by the conscious mind. However, when denied, it can result in unconscious self-loathing, anger and aggression. Ultimately, these emotions can be projected outwards onto the chronically ill and dying, in the form of psychologization and moralization.

Through these buttressing rationalizations, the sick can be blamed for their own illnesses, stigmatized as being »other,« and ostracized. By scapegoating the »other« in this fashion, everything that is deemed bad about the self's mortality may be projected onto the chronically invisibly ill, and they can be offered as a sacrifice through marginalization. Through ostracization, society may distance itself from the person and their disorder so that members of society can conveniently forget about both the person and his or her illness. This allows society to minimize the risk of contagion unconsciously associated with the illness, and to avoid heeding the moral imperative to offer the affected person some kind of support. Unfortunately, this phenomenon can leave much needless suffering in its wake.

Conclusion

The unconscious biopsychosocial denial of death project spoken of by Becker (1997) is of great significance, but little can be done to eradicate it. It is almost as built-in to human nature as breathing and eating. Nonetheless, on an individual level, we can all struggle against our unconscious need to subscribe to the denial of death defence and its rationalizations whenever possible.

Moreover, there are steps which may be taken collectively to mitigate its effects in certain circumstances. Specifically, as Banja (2005) notes, the medical profession may attempt to more effectively regulate the expression of narcissism and pseudo-narcissism within its ranks. Within this context, Gallagher, Wallace, Nathan and McGrath (2015) recommend that the medical school training process should be re-examined so as to ensure that a more biopsychosocial approach to teaching medicine is not only espoused but taken. By teaching medical school students more constructive coping techniques—including through the implementation of medical-student counselling sessions—more adaptive stress-handling techniques could be learned, and empathy with patients could be encouraged. Through this combination of factors, physicians may be made more aware of their tendencies to distance themselves from the suffering of their own patients, and they may be less inclined to »turf« conditions that they do not fully understand.

Further, persons with chronic illnesses could take certain steps, themselves. Specifically, they could establish a relationship with a medical team—including a GP or PCP and psychotherapist—who have a biopsychosocial approach to medicine and counselling. In this way, those with chronic illnesses could be assisted in coming to terms with a chronic physical invisible illness in a positive and constructive fashion. By assisting with pulling back the internal curtains of anger, resentment, bargaining, self-blame and other emotions, the psychologist or psychotherapist could free the mind's energies to focus on more productive issues like adaptation and resilience. Within this context, the psychotherapist could assist the person to see that their illness is merely a misfortune, with no meaning in and of itself. In that way, counselling could be instrumental in helping the person to have the strength to confront social stigmatization and prejudice. This would, in turn, facilitate the implementation of positive engagement techniques which could assist the affected person in integrating their illness into their lives in a functional manner.

References

Adib, N., Davies, K., Grahame, R., Woo, P. and Murray, K.J. (2005). Joint Hypermobility in children: a not so benign multisystem disorder? *Rheumatology, 44*, 744-750.

Banja, J. (2005). *Medical Errors and Medical Narcissism.* Sudbury, MA: Jones and Bartlett.

Becker, E. (1997). *The Denial of Death.* NY, New York: Free Press Paperbacks.

Bultmann, R. (1961). *Kerygma and Myth.* New York, N.Y.: Harper and Row.

Campbell, J. (1989). *The Power of Myth.* New York, N.Y.: Batham Doubleday.

Castori, M. (2012). Ehlers-Danlos Syndrome, Hypermobility Type: An Underdiagnosed Hereditary Connective Tissue Disorder with Mucocutaneous, Articular, and Systemic Manifestations,. *ISRN Dermatology, 2012*, 1-22.

Elbert, T., Candia, C.A.V., Altenmüller, E., Rau, H., Sterr, A., Rockstroh, B., Pantev, C., and Taub, E. (1998). Alteration of digital representations in somatosensory cortex in focal hand dystonia. *Neuroreport,* 9(16), 3571-3575.

Eliade, M. (1954). *Cosmos and History, The Myth of Eternal Return.* New York, N.Y.: Harper Torchbooks.

Freud, A. (1993). *The Ego and the Mechanisms of Defense.* London, UK: Karnac Books.

Freud, S. (1919). *Totem and Taboo, Resemblances Between the Psychic Lives of Savages and Neurotics.* New York, N.Y.: Moffat Yard and Co.

Freud, S. (2010). The Future of an Illusion. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XXI (1927-1931)* (pp. 1-56). Pacific Publishing Studio.

Gallagher, S., Wallace, S., Nathan, Y. and McGrath, D. (2015). Soft and Fluffy, Medical Students' Attitudes Towards Psychology in Medical Education. *Journal of Health Psychology,* 21(1), 91-101.

Gelo, O, Vilei, A., Maddux, J. and Gennaro, A. (2015). Pathopsychology as Social

Construction: The Case of Anorexia Nervosa. *Journal of Constructivist Psychology,* 28(2), 105-125.

Gelo, O.C.G, Ziglio, R., Armenio, S., Fattori, F. and Pozzi, M. (2016). Social Representation of Therapeutic Relationship Among Cognitive-Behavioral Psychotherapists. *Journal of Counseling Psychology,* 63(1), 42-56.

Haidt, J., McCauley, C. and Rozin, P. (1993). Individual Differences in Sensitivity to

Disgust: A scale sampling seven domains of disgust elicitors. *Personality and Individual Differences,* 16(5), 701-713.
Knafl, K. and Gilliss, C. (2002). Families and Chronic Illness: A Synthesis of Current Research. *Journal of Family Nursing,* 8(3), 178-198.
Kubler-Ross, E. (2014). *On Death & Dying, What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families.* New York: Scribner.
Lin, P.T. and Hallett, M. (2009). The Pathophysiology of Focal Hand Dystonia. *J Hand Ther,* 22(2), 109-114.
Lumley, M.A., Jordan, M., Rubenstein, R., Tsipouras, P. and Evans, M.I. (1994).
Psychological Functioning in Ehlers Danlos Syndrome. *American Jornal of Medical Genetics,* 53, 149-152.
McSharry, B.C., Toth, E.F., and Koch, D.E. (2018). An Analysis of the Phenomenon of »Chronic Physical Invisible Illness Denial,« *Kairos*, 11/3-4/2018, pp. 63-76.
Murray, B., Yashar, B., Uhlmann, W.R., Clauw, D.J., Petty, E.M. (2013). Ehlers Danlos Syndrome Hypermobility Type: A Characterization of the Patients' Lived Experience. *Am J Med Genet,* Part A 161A, 2981-2988.
Rieken, B. (2015). The Prehistory of Psychotherapy and its Implications for Psychotherapy Science: Shamanism, Folk Medicine, Philosophy, and Religion. In O. P. Gello, *Psychotherapy Research: Foundations, Process and Outcome* (pp. 9-37). Vienna, AU: Springer.
Sim, J. and Madden, S. (2008, July). Illness experience in Fibromyalgia Syndrome: A metasynthesis of qualitative Studies. *Social Science and Medicine, 67(1)*, 57-67.
Skevington, S. (1995). *Psychology of Pain.* Chichester: John Wiley & Sons.
Sontag, S. (1991). *Illness as Metaphor & Aids and its Metaphors.* New York: Penguin Classics.
Sprinkle, J. (2000). The Rationale Of The Laws Of Clean And Unclean In The Old Testament. *Journal of the Evangelical Theological Society,* 43(4), 637-657.
Stein, H. (1986). »Sick People« and »Trolls«: A Contribution to the Understanding of the Dynamics of Physician Explanatory Models. *Culture, Medicine and Psychiatry,* 10(3), 221-229.
Strating, M.M.H, Suurmeijer, T.P.B.M., and Van Schuu, W.H. (2006). Disability, social support, and distress in rheumatoid arthritis: Results from a thirteen-year prospective study. *Arthritis Care & Research,* 55(5), 736-744.
Weber, M. (2005). *The Protestant Ethic and The Spirit of Capitalism.* New York, N.Y.: Routledge.
Werner, A. and Malterud, K. (2003). It is hard work behaving as a credible patient:
encounters between women with chronic pain and their doctors. *Soc Sci Med,* 57(8), 1409-1419.