The Illness/Non-Illness Treatment Model: Psychotherapy for Physically Ill Patients and Their Families

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The model is based on four theoretical concepts: Duality, Contradiction, Complementarity, and Unity. This article presents the responses of patients to therapeutic interventions utilizing Differentiation/Integration Work to draw the distinction between Illness and Non-Illness in the psychotherapeutic themes and attitudes of the physically ill and/or disabled. The findings indicate that in this special population, the patient is stimulated to learn the language of change and how to overcome difficult situations. The model suggests a new clinical mode of treatment in which the physically ill and/or disabled are helped to cope with actual motifs and thoughts related to Non-Illness or Non-Disability.

THE ILLNESS/NON-ILLNESS CONCEPTUALIZATION

In the psychotherapeutic process, a physically ill/disabled patient generally uses words that describe medicine, biology, medical treatment, pain, drugs, and hospitalization; this is the language of “Illness” which is a universal language of medicine.

The patient also uses words that describe thoughts, emotions, behaviors, relationships, intra-, and-inter ties. This is the language of “Non-Illness” in which the words used are neither medical nor biological.

Illness and Non-Illness talk share a conceptualization made of four logical rules:

1. **Duality:** Illness *and* Non-Illness. During the psychotherapeutic process, the patient has two ways to express himself: either he/she shares his illness
motifs, or he shares his non-illness motifs. The words of the patient can be related only to either illness, or non-illness, which co-exist together in the patient’s and the therapist’s minds.

2. **Contradiction:** Illness *versus* Non-Illness. Illness contradicts non-illness and vice versa. The prefix of “non” is a complete contradiction to the word following the “non” prefix. The patient can use illness talk or anything that is *not* illness talk. There is a clear differentiation between the two concepts.

3. **Complementarity:** Illness and Non-Illness *complement* each other. When the patient starts to talk on illness motifs, his/her illness talk will be followed by a shift to non-illness talk. This shift is done only because illness and non-illness complement each, having an interrelated and dependent relationships.

4. **Unity:** Illness *together* with Non-Illness. There is a co-existence of two (=dual) opposites (=contradiction) and dependent parts (=complementarity) which live together in a one frame of reference.

The four concepts of duality, contradiction, complementarity, and unity are relevant to any cognitive, intellectual, emotional and behavioral activity of human experience. In any sharing of a physical illness, experience, the physically ill patient talks either on “illness,” or his/her experience or perception of the illness, now shifted to be a “non-illness” motif. The two shift alternately in a figure–ground relationship as illustrated in Figure 1.

When “Illness talk” is at the center of psychotherapy, “illness” is the Figure, and “Non-Illness talk” is the Ground. When “Non-Illness talk” is at the center of psychotherapy, “non-illness” is the Figure, and “illness” is the Ground. The shifting back and forth between figure and ground appears continuously during psychotherapy, whenever the patient shifts between “illness” and “non-illness” in his/her narrative. The four concepts can be applied in the Figure–Ground relationship gestalt:

![FIGURE 1](image-url) Illness/Non-Illness Figure–Ground Relationships.
1. **Duality**: A dual relationship exists between “illness” and “non-illness” as figure and ground, which alters continuously.

2. **Contradiction**: “Illness talk” is in a contradictory relationship to “non-illness talk,” as figure in a contradictory relationship to ground, and vice versa.

3. **Complementarity**: “Illness talk” complements “Non-Illness talk,” and vice versa. One cannot perceive figure without a ground, and vice versa. Figure and Ground complement each other.

4. **Unity**: “Illness talk” and “Non-Illness talk” co-exist in any human experience. This co-existence of figure and ground, and vice versa, is located in any united, cognitive, emotional, and behavioral organization format.

The four concepts explain how change occurs during the psychotherapeutic process with physically ill/disabled patients. In order to create a change, one should have to assume a relationship between two elements, as the lowest number of elements in any united conceptual framework. These two elements should contradict each other and should complement each other. These two elements cannot exist separately. Each of these two elements is dependent on its complementary element.

Why is it both necessary and important that shifting between illness and non-illness will occur during therapy?

The answer to that important question is as follows:

1. Usually, at the beginning of therapy, patient holds “non-illness” themes as if they are “illness” themes. As mentioned before, thoughts, emotions, and cognitions are all non-illness motifs that are subject for change in patient’s life. Therapy helps the patient to see the difference between illness and non-illness, so he/she will be able see the difference between them.

2. Non-Illness themes might be as difficult and miserable for the patient as Illness themes. However, in Non-Illness themes the patient can introduce hope and a hope for change. This is why it is so important to see the difference between illness and non-illness.

3. Non-Illness themes restore mastery and control to patient’s life. Working with feelings, emotions, and cognitions resembles psychotherapy with a physically healthy individual or a family.

4. When therapy progresses and succeeds, the patient can view illness and non-illness motifs as tied again having a dual, contradictory, and complementary relationships, however, at that point when therapy ends successfully, illness and non-illness motifs are better controlled and held more comfortably in the patient’s mind.

Psychotherapy can help patients only by way of **subjectivity**: Subjectivity means the wording of a particular patient. The words of the patient help to
shift from a medical symptom which is a clinical-medical data (Illness) to a particular, subjective language of the patient (Non-Illness) which is the talk, or an acoustic data of hearing the patient speaks.

THE ILLNESS/NON-IllNESS TREATMENT MODEL

The initial formulation—The Non-Illness Intervention Model (Navon, 1999)—has recently been modified and is herein presented as a new model under the title The Illness/Non-Illness Treatment Model.

The Illness/Non-Illness conceptualization described previously, gives the treatment model its sense of direction in helping the patient struggling with major illness and/or disability to shift freely between illness and non-illness. Actual therapy with the physically ill and/or disabled individual is done utilizing the treatment model which is composed of four components.

Component A: Building Rapport—Illness Themes

This component relates to the very early stages of psychotherapy when the therapist establishes therapeutic rapport and alliance with the physically ill and/or disabled patient, empathizing with but also scrutinizing the verbal account of the illness. The therapist, shows knowledge of medical issues thereby reinforcing the patient’s feeling of being cared for by a person with an intelligent awareness of tests, drugs, and rehabilitation programs. When the patient feels that the therapist speaks her/his “illness language,” trust will develop and the two can proceed. The therapist's healing powers are enhanced by medical knowledge, which affects transference and contributes to the sense of independence and freedom to improve the quality of change achieved in therapy (McDaniel, 1992).

Component B: Differentiation/Integration Work—Illness/Non-Illness

“Differentiation/Integration work” is the cardinal component of the Illness/Non-Illness Treatment Model: it allows for distinguishing and differentiating between the two conditions, as demonstrated in the figure-ground relationship in Figure 1. In therapy, this continual, interactive, reversible flow between “illness” and “non-illness” facilitates differentiation/integration.

In practical terms, differentiation/integration does not aim at splitting medicine and psychosocial motifs, regressing to the traditional pre-Engel body–mind dichotomy model (Engel, 1977; 1980), but for psychotherapeutic reasons is directed at delineating the difference between the two.

Example: A young student with Crohn’s disease applied for psychotherapy.

**Patient:** “. . . I’ve had enough of coping and struggling with this rotten illness, day in day out. . . I feel trapped. . . bogged down . . . I’ve got diarrhea
and stomach-ache . . . I take steroids and suffer from the side effects . . . I focus on my body all the time . . . I’m not sure about my future . . . when will I have a break from this suffering? . . . too much energy is spent on food and digestion . . . I’ve got social problems . . . I’m already an outsider . . . different from healthy people . . . I have to take drugs at fixed intervals and I hate it . . . I’m desperate . . . how will it all end? . . . ”

The Differentiation/Integration Work classifies the Crohn’s patient’s expressions into “Illness” and “Non-Illness,” translating them into the two themes in the patient’s anecdotal material, which is dualistic, contradictory, complementary, and, at the same time, unified into one conceptualization. The following are categorized as “Illness/Non-Illness:”

“ . . . I’ve had enough” (=non-illness); “coping and struggling with this rotten illness” (=illness); “I feel trapped, bogged down” (=non-illness); “I’ve got diarrhea, stomach-ache . . . ”I take steroids and suffer from the side effects” (=illness); “I focus on my body all the time . . . ”I’m not sure about my future . . . ”when will I have a break from this suffering” (=non-illness); “too much energy is spent on food and digestion” (=illness); “I already have social problems . . . I’m an outsider . . . different from healthy people” (=non-illness); “I have to take my drugs at fixed intervals” (=illness); “I hate it” (=non-illness); I’m desperate . . . how will it all end? . . . (=non-illness).

The management of Differentiation/Integration Work does not preclude all talk of “illness” but rather gives the patient the potential to loosen the ties of imprisonment to illness and reach a balance, placing the emphasis less on illness and more on non-illness and the good things of life.

Component C: Differentiation Work—Patient Attitudes

Adversity and suffering will frequently be translated into an extreme “black and white” cognitive expressive style, with total belief in the accuracy of self-description of the affliction. These expressions are best described as patient attitudes or beliefs (Rolland, 1994). They are a mind-set that obstructs therapy and will require Differentiation Work if the patient is to achieve a more balanced approach to the life impact of the illness. There follow four categories of attitudes are based on actual words used in the therapy:

1. **Total**: “I feel depressed all the time . . . ever since I became ill.”

2. **Single**: “I was sick once . . . that’s why I’m still anxious.”

3. **One-Sided**: “Ever since I got sick, I focus entirely on Art—just Art.”

4. **Rigidity**: “I’ve got to be well!”

To effect change, the therapist employs Differentiation Work to distinguish between the patient’s attitudes:
1. **Partial (vs. Total):**
   
   “...sometimes you’re depressed, but then at other times you’re not.”

2. **Plural (vs. Single):**
   
   “You’ve had many things happen to you in the past that didn’t make you feel anxious.”

3. **Multi-faceted (vs. one-sided):**
   
   “Art could be covering up some other aspects of your life.”

4. **Flexibility (vs. Rigidity):**
   
   “Sometimes you feel well and sometimes you feel ill.

Component D: Illness/Non-Illness Themes

At this stage of therapy, the patient may choose either “illness” or “non-illness” language, or both. Differentiation/Integration Work are now dominant at this stage of therapy. Illness talk can be a figure to non-illness talk as a background and vice versa. This is why the patient can shift freely from Differentiation to Integration and vice versa in his/her Illness/Non-Illness talk. If, for example, the case is one of mourning, the “illness talk” will continue. A difference can be felt when “non-illness” language begins, with the patient feeling sufficiently independent to inter-change or inter-connect the two languages. Non-illness talk is potentially able to change the patient’s life once the road is perceived and opens up. Therapy is the medium whereby the patient recognizes that illness talk can be exchanged for a more optimistic attitude. The therapist is now able to select a type of treatment based on her/his own psychotherapeutic background, whether psycho-dynamic, cognitive-behavioral, or structural-strategic (see Figure 2).

Figure 2 shows the model’s four components, beginning with Rapport Building in illness features (A), followed by Differentiation/Integration

![FIGURE 2 The Illness/Non-Illness Treatment Model.](image-url)
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Work (B), and pointing up differences in patient attitudes (C), ending with Illness/Non-Illness motifs (D).

To illustrate the Illness/Non-Illness treatment Model at work, two case reports are presented in the following section.

Case 1

I present the case of Ruth who was referred to me by Dr. K. (one of our Rheumatologists) from the Rheumatology Department located at our Rehabilitation Center of our Tel Aviv Medical Center at Tel Aviv, Israel. Dr. K. evaluated Ruth as suffering and complaining of psychological stress, anxiety, depression, family difficulties, etc. Usually, new patients coming to our Rheumatology Department are told by the rheumatologists that there are psychological services (both individual and family therapy) done at the department under my direction. Ruth heard from another colleague of mine about me and was very pleased to be referred by Dr. K. who called me on the telephone and told me that Ruth is a new Lupus patient of hers and is now well treated medically, resulting presently in a reasonable balanced medical condition. The patient is taking drugs and comes for check-ups and treatments on a regular basis.

Ruth, a 48-year-old female with Lupus (SLE) for more than ten years, lives at Tel Aviv. She is divorced for many years and lives alone. She does not have any communication with her ex-husband. She has two adult children. One son lives at Tel Aviv, and her other son is married and lives in Europe. Both sons are on good terms with their mother. Ruth requested psychotherapy because she complained of anxiety, depression, anhedonia, lack of energy, weight loss, lack of meaning in life, aimlessness, and resentment at her profession of high-school teacher. Ruth’s illness talk tended to be detailed; also, she was up-to-date with medical innovations for her Lupus condition. On the other hand, she was afraid of carrying out the requisite medical check-ups, partly through fear that cancer would be revealed. Deep down she felt she could be helped by complementary and Chinese medicine, believing that Lupus often derives from mental and psychological sources. She had already had some unsuccessful Acupuncture and Shiatsu treatments and was practicing Tai Chi.

I had twelve sessions with Ruth. The early sessions (first to fourth) were focused on her illness features and complementary medicine practices. This was the time for establishing rapport and joining with her in her illness. This is usually what I do at the beginning of therapy: join the patient’s “illness language” in order to develop rapport and trust. Subsequently, she began talking about what her illness meant to her. When a patient talks about a “non-illness” motif, I start differentiating/integrating illness and non-illness motifs in order to facilitate the patient the potential to loosen the ties of imprisonment to illness and reach a balance, placing the
emphasis less on illness and more on non-illness and the good things of life.

The following are excerpts of some sessions (fifth and on), with intervention remarks shown in parentheses.

**Ruth:** “... perhaps there’s something deep in me that affects my medical condition.”

**Therapist:** “Is this ‘something deep in me’, as you said, related to the Lupus or to something that’s not related to it?”

(Illness/Non-Illness Differentiation/Integration Work).

**Ruth:** “The ‘something’ is not related to the Lupus: it has to do with my feelings... my inner thoughts... inner beliefs.” (Ruth has differentiated between her Lupus and herself).

**Therapist:** “… Which means that all these haven’t much to do with Lupus... wouldn’t you say so?”

(Focusing on Illness/Non-Illness Differentiation/Integration Work).

**Ruth:** “... Yes, indeed. Lupus is a medical illness. My inner thoughts and beliefs belong to me. They are not related to Lupus”

(Here is a demonstration how the therapist helped the patient to differentiate between her disease (=illness) and her psychological way of thinking and feeling (=non-illness).

Ruth, now on her sixth session became aware and attentive to her verbal expressions as to what “belongs” to her Lupus, which is a universal language of medicine, and what “belongs” to her thoughts, emotions, behaviors, relationships, and intra- and-inter ties. Therefore, psychotherapy can help her only by ways of subjectivity: There is a transformation from a real medical data into a subjective data which have the wording of Ruth being more subjective now (seventh session). Ruth is more willing to introduce into her therapy her past relationships with her family of origin.

**Ruth:** “I had an older sister and brother. My parents worked hard... for long hours outside the house. When I was ten my mother became sick. I didn’t know too much about her illness. No one talked to me about it—she had breast cancer. I was considered to be 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 that there was no one to take care of me. I didn’t trust my father too much... we were never close...”

**Therapist:** “Sadly, your mother’s illness and death are facts... that can’t be changed. What can be done is to work... work on your emotions, psychological ‘sensitivity’, loneliness, and the fact that there was a certain distance between you and your father wouldn’t you say so?”

(The therapists continues to differentiate between what can’t be changed as facts (=illness) from what can be changed, as emotional feelings and “sensitivity” (=non-illness).
Here is also a subtle suggestion for Ruth to “decide” whether to proceed in her therapy in doing “mourning work” or to work on changing her feelings. She decided to listen to her inner voices for meaning and hope.

**Ruth:** 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 bear 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!“

**Therapist:** “Great! Your thoughts about your ‘sensitivity’ are non-illness ones, which means they can be dealt with more effectively.

**Ruth:** “Yes!”

In the remaining four sessions (eighth to twelve), Ruth continued to describe her past memories and relationships at her family home, 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”). This enables me to reflect on “black and white” emotional attitudes phrased by Ruth in an extreme and rigid way:

**Therapist:** “…regarding your attitude to your mother’s illness: was she ‘always’ sick? … could you agree to say ‘sometimes’ instead of ‘always’? (= This facilitated more non-illness talk about past memories with the mother). You said: “I was never told that…” instead you might consider saying: “When I was told about . . . ? Or, ‘when I wasn’t told about . . . ?”

(Suggesting more flexible ways to look upon Mrs. A’s extreme attitudes by replacing “sometimes” instead of “always, and “when” instead of “never”).

**Ruth:** “Yes, in fact I could.”

**Therapist:** “You also said: “The family always thought that you were too sensitive.” Were there other situations where family members didn’t think you too sensitive?” (Looking for differences in Ruth’s attitude).

**Ruth:** “I see. Yes, that makes sense.”

(Only after Ruth was able to “separate” from her extreme perceptions and reflections concerning her relationships with her parent, was she more competent to see herself now more resilient and much more psychologically balanced.)

Slowly, the narratives about her Lupus condition and her mother’s illness formed a *background*, while talk about feelings, emotions, losses, reconciliation, positive motivation, and work turned into a *figure* (see Figure. 1). Furthermore, Ruth’s non-illness language made her more accessible, she gained weight and became more energetic and increasingly satisfied with her life.

The outcome of her therapy resulted in a much better emotional mastery concerning her life at her parents’ home and her capacity to gain psychological strengths at the present.
The physically ill and/or disabled are naturally intensely concerned with the negative life impact of their conditions: “My illness 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” are phrases frequently heard in the clinic. The patient repeatedly reverts to the seriousness of his plight and together with the therapist will often land in a “stuck” situation. The therapeutic interaction cannot go forward, consequently the patient sometimes loses interest in or even quits therapy, bringing about or perhaps perpetuating an impasse in medical and psychotherapeutic encounters (Jaber et al., 1997).

Here is a demonstration of such a “stuck case.”

Case 2

David is 28 years old and lost his right leg in a car accident one year ago. He was depressed, preferred staying home in bed, stopped seeing friends and became quite passive. His parents referred him to therapy as he was very poorly motivated to seek help. David needed to overcome his resistance to psychotherapy and find out whether it could assist him.

The following is an excerpt of the first session. The terms applied to the therapist’s intervention or patients’ attitudes are shown in parentheses.

David: “. . . how can therapy help me? Will therapy bring back my leg? My whole world has collapsed . . . shattered . . . I’ve no future without my leg . . . I’m lost . . . what should I do? (=A Total Attitude)

Therapist: “Please tell me more about your missing leg . . . what treatment you’ve had so far . . . and what you’re having now” (=Illness)
(Mr. B describes his car accident in detail and the various treatments he has received).

Therapist: “. . . and what’s happening now? (=Trying to create differentiation/integration between Illness/Non-Illness language.)

David: Well, I haven’t got a leg now . . . can you bring it back?”

Therapist: “I cannot. Do you think anyone can? (=Therapist tries to let patient seek solutions for him in order to enhance compliance)

David: “. . . Well, not really . . .

Therapist: “You see, no one can reverse the situation . . . but this doesn’t mean that you have to stay home and get depressed” (=Differentiation/integration work: Illness/Non-Illness)

David: “That’s how my psyche reacts all the time to my world . . . a world in ruins” (=A Total Attitude)

Therapist: “Your psyche reacts like that all the time? Is there any time at all when it reacts differently?”(Differentiation Work on David’s Total Attitude)

David: “. . . Sometimes I’m less depressed . . . ” (=Differentiation/Integration Work has been accomplished.)
Therapist: “...OK, “less depressed” sounds better than “more depressed”... What made you come to therapy: is it because of your missing leg; or because you’re missing your leg?” (=Differentiation/Integration Work: Illness/Non-Illness)

David: “…I miss the leg… I don’t stop thinking about having my leg back again... apart from that idea, everything else is a waste of time” (=Stuck Situation)

Therapist: “…And suppose you had your leg, then what? (=Challenging Question)

David: “I don’t believe I’m going to have it...” (Challenging Question brings David back to reality.)

Therapist: “Maybe you can live without a leg?”

David: “Maybe, but I don’t accept that.”

Therapist: “When will you start accepting that? (=Future Question)

David: “When I accept the fact that I’ve lost my leg and can live without it.”

Therapist: “What would be the first sign of that?” (=Future Question)

David: “When I stop feeling ashamed of myself—and in front of others—for being disabled.”

Therapist: “…so, there are two things: a missing leg—which is related to disability; and a sense of shame—which is connected with non-disability” (=Differentiation/Integration Work).

David: “Yes. Both are related to each other.” (=Mr. B reinforces the dual, contradictory, and complementary conceptualization of the Illness/Non-Illness Conceptualization)

Therapist: “Can you explain that?” (=Differentiation/Integration Work)

David: “If I had the leg, I wouldn’t be ashamed, and vice versa.” (=Complementarity)

Therapist: “Do you feel that way inside yourself, or rather that others see you that way?” (=Differentiation: The patient and others.)

David: “Yes. Inside myself. And also that others pity me. People don’t tell me the truth... that I’m to be pitied...”

Therapist: “David, you’ve already mentioned a few important subjects for therapy, like “to accept,” to be ashamed,” “people pity me,” “people don’t tell the truth,” “I’m a poor wretch.” These are very harsh expressions, but you can work and change them and along with them the way you relate to your loss. Unfortunately, the leg can’t be brought back, but the expressions can be changed. What do you have in mind now, David?” (=Differentiation/integration Work.)

David: “I came in feeling skeptical. Now I’m ready to cooperate with you.” (=Differentiation/Integration Work has succeeded.)

Therapist: “We’ll try, in our meetings, to see what “belongs” to your leg and what “belongs” to David...”(=Differentiation/Integration Work.)
David: “O.K. I feel more convinced now.”
(David decided to continue to come to therapy.)

At the start of the sessions, the therapist joined with David in his disability motifs. The therapist utilized Differentiation/Integration Work as long as he resisted therapy and remained stuck in a rigid attitude of mourning the loss of his leg. The persistent Differentiation/Integration Work allowed him to break through his resistance and, more specifically, to bring about a therapeutic change in his *Total Attitude* to his loss and severe mourning.

As therapy proceeded, David’s psychological well-being improved. He returned to work, began meeting people, and was livelier and happier.

DISCUSSION

The Illness/Non-Illness conceptualization utilizes four concepts: Duality (Illness *and* Non-Illness), Contradiction (Illness *Vs.* Non-Illness), Complementarity (Illness and Non-Illness *complement* each other), and Unity (Illness *together* with Non-Illness).

On the basis of this conceptualization, the treatment model utilizes the work of Differentiation/Integration, which helps the patient acquire the language of change, grow aware of the value of Non-Illness motifs, and realize that a shift in thinking in this direction is possible.

The therapist should, from the outset, proceed slowly and cautiously using “pacing and leading” techniques (Brown & Fromm, 1986) and always endeavor to join with the patient in working to achieve cooperation in the event of resistance. This delicate work demands therapeutic sensitivity, attention to patient nuances and careful and systematic listening to verbal cues, without missing the non-verbal ones. If the therapist works along these lines, it is likely that a positive replacement of perceived ideas will eventually occur in the patient: he/she will be ready to handle non-illness aspects and work with the therapist at situating them more saliently in the therapeutic landscape.

As an integral constituent of the social constructionist movement in psychology (Gergen, 1985), postmodern therapists subscribe to the notion that reality assumptions (and we all make them) develop out of communication, language, and conversation with others. This would imply that our present knowledge is elaborated within a social context. However, beyond the scope of outward experience of inner thoughts and feelings, *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 et al., 1988).

The Illness/Non-Illness Treatment Model presented in this article is an addition to the field of social constructivism, in which language and meaning
are the core ingredients of psychotherapeutic interaction with a special kind of population—physically ill and/or disabled patients and their families. This model may be applied to either individual and conjoint couple or family therapy with a physically ill member, without altering the intervention approach for either the sick or the healthy member, if for example more patients’ family members are included in the therapy. Their healthy family members sometimes represent a “non-illness” element, which reinforces the therapists’ and patients’ ideas about change by adopting the “non-illness” route. This has relevance for any motivated family member, well or ill, seeking therapy for reasons of acute, chronic, or terminal illness, or illness of a spouse, parent, grandparent, or child.

The Treatment Model is a “how to” and an intervention-oriented model. It serves as a supervision and consulting instrument, not only for psychotherapists, but also for medical staff (physicians, nurses, physiotherapists, occupational therapists, etc.) who encounter physically ill patients in their daily routine work. It enables utilization of multiple approaches to psychotherapy, such as Dynamic, Cognitive, Narrative, Structural, Short-Term, and Strategic orientations.

Finally, because of its exceptional capacity to handle difficult situations, the model is an enhanced procedure for negotiation with patients who are referred by physicians or other medical bodies. In such circumstances, it may be expected that it is the referred rather than the self-referred patient who will resist therapy, because (as in Case 2) they may not have considered this direction as relevant to their medical condition. Therapists with physically ill, resistant patients are in need of a treatment framework for managing resistance and transforming it into cooperation. The present model might be considered beneficial in handling these “stuck” and/or resistant cases.

Clinically, and from the viewpoint of clinical experience and practice, the model may be regarded as containing some major advantages for physically ill patients and their families. Any such benefits will, of course require further investigation.

REFERENCES


