The Strange Case of Medical Hypnosis 2: Attachment, Resistance, and Secondary Gain

Chronic illness can be improved by a program of psychosomatic learning.

"To a very large extent, men and women are a product of how they define themselves."
— **Jeremy W. Hayward**, senior teacher of Shambhala Buddhism

Awareness

We have both conscious and unconscious awareness. Conscious awareness works in conjunction with our reasons and intentions. Our conscious perceptions are those we recognize and remember.

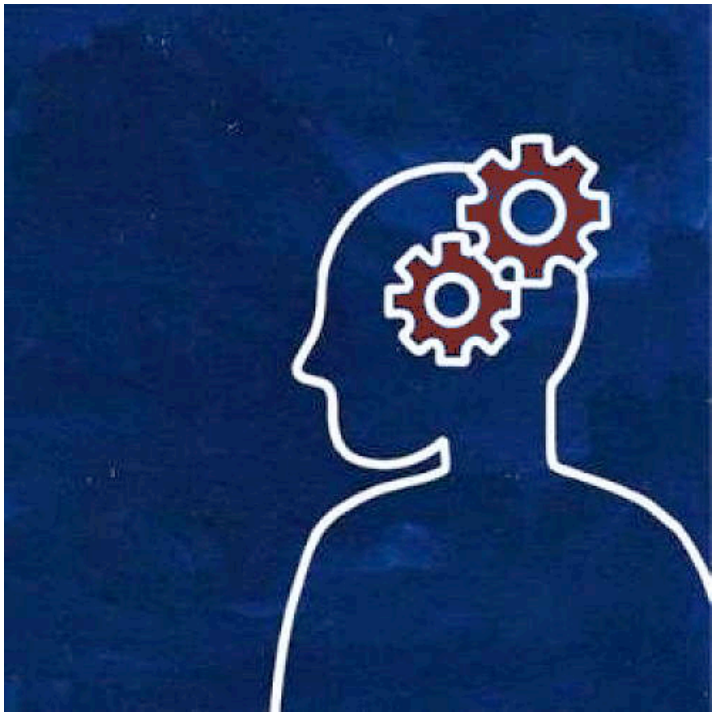
Our unconscious awareness moves on a separate track and has a form of intentionality that feels different in the rare instances when we're conscious of its effect, but we rarely are. Seen as "the silent observer" our unconscious awareness is said to monitor and express our deeply felt and less readily expressed identity.

Our unconscious awareness reflects our values and sense of self. Rooted in our subconscious, it does not answer to our intellect, but it is not entirely emotional either. One might say that it is pragmatically spiritual in the sense that it's more fundamental.

Most of our thoughts originate in our unconscious awareness. We can't see how they form, but it's likely a combination of stimulation, associations, and emotions. The product of these is an idea that emerges fully formed in our conscious awareness. Such an idea might express itself to us in the form of a statement, such as, "This feels right," or "I am reluctant."

Since our unconscious awareness cannot be isolated or analyzed, we cannot be sure of its extent. We don't know if it's tied to our bodily systems or if it's separate from them. It's possible that unconscious awareness is partly cognitive and partly somatic. That is to say, that it's partly in our heads and partly in our bodies as extensions of our nervous, endocrine, immune, cardio-vascular, hepatic, and digestive systems.

Our latent fears, hungers, hesitance, and excitements arise from our unconscious awareness. The connection between our two forms of awareness can be loose. We may feel drawn to or repelled by some circumstances without being aware of it. It can take anywhere from minutes to months for clarity to emerge. It may require more thought, recollection, or additional experience.



Behavioural Medicine

There is a vaguely defined field called Behavioural Medicine which roughly refers to anything having to do with the behaviour of people giving, receiving, or experiencing medical situations. It can refer to social, technical, or personal elements pertinent to wellness. Behavioural medicine is a field that has no real boundary.

Behavioural medicine is largely seen as mechanistic. That is, practitioners of behavioural medicine have an allopathic, linear view of medicine as being mechanical rather than regulatory. It is always simpler to ignore what is not obvious, and this seems to be a general philosophy in medicine, but it's

surprising to find this attitude here, where the situation is manifestly nonlinear.

Mechanical conditions involve no thought or intention; regulatory conditions stem from both conscious and unconscious actions. Regulatory problems do not admit mechanical solutions. Even mechanical issues, such as a broken bone, are rarely resolved by mechanical remediation alone.

Half of those practicing behavioural medicine are trained as psychotherapists. Current psychotherapy espouses a naïve, mechanistic approach that does not recognize unconscious awareness. This is largely due to a failure of mistaking relationships for causes. Greater insight is apparent in neurology, where one is more able to see the absence of the links between physiology and symptomatology.

Self-deception

"The first principle is that you must not fool yourself, and you are the easiest person to fool."
— **Richard P. Feynman**, physicist

When one's conscious and unconscious awareness are in conflict, conscious awareness becomes superficial and unconscious awareness goes into hiding. This is like a family conflict in which the family members cannot communicate, both because they don't speak and don't listen.

If aspects of oneself are repressed, one becomes neurotic, but if aspects of one's conflict manifest physically, one becomes ill. The psychological conflict is real, and the physiological consequences of it are also real. The result is a somatic illness with psychological elements.

These elements are not causes in the serial sense, they are factors in the regulatory scheme. That is, the psychological dysregulation contributes to and sustains the illness, and together these create the symptoms.

The influence of your unconscious easily escapes your awareness. Your body's dysfunction cannot recognize the role of your mind, and your mind won't take responsibility for your body. To recover this awareness you must overcome the obstacles of fear and self-deception. Think of this in the family

metaphor. The failure of family communication results in a collapse of family integrity and the ill health of its members.

In my role as therapist, I insist my client take an increasing role in solving their problems. This separates my clientele into two groups: those who accept a larger role and succeed in resolving their problems, and those who refuse and fail. Those who succeed recognize the role of their psyche in framing their distress, while those who fail reject responsibility. It's these people who fail to resolve their psychological conflicts who can go on to manifest their psychological conflict as a physical sickness in their bodies.

Fear

"When one is frightened of the truth,
then it is never the whole truth that one has an inkling of."
— **Ludwig Wittgenstein**, philosopher

I've had clients who presented chronic illness and who denied that their psyche played any part in it. In some cases I agreed, and I worked to help them focus on finding strength, comfort, and healing. In other cases—the majority of cases—I disagreed and felt their illnesses had psychological components.

These clients were frightened by the suggestion that their state of mind might be a cause of their condition. Our work to effect healing was quickly subverted by their rejection of responsibility. They could not admit they were as doing this, as that would require them to recognize the role they were playing. Instead, they found trivial fault in our process, schedule, billing protocol, or social roles.

To be clear, when these clients made progress and their psychological issues began to emerge or their physical problems were at risk of being healed, they fled from treatment. Their body needed healing, but their minds' refused to allow it.

I cannot be certain of this and it was rarely obvious, but I've come to see the pattern. It occurs when I can both see healing begin on the physical level, and witness rejection on the psychological level.

These clients were not trying to be offensive or contentious, but they were not honest either. They justified their reasons to stop treatment on grounds that seemed marginally rational to them, but I could see their reasons were contrived. Evading responsibility is a recognized trait of psychosomatic clients.

Courage

"Courage is not the absence of fear, but the mastery of it."
— **Mark Twain**, writer

You cannot argue courage into existence. If it's not there, then there is little you can do about it. Courage can be brought forward through a threat, enticement, or deception. In a functional sense, courage is commitment. Without commitment, whether or not you call it courage, you cannot achieve any goal. The stern approach to medical hypnosis insists clients commit to multiple sessions soon after starting.

To counter the likelihood of a client abandoning therapy, this approach requests payment for multiple sessions before starting a program of therapy. Treatment is not piecemeal, and abandoning a program of treatment halfway defeats the client's stated intention, achieves little to nothing, and furthers the misimpression that there is no mind-body connection.

I have not yet taken this hard-line approach, as my preference is to follow client's my direction. But medical conditions are different, and they represent a mind-body conflict in which it is the client's direction that is contributing to their condition and derailing their own progress.

To instill greater responsibility, the disciplinarian gives his or her clients homework. This amount to a program of action and intention of the sort a normally engaged person would naturally develop, but it is a lack of a natural healing course that is typical of chronic conditions. Homework could be regular relaxation, exercise, or disengagement from stress, listening to recorded audio material, journaling, or reporting on certain issues. If clients don't complete these assignments, the program either halts at that point or focuses on progress and resistance.

This is the disciplinarian's approach: the client makes a financial commitment before their fear of healing arises. When and if it this fear arises, choosing to flee from further sessions carries the prospect of a substantial financial loss.

Ian Wickramasekera is both a therapist and researcher in behavioral medicine. He describes what he

calls the Trojan Horse procedure for securing the compliance of a client experiencing a psychosomatic condition. He presents the client with authoritative evidence of the success of treatment that does not raise the spectre of their fears.

Being assured of a non-psychological program—falsely, as it turns out—the client has little justification for noncompliance. It is only after the client commits to a lesser goal, something less than a release of their attachment to their physical illness, that he approaches the psychological issues that maintain the condition.

Support

The origin of the somatic illness is partly one of dysregulation, but the dysregulation is based on psychic conflict and fear. Addressing the dysregulation requires addressing the fear that's hidden in the somatic condition. This is what the client does not want. The somatic condition plays a collaborative role in keeping the fear hidden.

> "They are patients whose somatic complaints have been unresponsive to multiple, conventional chemical and/or surgical interventions. Often the referrals are poorly made. Without rapid and effective patient reorientation by the behavioural medicine practitioner, these patients are unlikely to make or keep an appointment, or if they come in, to return after the first visit."
> — **Ian Wickramasekera** (1988, p.135)

Wickramasekera works to shape "the patient's cognitions into an educational model of illness, as opposed to a biomedical model in which the patient is the passive recipient of treatments… Shifting to an educational model (requires the client to) disable secondary gain or the rewards of the 'sick role' and physical symptoms."

In most cases of somatic illness, we assume the client wants to recover. Certainly, the client's more vocal part attests to this desire. But in the case of many psychosomatic conditions, this is not the whole story. The client may declare their desire to heal, but their symptoms run a mysteriously unresponsive course. There is no obvious benefit to being ill because the benefit lies in the absence of what can't be seen, and which the client is loath to consider.

Resolve

For most conditions, we aim for progressive improvement. Even with purely psychological problems, we expect symptoms to reduce to issues that can be addressed. This is not the case with some psychosomatic conditions because the symptoms are not caused by the problems, they are barriers that obscure them. When these barriers come down, the genuine problems will come up.

> "The course of learning real control of symptoms is not a short, positively accelerating course for which there is a 'quick fix.' Rather, it is an uneven course, with gradual elevation interrupted by regression as physiological self-regulatory competencies develop."
> — **Ian Wickramasekera** (1988)

Conflicted clients who abandon treatment are not ready to face their own disability. I don't know the reason, and it is unlikely my guesses would be welcome or helpful. This doesn't apply to all clients and all treatments, but is particular to treatments that require the client to take responsibility for their unconscious conflicts.

People must take responsibility, and I prefer they take it honestly. For a person to act without honesty sets them in opposition to the practitioner and themselves. If I hide behind a mask of authority—as many practitioners do—my scheme is a fraud.

> "The fourth and final component in the psycho-physiological role induction is directly and openly to investigate the psychosocial antecedents and consequences of the patient's symptoms. Now that the patient is no longer an imposter, he or she is out of the closet and is a psychotherapy candidate… At this fourth step, the patient's symptoms have typically shifted from predominantly somatic (pain, dizziness, etc.) to predominantly psychological complaints (e.g. phobias, anxiety, depression, etc.)."
> — **Ian Wickramasekera** (1988)

Caste in this light, psychosomatic illness starts to sound like a combination of Post Traumatic Stress and Dissociative Identity Disorder. Forcing a person into a realm of terror where their problems are clear may sound logical, but if they have already damaged their body as a means of burying the issues,

exposing their issues will only cause further damage. Their emergence must be organic and voluntary.

I suspect all illness has a psychosomatic component, and being at odds with oneself plays a role in all dysregulation. To resolve psychosomatic illness the client must build a bridge across a chasm that only they can see.

There is good news and bad news. The bad news is that your doctors cannot cure your chronic illness and prolong your life. The good news is that you can. I suspect many cases of chronic illness can be improved or resolved entirely by a program of psychosomatic learning.

> "Unexpressed feelings come forth later in uglier ways. Psychosomatic illnesses often are the reincarnation of cumulative resentment, deep disappointment and disillusionment repressed by the Lose/Win mentality. Disproportionate rage or anger, overreaction to minor provocation, and cynicism are other embodiments of suppressed emotion. People who are constantly repressing, not transcending feelings toward a higher meaning, find that it affects the quality of their relationships."
> — **Stephen Covey**, educator and author of *The 7 Habits of Highly Effective People*

References

Wickramasekera, I. S. (1988). Psychophysiological role induction or the Trojan Horse procedure, chapter 7, in *Clinical behavioral medicine, Some concepts and procedures*. Plenum Press (pp. 143-54).