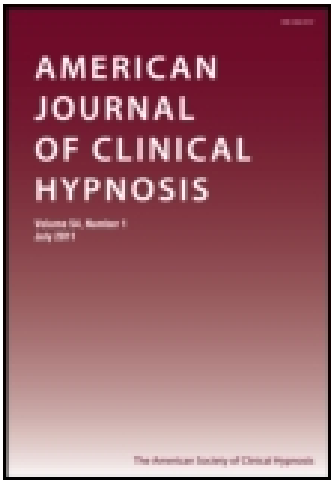

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The Illness/Non-Illness Model: Hypnotherapy for Physically Ill Patients

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The Illness/Non-Illness Model: Hypnotherapy for Physically Ill Patients

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This article proposes a focused, novel sub-set of the cognitive behavioral therapy approach to hypnotherapy for physically ill patients, based upon the illness/non-illness psychotherapeutic model for physically ill patients. The model is based on three logical rules used in differentiating illness from non-illness: duality, contradiction, and complementarity. The article discusses the use of hypnotic interventions to help physically ill and/or disabled patients distinguish between illness and non-illness in their psychotherapeutic themes and attitudes. Two case studies illustrate that patients in this special population group can be taught to learn the language of change and to use this language to overcome difficult situations. The model suggests a new clinical mode of treatment in which individuals who are physically ill and/or disabled are helped in coping with actual motifs and thoughts related to non-illness or non-disability.

Keywords: clinical hypnosis, hypnotic intervention, physical injury, treatment modality

Introduction

Cognitive hypnotherapy (CH) refers to an empirically based approach that uses cognitive behavioral therapy (CBT) to advance the role of clinical hypnosis within a recognized integrative model of psychotherapy (Alladin, 2012; Alladin & Amundson, 2011). A meta-analysis of 18 studies revealed that patients receiving CH showed greater improvement than at least 70% of patients receiving non-hypnotic treatment (Kirsch, Montgomery, & Sapirstein, 1995). One of the areas in which CH is applied is chronic pain, a challenging condition with physical, behavioral, social, emotional, and cognitive dimensions. Hence, in clinical practice hypnosis is often used in combination with other cognitive-behavioral interventions for pain management. This article proposes a focused, novel sub-set of the CBT approach to hypnotherapy for physically ill patients: the Illness/Non-Illness Hypnotherapy Model. The proposed sub-set is based upon the illness/non-illness treatment model of psychotherapy for physically ill patients and their families proposed by Navon (1999, 2005a, 2005b) and Waxman (2005). The basic

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premise of the illness/non-illness treatment model is that patients who are physically ill or disabled generally use words and language that refer to medicine, biology, medical treatment, pain, drugs, and hospitalization. These words constitute the language of illness, which is the universal language of medicine. Yet such patients also use words that describe their thoughts, emotions, behaviors, relationships, and internal and external ties in contexts other than their illness or pain. These words constitute the language of non-illness, which is made up of words that are neither medical nor biological. The proposed model is based on the belief that these two types of language co-exist in individuals who are physically ill or disabled and that bringing about a change in these individuals requires changing the balance between these two types of language.

Rules for Illness/Non-Illness in Hypnotherapy

During psychotherapy as well as during hypnotherapy, physically ill or disabled patients generally use both the language of illness and the language of non-illness. The dialectic between these two forms of language is based on three logical rules:

(1) Duality: Two types of verbal expressions—illness talk *and* non-illness talk—coexist in the verbal expressions of physically ill patients during psychotherapy and hypnotherapy. During hypnotherapy, patients express themselves either by sharing their illness motifs or by sharing their non-illness motifs. A patient's words are related only to illness or only to non-illness, though these two states coexist in the minds of the patient and the therapist.
(2) Contradiction: Illness and non-illness are also involved in a relationship of contradiction. Indeed, the prefix "non-" serves to negate the word that follows it. A patient can use either the language of illness or anything else that is *not* the language of illness, where the two concepts are clearly differentiated.
(3) Complementarity: Illness and non-illness also *complement* each other. When a patient begins using language with illness motifs, this illness language will be followed by a shift to non-illness language. Such a shift takes place *only* because illness and non-illness complement each other and have interrelated and dependent relationships.

These three major rules describe a dual-dialectical conceptualization, a novel theoretical conceptualization in psychotherapy (Navon, 2014). In sharing the experience of a physical illness, physically ill patients either will talk about their illness or will shift to a non-illness motif in talking about their experience or perception of the illness. The relationship between illness and non-illness can be illustrated by alternating perceptions of figure and ground relationship, as illustrated in Figure 1.

When the language of illness is the focus of hypnotherapy, the faces depicted in Figure 1 represent illness talk while the background represents non-illness talk. In contrast, when non-illness language is the focus of hypnotherapy, the faces represent

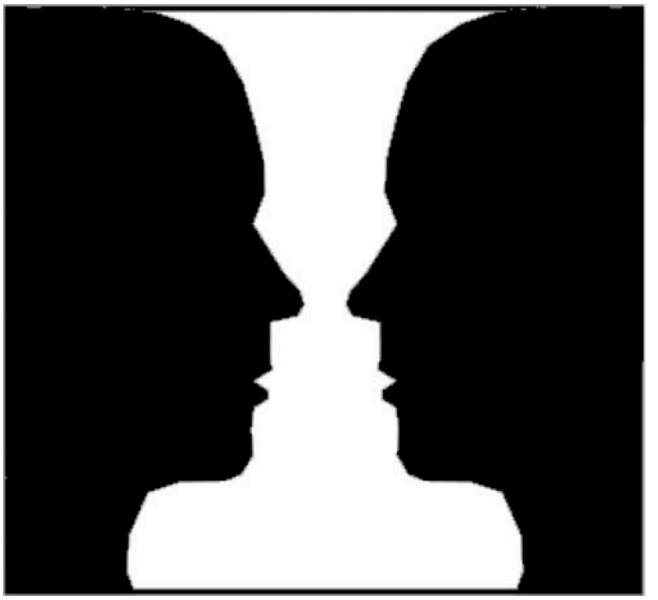

FIGURE 1 Figure-Ground relationships.

non-illness talk and the background depicts illness talk. For the figure to be perceived, it must coexist with the ground (duality). The figure serves as contrast to the ground (contradiction), while at the same time it complements the ground (complementarity).

These three logical rules explain how physically ill/disabled patients change during hypnotherapy. For change to occur, a relationship between *two* elements must be assumed as the lowest number of elements in any united conceptual framework. These two elements should *contradict e*ach other and at the same time *complement* each other. These two elements cannot exist separately. Each of these two elements is dependent on its complementary element.

For example, during psychotherapy or hypnotherapy, physically ill patients usually describe their illness in medical-biological terms and expressions. In expressing these illness themes, patients naturally use expressions such as the following: "Because of my illness I am depressed"; "I have lost my motivation to work"; "My illness has caused me to worry about my family"; "Nothing interests me anymore." These non-illness expressions describe emotions, feelings, and cognitions that are logically dependent on the patient's illness themes yet are also totally *subjective.* These non-illness motifs should not be treated within the medical-biological field, but rather at the psychotherapy and/or hypnotherapy clinic.

As posited in the illness/non-illness model, this shifting between illness and non-illness orientations is both necessary and important for hypnotherapy, for several reasons:

(1) At the beginning of hypnotherapy, patients usually refer to non-illness themes as if they are illness themes. As mentioned previously, thoughts, emotions, and cognitions are all non-illness motifs that are subject to change during the course of a patient's life. Hypnotherapy can help patients recognize and understand the difference between illness and non-illness.
(2) Non-illness themes can cause patients as much distress and misery as illness themes. Nevertheless, through non-illness themes patients can introduce hope and the possibility for change. For this reason, recognizing the difference between illness and non-illness is so important.
(3) Non-illness themes restore mastery and control to the patient's life. When it comes to feelings, emotions, and cognitions, hypnotherapy for individuals with physical illnesses is similar to hypnotherapy with those who are physically healthy.
(4) As hypnotherapy progresses toward success, the patient can view illness and non-illness motifs as being tied together through dual, contradictory, and complementary relationships. When hypnotherapy reaches a successful end, the patient is better able to control and maintain the illness and non-illness motifs.

Only by means of *subjectivity* can patients be helped by hypnotherapy. Depending upon the *wording* used during the hypnotherapy sessions, any particular patient can shift back and forth from a focus on medical symptoms (illness) to a description of subjective psychological motifs (non-illness).

The Illness/Non-Illness Hypnotherapy Model

The illness/non-illness model can be used to give hypnotherapy a sense of direction in helping patients struggling with major illnesses and/or disabilities shift freely between illness and non-illness. The actual hypnotherapy with a physically ill and/or disabled individual utilizes the following four components:

Component A: Building Rapport—Illness Themes

The rapport-building component refers to the beginning stage of hypnotherapy, when the hypnotherapist establishes therapeutic rapport and alliance with the physically ill and/or disabled patient both by empathizing with the patient and by scrutinizing the patient's verbal account of the illness. The hypnotherapist demonstrates knowledge of medical issues, thereby reinforcing the patient's sense of being cared for by someone with intelligent knowledge about tests, drugs, and rehabilitation programs. When the patient feels the hypnotherapist is speaking her/his illness language, trust develops and the two can proceed. The hypnotherapist's healing powers are enhanced by medical knowledge, which generates positive transference and contributes to the patient's

sense of independence and freedom to improve the nature of the change achieved in hypnotherapy (McDaniel, Hepworth, & Doherty, 1992).

Component B: Differentiating Illness From Non-Illness

In both psychotherapy and hypnotherapy, differentiation/integration work is a cardinal component of the illness/non-illness treatment model. Such work helps the patient distinguish and differentiate between the two conditions of illness and non-illness, as depicted in the figure–ground relationship in Figure 1. In hypnotherapy, this continual, interactive, reversible flow from illness to non-illness and back again facilitates differentiation. In practical terms, differentiation is directed at delineating the difference between patients' narratives that describe "illness" motifs and their other narratives that describe "non-illness" motifs.

Example: A 50-year-old patient with type 2 diabetes mellitus (DM) sought hypnotherapy treatment. The patient was given hypnotic suggestions to relax him and help him enter a state of trance. The therapist deepened the trance through suggestions of going down a distant flight of stairs. When the patient entered a trance-like state, the hypnotherapist said:

> Hypnotherapist: Tell me what is going on with your illness?
> Patient: I've had enough of coping and struggling with this rotten illness, day in day out . . . I feel trapped . . . bogged down . . . I feel weak and fatigued . . . I give myself insulin injections twice a day . . . I focus on my body all the time . . . I'm not sure about my future . . . when will I have respite from this suffering? . . . I devote too much energy on food . . . I've got social problems . . . I'm already an outsider . . . different from healthy people . . . I have to give myself injections at fixed intervals and I hate it . . . I'm desperate . . . how will it all end?

By means of differentiation work, the hypnotherapist helps classify the DM patient's expressions into expressions of illness and expressions of non-illness. The expressions are then translated into the two themes in the patient's anecdotal material, which is marked by duality, contradiction, and complementarity:

> "I've had enough" (non-illness); "coping and struggling with this rotten illness" (illness); "I feel trapped, bogged down" (non-illness); "I feel weak and fatigued" (illness); "I give myself insulin injections twice a day" (illness); "I focus on my body all the time" (illness); "I'm not sure about my future" (non-illness); "When will I have respite from this suffering" (non-illness); "I devote too much energy on food" (illness); "I've got social problems" (non-illness); "I'm already an outsider" (non-illness); "different from healthy people" (non-illness); "I have to give myself injections at fixed intervals" (illness); "I hate it" (non-illness); "I'm desperate" (non-illness); "how will it all end?" (non-illness).

To help this patient differentiate illness from non-illness, I utilized the Spiegel split-screen technique (Spiegel, 1989, 1996, 2010). This technique is particularly useful in helping patients see a traumatic situation from different points of view. It enables them to

give themselves credit for what they did to protect themselves or someone else. It facilitates the restructuring experience and provides a generic framework that can be used with many types of problems experienced by physically ill patients. According to David Spiegel:

> It provides the patient with an opportunity to review a traumatic event in a way that is less intense than reliving it directly, so you can use this technique to cool things down a little. Second, it carries with it the idea that we can separate our *psychological* experience from our *physical* experience. (Spiegel 2010, p. 35)

Prior to using the split-screen technique, I employ a three-step protocol:

(1) I familiarize the patient with "hypnotic-like" experiences to reinforce the debunking of myths about hypnosis and to ameliorate potential underlying fears about the modality.
(2) I enhance the patient's hypnotic responsiveness by using a number of inductions taken from Ernest and Josephine Hilgard (Hilgard & Hilgard, 1994) and from David Spiegel (Frischholz, Spiegel, Trentalange, & Spiegel, 1987). These inductions can include eye closure induction, arm levitation induction, hand versus heavy hand induction, and an induction involving going downstairs far away and choosing a safe and calm place. Using these inductions I encourage the patient to shift from a light state of trance to a deeper state of trance (Barabasz, Olness, Boland, & Stephen, 2010).
(3) I introduce the split-screen hypnotic suggestions based on Spiegel's distinction between psychological and physical experience. At this point I suggest adding the useful linguistic distinction between illness (physical) versus non-illness (psychological). During the hypnotherapy session, whenever the patient hears a "non-illness" expression, a psychotherapeutic change can potentially occur that will enable the patient to introduce non-illness thinking into all aspects of his or her life. Furthermore, when the hypnotherapist assigns the name non-illness to the right side of the screen, the right side becomes a positive and constructive suggestion, in contrast to the left side of the screen, which was assigned the name "illness."

Hypnotherapist: Now, you see before you a large screen divided into two columns. At the top left of the screen you can see the heading Illness and on the top right of the screen you can see the heading Non-Illness. Let's try to classify the descriptions you gave of your illness according to these two headings. Under the Illness column, let's list the following: "coping and struggling with this rotten illness;" "I feel weak and fatigued;" "I give myself insulin injections twice a day;" "I focus on my body all the time;" "I devote too much energy on food and digestion;" and finally "I have to give myself injections at fixed intervals." Now let's put some of your other descriptions under the Non-Illness heading: "I've had enough;" "I feel trapped, bogged down;" "I'm not sure about my future;" "when will

I have respite from this suffering?;" "I've got social problems;" "I'm already an outsider;" "different from healthy people;" "I hate it;" "I'm desperate;" and finally "how will it all end?" Very good.

Figure 2 describes the patients' narratives divided into "illness" and "non-illness."

Component C: Illness/Non-Illness Themes

At this stage of hypnotherapy, the patient has the choice of using illness language, non-illness language, or both. Efforts toward further differentiation can now proceed. A *difference* can be felt when the patient begins using *non-illness* language. Non-illness talk has the potential to change the patient's life once he or she becomes aware that illness is no longer a barrier to enjoying other non-illness behaviors. The split-screen hypnotherapy technique is the medium through which the patient recognizes that illness talk can be exchanged for a more optimistic attitude, namely non-illness talk.

Figure 3 depicts the Illness/Non-Illness Hypnotherapy Model, which consists of three levels. The first level is the theoretical level and contains the three logical rules. The second level applies these three logical rules to the illness/non-illness motifs of physically ill patients. The third level is the clinical-practical level and utilizes the illness/non-illness split screen.

The Illness/Non-Illness Hypnotherapy Model is demonstrated by the following case study. Tamar is a 52-year-old female who was diagnosed with Crohn's disease over 10 years ago. Tamar has been divorced for many years and lives alone. She has two

ILLNESS	NON-ILLNESS
"Coping and struggling with the rotten illness"	*"I've had enough"*
"I've got weakness and fatigue"	*"I feel trapped, bogged down"*
"I take twice a day injections of insulin"	*"I'm not sure about my future"*
"I focus on my body all this time"	*"When will I have a break from this suffering"*
"Too much energy is spent on food"	*"I already have social problems"*
"I have to inject at fix intervals"	*"I'm an outsider"*
	"Different from health people"
	"I have it"
	"I'm desperate"
	"how will it end"

FIGURE 2 The divided screen narratives.

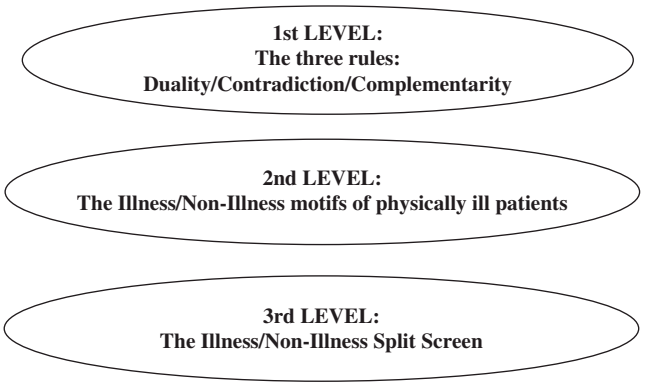

FIGURE 3 The Illness/Non-Illness Hypnotherapy Model.

adult sons who are on good terms with her. Tamar complained of anxiety, depression, anhedonia, lack of energy, weight loss, lack of meaning in life, aimlessness, and resentment of her profession as a high school teacher. Tamar's illness talk tended to be detailed. Moreover, she was up-to-date on medical innovations for her Crohn's condition. On the other hand, she believed that Crohn's often derives from mental and psychological sources.

The first two sessions focused on the features of her illness. This was the time for establishing rapport and connecting with her illness talk. Subsequently, she began talking about what her illness meant to her. The hypnotherapist put Tamar into a trance by having her count to 10 as she went down the stairs while visualizing a safe, quiet, relaxing favorite place. The following are excerpts from the fifth session, with intervention remarks shown in parentheses.

Hypnotherapist: What do you think affects your medical condition?

Tamar: . . . perhaps there's something deep in me that affects my medical condition.

Hypnotherapist: Is this "something deep in me," as you put it, related to the Crohn's or to something else that is unrelated? (work on differentiating illness from non-illness).

Tamar: The "something" is not related to the Crohn's. It has to do with my feelings . . . my inner thoughts . . . inner beliefs. (Tamar has made a distinction between her illness, Crohn's, and her non-illness, herself).

Hypnotherapist: Which means that all these don't have much to do with Crohn's . . . wouldn't you say so? (Focus on work to differentiate illness from non-illness.)

Tamar: Yes, indeed. Crohn's is a medical illness. My inner thoughts and beliefs belong to me. They are not related to Crohn's. (Demonstration of how the hypnotherapist helped Tamar differentiate between her disease (= illness) and her psychological way of thinking and feeling (= non-illness.)

Hypnotherapist: Now, you see before you a large screen divided into two columns. At the top left of the screen you can see the heading Crohn's Disease and at the top right

of the screen you can see the heading No Crohn's Disease. (Here the right side becomes the *right* and positive suggestion of non-illness.) Let's try to classify the descriptions you gave of your illness according to these two headings.

Through the hypnotist's suggestions, Tamar becomes aware of and attentive to her verbal expressions. She begins differentiating expressions that "belong" to her Crohn's, that are part of universal language of medicine, from those that belong to her thoughts, emotions, behaviors, relationships, and inner and outer ties.

Tamar: I had an older sister and an older brother. My parents worked hard . . . for long hours outside the home. When I was 10 my mother became ill. I didn't know too much about her illness. No one talked to me about it—she had breast cancer. I was considered too 'sensitive' to hear bad news about suffering and illness. My mother died when I was 14. After her death, I felt alone in the world. I felt there was no one to take care of me. I didn't trust my father too much . . . we were never close . . .

Hypnotherapist: Sadly, your mother's illness and death are facts that can't be changed. What can be changed is to work on your emotions, your psychological sensitivity, and your loneliness, wouldn't you say so? Put your mother's death on the *left* side of the screen (pause). Now put on the following on the *right* side of the screen: emotions, hope, less sensitive. (A subtle suggestion is also made to Tamar to decide whether to proceed with her mourning during her hypnotherapy or whether to work on changing her feelings.) Tamar decides to listen to her inner voices seeking meaning and hope.

Tamar: Yes, I certainly go along with that. Perhaps I've been paying for the loss of my mother and shouldering the burden of my illness for as long as 10 years. Maybe the idea that I was considered too sensitive to hear bad news about suffering and illness is no longer true for me. Perhaps I can be stronger now, more capable . . . suffer . . . not necessarily die . . . but survive!

Hypnotherapist: Great! Your thoughts about your sensitivity are non-illness thoughts. This means they can be dealt with more effectively.

Tamar: Yes!

Tamar continued to describe her past memories and relationships with her family, reflecting on her sick mother ("she was always sick") and how she was protected from bad news ("I was never told that my mother was so sick"). These descriptions enable the hypnotherapist to reflect on Tamar's extreme and rigid phrasing of her emotional attitudes in "black and white."

Only after Tamar was able to separate her extreme perceptions and reflections concerning her relationships with her parents on the split screen was she able to see herself as more resilient and much more psychologically balanced. Slowly, the narratives about her Crohn's condition and her mother's illness moved into the *background*, while talk about her feelings, emotions, losses, reconciliations, positive motivations, and work moved into the foreground and became the *figure* (see Figure. 1). She began to gain weight and became more energetic and more satisfied with her life. Her hypnotherapy resulted

in much better emotional mastery over her life at her parents' home and improved her capacity to muster psychological strength in the present.

Discussion and Conclusion

Those who are physically ill and/or disabled are naturally deeply concerned with the negative life impact of their conditions: "My illness/disability doesn't let me move on in . . . "; "If I weren't sick or disabled, I could do whatever I wanted . . . "; "If I were really well, I'd be free." Phrases such as these are frequently heard at the clinic. Patients repeatedly revert to the seriousness of their plight and, together with the hypnotherapist, often become stuck. The hypnotherapeutic interaction cannot go forward. Consequently, the patient sometimes loses interest in the hypnotherapy or even quits, bringing about or perhaps perpetuating an impasse in any future medical and psychotherapeutic encounters (Jaber, Trilling, & Kelso, 1997).

Differentiation helps patients stop defining their lives in illness terms. It shifts the focus away from illness toward those non-illness aspects of their life that will hopefully increase their resiliency. Differentiation work utilizing a split screen does not preclude all talk of illness. Nevertheless, it does give patients the potential to loosen the ties that are imprisoning them within illness and enables them to reach a balance in which the emphasis is placed less on illness and more on non-illness and the good things in life.

The Illness/Non-Illness Hypnotherapy Model is a three-level hierarchical model, ranging from the theoretical level (first level) through the level of illness/non-illness motifs (second level) to the clinical-practical level of the split-screen technique (third level). By visualizing the split screen at the third level, patients acquire the language of change and become aware of the value of non-illness motifs in their lives.

In applying this model, the hypnotherapist should proceed slowly and cautiously from the outset, using pacing and leading techniques (Brown & Fromm, 1986) and always endeavoring to join the patient in working to achieve cooperation in the event of resistance. This delicate work demands hypnotherapeutic sensitivity, attention to patient nuances, and careful and systematic attention to verbal cues, without missing non-verbal ones. If the hypnotherapist works along these lines, the patient will likely achieve positive replacement of perceived ideas. He/she will be ready to handle non-illness aspects and work with the hypnotherapist in positioning these more saliently in the hypnotherapeutic landscape.

The notion that our assumptions about reality develop out of communication, language, and conversation with others is an integral constituent of the social constructionist movement in psychology (Gergen, 1985). Indeed, most postmodern therapists subscribe to this notion, which implies that our present knowledge is elaborated within a social context. Yet beyond the scope of our outward experience of inner thoughts and feelings, our *language* both shapes and is shaped by reality, by observing and distinguishing

between our observations, by sharing our perceptions with others through language (Goldenberg & Goldenberg, 1996). This type of theoretical orientation is based on social constructivism (de Shazer, 1988; Efran, Lukens, & Lukens, 1988).The Illness/Non-Illness Hypnotherapy Model presented in this article contributes to the field of social constructivism, in which language and meaning constitute the core ingredients of psychotherapeutic interaction with a special kind of population—physically ill and/or disabled patients.

In contrast to other models in the chronic illness literature whose orientation is described in abstract terms, the Illness/Non-Illness Hypnotherapy Model described here is a practical "how to" intervention-oriented model of treatment. Indeed, because of its exceptional capacity for handling difficult medical situations, the model can serve as an enhanced procedure for negotiation with patients who have been referred by physicians or other medical bodies. In contrast to self-referred patients, these patients can be expected to be resistant to hypnotherapy. Hypnotherapists who work with physically ill or disabled individuals who demonstrate resistance to treatment are in need of a treatment framework to manage this resistance and transform it into cooperation. The proposed model may be beneficial in handling such resistant cases. The split-screen technique can help those who are physically ill or disabled free themselves from visualizing their lives in *one* fixed frame only. The introduction of *two* frames to the patient (as in the split screen) offers an immediate *choice*, and during the hypnotherapy the patient can be encouraged to choose the *right* and *positive* side of life. Indeed, Milton Erickson's "illusion of alternatives" demonstrates that only when *two* alternatives are introduced for a single proposition can the patient make a change in his/her cognitive and behavioral approach by choosing one of them (Rosen, 1982).

Further research is needed to discover whether this refinement of CBT can be generalized to other pain patients and thus to determine whether the distinction between illness and non-illness is an important causative factor in the treatment of chronic illness and pain.

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