

MEDICAL FAMILY THERAPY CASEBOOK

Listening to Illness/Nonillness Motifs: A Case of Fibromyalgia

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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 uses also words that describe thoughts, emotions, behaviors, relationships, intra-, and interties. This is the language of "nonillness," which is the unique language of subjectivity. Psychotherapy can help patients only by ways of subjectivity, that is, using the patient's words. The words of the patient shift back and forth from medical data, which is a universal medical language of the patient (illness) to a particular subjective language of the patient (nonillness). A case example demonstrates this differentiation work.

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Some physically ill and disabled patients are intensely concerned about the negative impact of their conditions on their life: "My illness doesn't let me move

on," "If I weren't sick or disabled, I could do whatever I wanted," "If I were really well, I'd be free." These phrases are sometimes heard in the clinic. The patient reverts to the seriousness of his or her plight and lands in a "stuck" situation. If the therapeutic interaction does not go forward, then the patient may lose interest in or even quit therapy, contributing to an impasse in the provision of care (Jaber, Trilling, & Kelso, 1997).

Whenever patients tie their "illness motif" to negative outcomes in life, I suggest that they also listen to another voice within themselves, what I call their "nonillness motif," which is about *change*. The addition of the nonillness voice enables patients to "differentiate" themselves from the illness voice, which is usually perceived by physically ill patients as not possible to change. By contrast, the nonillness voice often includes a more hopeful viewpoint and helps patients loosen the bonds of their illness and, in the process, reach a better balance in their life, one that places less emphasis on illness and greater emphasis on nonillness experience (Navon, 1999, 2005). In my therapy with ill patients and their families, I help patients differentiate illness talk from nonillness talk and ultimately reintegrate both forms of talk in a more constructive and meaningful way. The following case is an example.

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THE CASE OF MIRIAM

Miriam¹ was referred to me by Dr. A. from the rheumatology department at Tel Aviv Medical Center in Tel Aviv, Israel. Dr. A. and I, he a senior rheumatologist and I a medical and rehabilitation psychologist, instituted a medical and psychological service for fibromyalgia patients in 2003. We collaborate together with each fibromyalgia patient who comes to us for treatment. Dr. A. examines and treats the fibromyalgia patient and refers the patient to me for psychological treatment.

Dr. A. described Miriam as a patient with fibromyalgia syndrome, a widespread musculoskeletal pain and fatigue disorder with unclear causation. Fibromyalgia involves pain in the soft fibrous tissues of the body, such as the muscles, ligaments, and tendons. The diagnostic criteria for fibromyalgia include up to 18 pain trigger points, poor sleep and/or sleep disorders, and mood disturbances, typically depression and/or anxiety.

Miriam was a 45-year-old woman from Tel Aviv who was married and had two children (15 and 12 years old). She worked part time as a remedial reading therapist for children. During the intake process, Miriam complained of muscle and joint pains. She had 17 trigger points, was depressed, and suffered from fatigue, poor sleep, and lack of energy. She felt “empty” and lacked what she called “a lust for life.”

Miriam’s illness talk was very clear and detailed. After 2 years suffering from fibromyalgia, she had become an expert on her disease. Nevertheless, Miriam was very pessimistic about the possibility of being cured. She took antidepressant drugs, did physical fitness exercises, and turned to Chinese medicine disciplines such as shiatsu and acupuncture.

Miriam was motivated to meet me and start psychotherapy. I had 12 sessions with her. The early sessions focused on her illness, providing me an opportunity to establish rapport and join with her around her

illness language. Subsequently, she talked about what her illness meant to her. When she talked about a nonillness motif, I started to differentiate/integrate illness and nonillness motifs to help her free herself from the misery of illness and reach a better emotional state by placing less emphasis on illness and greater emphasis on more hopeful nonillness perspectives.

Miriam: Sometimes I think that I am the cause of my fibromyalgia. I had brought it to myself, to my life.

Shaul Navon (SN): Is “I am the cause of my fibromyalgia” and “I had brought it to myself, to my life,” as you said, is it related to fibromyalgia or to something that’s not related to it?

Here I start to differentiate illness from nonillness.

Miriam: The “I am the cause” has to do with how I feel . . . how I think of myself . . . how I believe. [Here Miriam is differentiating between her fibromyalgia and herself.]

SN: . . . Which means that feelings, thoughts, and beliefs haven’t much to do with the medical aspects of fibromyalgia. . . . Wouldn’t you say so?

I focus once more on illness/nonillness differentiation/integration work.

Miriam: Yes, indeed. Fibromyalgia is treated by drugs and medical examinations. It is a medical illness. My inner thoughts and beliefs belong to me. They are not related to fibromyalgia.

¹ The name has been changed to protect patient confidentiality.

Here I try to help the patient differentiate between her medical condition (illness) and her psychological way of thinking and feeling (nonillness).

Miriam, now in her seventh session, became aware of and attentive to her verbal expressions about what “belongs” to her fibromyalgia, which is a *universal* language of medicine, and what “belongs” to her thoughts, emotions, behaviors, and relationships, which is a *subjective* language. Miriam’s language helped her shift from the clinical–medical data of physical symptoms (illness) to the subjective language of her own experience (nonillness).

Having become more subjective, Miriam was now able to focus on past relationships with her family of origin.

Miriam: I grew up with my two parents and my younger brother. My life as a child was difficult. My parents worked hard . . . for long hours outside the house. When I was 12, my parents divorced. My father left our home. I stayed together with my brother and my mother. Then, my mother became sick. I didn’t know too much about her illness. No one talked to me about it—she had melanoma. My aunt moved to our home to help my mother. I was considered to be too “sensitive” to treat and help my mother in her illness. My mother died when I was 15. After her death, I was very much depressed. I felt very much alone. I loved my mother so much and missed her. I needed very much love and protection. . . . I was never close to my father. . . . I couldn’t get TLC, tender loving care, from him.

SN: Sadly, your mother’s illness and death are facts . . . that can’t be changed. What can be done is to see whether you can make a change in your emotional, psychological “sensitivity,” feelings of loneliness, and the fact that

there was a “TLC distance” between you and your father, wouldn’t you say so?

I continued to differentiate between a no-change event (illness and death) and areas that could be changed: emotional feelings and “sensitivity” (nonillness). Miriam preferred to listen to her inner voices of nonillness by searching for meaning and hope:

Miriam: For years I believed that if I am so “sensitive,” I could not cope with any physical suffering. I came to therapy to examine and ask myself whether being “sensitive” belongs to the past when I was 15-year-old teenager. . . . Perhaps now it is the right time to reexamine this notion [being sensitive] and see if I could now be more resilient and more capable to fight my fibromyalgia . . . to suffer, but survive!

SN: Your ability to reexamine your “sensitivity” is a nonillness issue, which means that you can try and change this notion.

Miriam: Absolutely, yes!

In the remaining sessions, Miriam continued to be concerned about her chronic medical condition: “I can’t stand it anymore: Either I’m well or I’m sick. I’ve been depressed ever since I became ill.” In response to her “black and white” (well or sick) and global (“ever since”) emotional attitudes about her illness, I began to introduce greater variance or flexibility to her perspective:

SN: Regarding your attitude to your illness: “either–or” . . . would you agree to say “sometimes” instead of “either–or”? You also said, “I’ve been depressed ever since I became ill.” Instead, you might consider saying, “Sometimes I’m depressed, but then at other times, I’m not,” or, “I’m not always depressed.”

Miriam: Yes, in fact I could.

SN: You also said, “I was considered to be too ‘sensitive’ to treat and to help my mother in her illness.” Were there other situations where you were *not* considered to be too sensitive?

Miriam: Yes. Sometimes there were some situations at home that I was not considered being “too sensitive” to cope with . . .

SN: . . . so here again, “sometimes being too sensitive” is a better descriptive narrative than “always being too sensitive,” isn’t it?

Miriam: I see. Yes, that makes sense.

Only when Miriam was able to change her rigid perceptions and reflections concerning her fibromyalgia did she become more competent to see herself now more resilient and much more psychologically balanced.

In the end, Miriam reached a better emotional status and established greater psychological control of her life. Throughout therapy, talk about her fibromyalgia gradually was replaced by nonillness themes such as emotions, losses, self-esteem, positive motivation, and so forth. Miriam felt that she became more energetic and more satisfied with the quality of her life.

CONCLUDING THOUGHTS

The treatment of Miriam convinced me once again that therapy with physically ill patients can be effective when the illness is treated as if it is not “present” in the therapy room. Physically ill patients who seek psychotherapy can make a *change* by trying to change their nonillness issues. This kind of change helps the physically ill patient to perceive illness in a more balanced way. Psychotherapy helps physically ill patients to see that it is their *nonillness* that

is changing, so they can now cope better with the chronic phase of their illness.

I learned an important lesson from Miriam and other similar cases in medical family therapy: *Subjectivity* is critical to effective psychotherapy. The meaning of illness is transformed from a medical entity into a subjective one on the basis of the language used by the patient to describe it. The words of the patient transform the story of the medical symptom, which is expressed in clinical–medical terms (illness), into a subjective story (nonillness) that is expressed in the everyday language of a particular patient. This nonillness, subjective symptom creates a *shift* that might lead to a desired *change* by means of psychotherapy.

Finally, the treatment of Miriam inspired in me considerable optimism, because even in the face of a chronic and serious illness, it is the *nonillness* that can be changed. When therapy progresses and succeeds, the patient can look on illness and nonillness motifs as linked, often having dual contradictory and complementary relationships; however, when therapy ends successfully, illness and nonillness motifs are better controlled and held more comfortably in the patient’s mind.

As a therapist, I never forget that nonillness themes restore mastery and control to patients’ life.

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