J Contemp Psychother
DOI 10.1007/s10879-017-9368-5

ORIGINAL PAPER

Two-Track Differentiation Paradigm in Psychotherapy

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Abstract This paper describes the Two-Track Differentiation Paradigm, an updated therapeutic methodology within psychotherapy. The Two-Track Differentiation Paradigm is based on the assumption that patients habitually regard their problems as one-dimensional and thus tend to become rigid in their attitudes toward these problems. The paradigm suggests a psychotherapeutic process of enriched reframing called Differentiation. This Differentiation between patients' negative and positive narratives and perceptions offers them more options and frees them to contend with their problems more effectively. Thus, with the Two-Track Differentiation Paradigm, cases of impasse and stuck psychotherapeutic situations are turned into cases of cooperation.

Keywords Psychotherapeutic paradigms · CBT intervention techniques · Psychotherapeutic impasse

Monoideism, Duality and Contradiction

Monoideism

Monoideism is a state in which the mind is focused or the attention is fixed on one idea. It is a state of prolonged absorption in a single idea, as in mental depression, trance and hypnosis (Kaffman 1981). For example, a patient with OCD may insist and believe that only if he washes his hands 28 times every day his healthy mother will live and not die. This belief is a monoideistic and obsessive idea, encompassing one and only one thought or belief. This patient cannot see any alternative to washing his hands 28 times a day. The only chance for this behavior to change is for the patient to commence therapy. For example, if as the result of therapy, the patient washed his hands only three or five times a day rather than 28, this would be regarded as a positive psychotherapeutic change representing a new flexible alternative for the patient's monoideistic view of hand washing. The patient's single-frame view of the problem would be transformed to a two-frame view—a dual (or even plural) state of mind (Navon 2015). Any monoideistic view of a patient's problem generates a stuck and resistant therapeutic situation. Turning a stuck and resistant situation into one of cooperation requires a dual-track intervention.

From Monoideism to Duality

Duality

Duality refers to the existence of two elements, objects, concepts, human expressions or states of mind that contradict and/or complement one another. The discipline of philosophy has always been heavily steeped in arguments concerning duality (sometimes plurality), and contradictory elements have dominated the realm of philosophical thought, reasoning and knowledge. As suggested by the word "dual," *duality* refers to having two parts, often with opposite meanings, as in the *dualities* of good and evil, peace and war, love and hate, up and down, and black and white. Dualism is closely associated with the thought of René Descartes

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Published online: 28 August 2017

(1641), who was the first to formulate the mind–body problem in the form in which it exists today (Cottingham et al. 1984). Dualism stands in contrast to Monoideism. Some examples of duality include an object versus the perception of the object, and the conscious versus the unconscious (Kahn 1988).

Contradiction

Contradiction refers to a logical falsehood, which is a statement that, by virtue of its form, cannot be used to make a true assertion, as in the following statement: "Sugar is sweet and sugar is not sweet" (Seddon 1996). In addition, a contradiction can exist between two elements, objects, concepts, human expressions or states of mind that oppose one another: cold versus hot, justice versus injustice, something versus nothing (Kahn 1988). Duality creates contradiction. In classical logic, a contradiction comprises a logical incompatibility between two or more propositions. Contradiction occurs when the propositions, taken together, yield two conclusions constituting logical and usually opposite inversions of each other.

CBT helps patients correct false self-beliefs that can lead to certain moods and behaviors (Beck 2011). During psychotherapy, the therapist usually helps the patient work through several steps. First, the patient learns to acknowledge that some of his or her perceptions and interpretations of reality may be false (due past experience or for hereditary or biological reasons), and that these interpretations lead to negative thoughts and maladaptive behaviors. Next, the patient learns to recognize the negative (surface or "automatic") thoughts and discovers *alternative* positive thoughts that reflect reality more closely (Beck 1976). For example, the technique of *reframing* offers an *alternative* positive narrative to the patient's presenting problem, one that fits the "facts" of the same concrete situation equally well or even better and thereby changes its entire meaning (Watzlawick 1978; Manicavasagar et al. 2012).

Although the effectiveness of CBT for treating a variety of psychopathologies is undeniable, one should consider an important limitation. In CBT therapy the process of reframing is conducted by the therapist. The therapist is the one who phrases the reframing, not the patient. This feature could hinder the psychotherapeutic process and have negative aftereffects.

For example, the narrative ensuing from the *therapist's* reframing might be experienced by the patient as "out of context," which would mean that the reframing as phrased by the therapist might not fit the patient's viewpoint and subjective perception (Omer 1994). Furthermore, the patient might view the new narrative as alien, invalidating, or non-empathic to the self. This, in turn, could lead to an explicit rejection of the reframed narrative, or alternatively, under conditions when the patient tries to please the therapist, to inauthentic acceptance of the therapist's reframing. Both options could lead to an impasse during therapy, hampering the healing process.

From Duality to Differentiation and Creation of an Alternative Narrative

The proposed Two-Track Differentiation Paradigm is an innovative technique aimed at expanding and enriching the reframing method. Specifically, the Two-Track Differentiation Paradigm aspires to help overcome the shortcomings of reframing and thus further the therapeutic process. With this enriching reframing technique within Cognitive Behavioral Therapy, the patient's narratives are *differentiated* into a positive narrative and a negative narrative. Thus, the Two-Track Differentiation Paradigm has the potential to overcome the aforementioned therapist's reframing shortcomings and to transform Monoideism to duality.

The Two-Track Differentiation Paradigm is an expansion of the Illness/Non-illness Model (Navon 2005a, 2016). According to this model, physical illness or disability represents a typical situation of being stuck in life. Patients who are physically ill and/or disabled are naturally deeply concerned about the negative life impact of their conditions and therefore become stuck: "My illness/disability 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." Phrases such as these are frequently heard at clinics. Such verbal expressions are one-sided and do not represent the whole picture. The psychotherapeutic interaction cannot go forward. Consequently, the patient sometimes loses interest in the therapy or even quits, bringing about or perhaps perpetuating an impasse in any future medical and psychotherapeutic encounters (Jaber et al. 1997).

Physically ill/disabled patients generally express an "illness" narrative. These patients often use words that describe medicine, biology, medical treatment, pain, drugs and hospitalization. This is the language of "illness," which is a universal language of medicine. Yet, patients also express a "non-illness" narrative when using words that describe thoughts, emotions, behaviors and relationships. This is the language of "non-illness", which is the unique and subjective language of each patient. Patient narratives shift back and forth between medical data, which is the patient's universal medical language (illness), to each patient's particular subjective language (non-illness).

Expansion of the Illness/Non-Illness model to psychological problems, as reflected in the Two-Track Differentiation Paradigm in psychotherapy, suggests that patients who suffer from psychiatric symptoms and psychological difficulties may hold two competing narratives. At the outset of therapy, the patient maintains the notion that everything in his/her

life is *illness*. This is a one-sided, monoideistic ideational context that results in painful therapeutic failure to penetrate the monoideistic armor. This monoideistic preoccupation may be all-inclusive and pervade the individual's entire life. But this is only *one* frame of reference. As the therapy progresses, the patient may add/introduce an *alternative* view in the form of a *non-illness* narrative. This is achieved by the Differentiation Work tool (Navon 2016). Very soon in the therapy, the patient begins to have two narratives: Illness and Non-Illness. The patient can differentiate between these narratives. Creation of the patient's *Non-Illness* narrative involves an act of distancing the patient from his/her *illness*. This procedure does not negate the pathological narrative (illness); rather, it emphasizes the adaptive (non-illness) narrative. As normalization of the patient's cognitive and behavioral position has a therapeutic effect (Minuchin and Fishman 1981), these processes have the potential to extricate the therapy from potential impasses, thus furthering the healing process.

The Two-Track Differentiation Paradigm bypasses potential difficulties that may result from reframing conducted by the therapist. The paradigm is designed so that patients will be able to differentiate between alternatives and follow the positive *alternative* narrative based on the *patient's own subjective verbal expressions and idiosyncratic language*. It is the patient that creates the *positive alternative* using his/her own words. The patient now has two psychotherapeutic alternatives: a positive one and a negative one. Hence, the chances are low that patients will view the alternative narrative as invalidating their own inner experiences and resist adopting it. Moreover, the proposed Two-Track Differentiation Paradigm is not aimed at replacing the patient's old narrative by the new one, as in classical therapist reframing. Rather, the paradigm seeks to enrich, facilitate and further improve the patient's stuck situation by *differentiating the* pathological narrative from the non-pathological narrative. The patient does not have to negate or relinquish the pathological narrative, which may have some important functions, but rather learns to devote more attention to the non-pathological narrative, which exists simultaneously. In this way, the proposed paradigm attempts to convert a psychotherapeutic impasse into a turning point that brings about psychotherapeutic change and a sense of mastery and control over patients' lives. This enriched reframing is specifically suited to difficult patients who adhere to their negative stuck problem.

The leading psychotherapeutic tool of the suggested paradigm is the Differentiation Work tool, which helps patients separate their narratives into two alternatives. The two alternatives have a dual-contradictory relationship. The first alternative (the patient's problem) is seen as a stuck, negative and problematic situation. The second alternative is the patient's *positive alternative* verbal expression that is intended to "unstick" or extricate the patient from the stuck problem/situation.

The suggested paradigm is an enriched reframing and an act of differentiation which binds the negative and positive alternatives *together*. This signals to the patient that while both alternatives are *right*, the therapeutic focus and direction should follow the positive alternative. As the negative narrative may have a defensive function, or alternatively may be central to the patient's self-definition, any challenge to it could arouse resistance. The suggested paradigm does not propose a "confrontation" with the patient's distorted negative cognition, but rather diverts the patient's attention to an alternative positive way of thinking. Furthermore, by means of deemphasizing and minimizing the importance attributed to the patient's negative narrative and diverting the patient's attention away from the maladaptive style of thinking, patient and therapist reach mutual agreement and the patient becomes more open to creating a new narrative.

Clinical Work Based on the Two-Track Differentiation Paradigm

Clinical work with the Two-Track Differentiation Paradigm is a two-step stage process:

1st Stage: The Presenting Problem = One Frame = Stuck position

The opening sessions are devoted to achieving a full understanding of the patient's problem. At this stage the patient's description is a one-frame narrative representing a stuck position.

2nd Stage: Differentiation Work = Two Frames = Unstuck Position

Differentiation work is used to turn the patient's single-frame narrative of the *stuck* presenting problem into a two-frame narrative. Based on the patient's description, the therapist labels the additional frame as the *non-problem* frame. Now, the problem is turned into a two-frame narrative. At this point, there are *two* options instead of *one* option, *two* alternatives instead of *one* choice representing the patient's original negative presenting problem. In labeling the *non-problem* frame, the therapist might use the prefix "non" to present a *positive* alternative to any negative verbal expression. This is a very powerful tool that can be seen as a type of non-formal hypnotic suggestion used by the therapist to create a change without confronting the patient. In some sense the therapist bypasses the stuck problem and diverts the focus of attention to another, more positive narrative (Hammond 1990; Meyerson and Konichezy 2009). The prefix "non"—as

in "non-disorder"/"non-diagnosis"/"non-illness"—generates a positive connotation. This "non" expression is very similar to the use of the expression "No Abnormality Detected" (NAD) in the medical profession to indicate that the patient is healthy and does not have any medical problem. Next, the therapist encourages the patient to direct his/her attention to an alternative narrative without any attempt to integrate between the narratives or to negate the pathologic narrative. The focus is simply diverted to a non-pathological position. These two frames or two alternatives have a dual and contradictory relationship. Thus, offering an alternative to the patient's presenting problem makes the patient *change* his/her views concerning this problem. The existence of two frames enables the patient to move between the two. Previously, at the beginning of therapy, the patient experienced the problem as everything, as all-inclusive, without any alternative. Now the patient has freedom of choice.

The following two short excerpts from two case examples demonstrate the Two-Track Differentiation Paradigm. In compliance with the ethics code of the American Psychological Association, names, ages, and dates of therapy were removed from the clinical case examples. Because they were not identified, both patients agreed to publication of the clinical material.

Case Study 1

A young lawyer, married with two children, came to therapy complaining of performance anxiety when having to appear in court for litigation. He also reported physical symptoms of anxiety, such as cold or sweaty hands and feet, dry mouth and problems swallowing. He had previously undergone psychodynamic treatment that did not help him overcome his performance anxiety. He acknowledged the notion that he has a distorted cognitive style and has trouble not adhering to this style. He also reported using anxiolytic drugs, which have not reduced his anxiety. His psychological history revealed a propensity for avoidant behaviors. During his childhood and later as a young adult, he was shy and introverted. He often became anxious if he had to speak in front of an audience. He never wanted to be "on stage" and all his adult life attempted to refrain from speaking in public. Nevertheless, he is a successful lawyer, works in a distinguished law firm, has a satisfactory marital life and describes himself as a warm and loving father at home. He has minimal social interactions with friends. He describes himself as a person who always aspires for perfectionism in fulfilling his professional duties as a lawyer. He tends to be strict with himself and thinks that this perfectionistic cognitive style may have a negative impact on his performance anxiety.

Following are the narratives of patient (P) and the therapist, the first author (SN), with descriptions and interpretations (in parenthesis) of how the Two-Track Differentiation Paradigm works:

Stage 1: Presenting problem = One frame = Stuck Position

P: I am anxious and unable to speak loudly and clearly in court in front of the judges and I am unable to cross-examine witnesses.

SN: Why are you anxious and unable to speak loudly and clearly in court in front of the judges and unable to cross-examine witnesses? (A "why" question that mirrors the patient's stuck frame will hopefully produce a second positive frame.)

P: Because I'll feel ashamed, embarrassed, disrespected and humiliated in the courtroom. (Now the patient describes his problems in different words.)

Stage 2: Differentiation Work = Two frames = Unstuck Position

SN: Well…let us differentiate between your narratives Being anxious is a psychological diagnosis. In contrast, when you say, "I'll feel ashamed, embarrassed, disrespected and humiliated in the courtroom," this is your appraisal of reality as a human being. It is different from feeling anxious. Feeling ashamed is a *cultural-normal* cognitive reaction to life events. It is a not a disorder, and it is not a diagnosis. It seems that the non-problem/disorder issues that you describe as "I'll feel ashamed, embarrassed, disrespected and humiliated in the courtroom" are the themes to be treated in therapy. However, as I mentioned before, these themes are normal cognitive-emotional reactions to life events. Now, as you proceed in therapy, you and I understand that these themes are non-problem/disorder themes. (The therapist differentiates between the problem/disorder and the non-problem/non-disorder. The therapist utilizes the Differentiation Paradigm approach.)

P: I see…

Therapy continued with six more sessions aimed at strengthening the patient's non-problem themes. During the therapy process, the patient became more able to maintain the alternative positive narrative, and talking about and dealing with his negative narrative became less and less relevant to him. His performance in court improved significantly and he stopped taking any anxiolytic drugs. Thus, he and his therapist mutually decided that the therapy had reached a successful end. At the end of therapy, the patient described his feelings of being released from his anxiety and reported on successful appearances in court.

Case Study 2

A young woman lost her husband in a car accident a year ago. She was left with three small children. After her personal tragedy she became depressed and commenced therapy. First she began psychodynamic treatment, which did not lead to any significant improvement in her condition. She also took an anti-depressive drug with limited positive impact.

She described her parents as overprotective towards her. She had been a shy child and an introvert teenager. Her marital history revealed that she was emotionally dependent on her husband. Her husband was an active, energetic businessman who was "the center of the home." She just followed him and supported most of his wishes.

In describing her depressive behavior, she explained that she uses up her minimal energy to be able to function at her job as secretary to the CEO of a large firm. She indicated that when she comes home from work, her mother helps her with her three young kids. She cries a lot and tries to conceal this from her children. She goes to bed early. During the year since her loss, she has not gone to any entertainment events and has minimized her social contacts with friends. During most of the day she is in a bad mood and has negative memories of her late husband's accident.

Stage 1: The presenting problem = One frame = Stuck position

P: I am ruined…I feel depressed…I don't see any improvement in my depression…I mourn my late husband…I cry a lot…You see that I only wear black clothes… a year has passed already…

SN: I see… Let us differentiate between your narratives: You describe your problem as a state of depression and a state of mourning. (Therapist tries to differentiate between a state of depression and a state of mourning.)

P: What is the difference? (The patient is ready to examine the difference between a state of depression and a state of mourning.)

Stage 2: Differentiation Work = Two frames = Unstuck Position

SN: I'll tell you the difference between a state of depression and a state of mourning: A state of depression is a psychiatric problem, a mental disorder. A state of mourning is a normative mental-psychological reaction and a way of behaving vis-à-vis your personal tragedy. Now, a state of depression should be treated as a negative medical and psychological condition that can hopefully be eliminated, while a state of mourning can continue as long as you wish and as long as necessary. Again, mourning for your beloved husband is normative and accepted cultural behavior, and our society supports this type of mourning behavior. Depression is an illness. Mourning is a non-illness behavior that should be kept as a sacred memory for our loved ones. (Therapist tries to differentiate between depression as an illness and mourning as a non-illness.)

P: So, will you please help me fight my depression and support my mourning process? (Now the patient sees the difference between the two and seeks to "unstick" her position.)

Therapy continued for ten more sessions, in which the patient increasingly adopted the new normal alternative narrative. Slowly her depressed mood lifted and her depressive behavior decreased, and she tried to invest her energy in mourning: She visited her husband's grave twice a week. She began writing "unsent letters" to him in which she described her grief.

After therapy ended, she reported that she was in a much better mood. She stopped taking the anti-depressive drugs. She went to entertainment events with friends and met with her friends more frequently.

Discussion

From both the theoretical and the clinical perspective, the Two-Track Differentiation Paradigm can be seen as an enriched reframing procedure that differentiates between the patient's negative and positive narratives. This novel approach aims at facilitating the classical reframing process within Cognitive Behavioral Therapy (Beck 2011). This paradigm seeks to overcome impasse situations and stuck problems and to avoid dead-end therapeutic results, which may result from the use of classical reframing technique.

The Two-Track Differentiation Paradigm metaphorically resembles extricating a car that is stuck in mud. In the first stage, the car is stuck in the mud and efforts to get it moving make it even more stuck. The second stage involves attaching the car with a cable to another vehicle and pulling it out of the mud. This short rescue process is the task of the Two-Track Differentiation Paradigm: To extricate the patient from his/her problematic situation and to bring about a change by creating a positive alternative narrative by means of utilizing differentiation between alternatives (negative and positive) and diverting attention from the negative alternative towards the positive one. Only then can the released car/patient move forward on the road without any problems. Under the direction of the therapist, the driver/patient is free to choose how to proceed.

The Two-Track Differentiation Paradigm facilitates a psychotherapeutic change utilizing the patient's own words and narratives. The therapist does not need to suggest any reframing. Here, the novel Differentiation Work tool helps find the positive alternative in the patient's narratives based on the rules of duality and contradiction. In the Two-Track Differentiation Paradigm, the use of the prefix "non," which presents a positive alternative to any negative verbal expression, can be seen as a type of non-formal hypnotic suggestion used to create a change, as occurs in hypnotherapy (Hammond 1990; Meyerson and Konichezy 2009). Hearing the prefix "non"—as in "non-disorder"/"non-diagnosis"/"non-illness"—creates a positive connotation for the patient. This "non-illness" expression is very similar to use of the expression "No Abnormality Detected" (NAD) in the medical profession to signify that the patient is fine and does not have any medical problem.

Additionally, this type of therapeutic paradigm turns patients into active participants in therapy without "forcing" them to leave their perceptions of reality behind. Patients seek therapy because they cannot find an answer or an alternative solution to their problems. The problems they bring to therapy are usually stuck and one-sided. Hence, the therapist must propose a tool that can release the problem to create a change. The Differentiation Work tool is geared to suggest two alternatives to the same problem, thus offering the patient a choice. This approach is different from classical CBT in which the patient tends to choose the therapist's *reframed* presenting problem.

The Two-Track Differentiation Paradigm helps patients differentiate between behavior patterns and make a choice, thus bringing about a sense of mastery and control over life. By employing the diagnostic perspective of the medical model, clinicians can add non-illness conversation into the medical encounter, thus bringing about a shift in patients' perceptions about their illness. (Waxman 2005).

This paradigm has the potential to be rapidly effective and to yield successful outcomes. It brings about a breakthrough in the early stage of therapy and is highly useful, especially with difficult and entrenched problems that failed to improve in previous treatments. To date, these benefits are evident in the clinical field and warrant further empirical investigation.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interests.

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