MCI Medical Coaching Institute

Medical Coaching Training Program

Module 2 – Process

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Contact details: MCI, Pinkas 4 St., Ramat Gan, Israel
Mail: office@mci-il.com,
Tel: +972-522421045

Welcome to the second module of the Medical Coaching training program.

In this module we focus on the first three of the four stages (namely "the Inner Compass, Commitment, and Journey of Health") of the medical coaching model.

The 4 stages of Medical Coaching:

1. Inner Compass
2. Commitment
3. Journey of Health
4. Return Home and Integration

1. The Inner Compass

The Inner Compass is an inner calling for change, growth and purpose

As Medical Coaches we help our clients turn their inner compass into a clear life vision and set the goals to achieve it.

2. Commitment

Embarking on an inner journey requires leaving the comfort zone, whether the journey is physical or spiritual.

This can be a frightening and challenging thing to do and requires a powerful commitment.

Commitment for change means different things for different people. In terms of commitment to a coaching process we have several tools we can use:

1. The Coaching Agreement
2. Setting Expectations
3. Addressing Payment
4. Addressing the Coaching Accountability
5. A 'commitment scale'

3. Journey of Health

During this journey our clients meet and create allies, discover strengths, cope with fears/ challenges/ limiting beliefs, get positive learnings out of past events and tap into their personal and collective sub-conscious.

The Journey includes 3 main interactive dynamics:

1. Overcoming hurdles and fear

- Toxic relationships
- Limiting beliefs
- Conflicts
- Anxiety
- Stress
- Loss
- Trauma
- Etc.

2. Connecting with resources and allies

- Empowering relationships
- Empowering beliefs
- Modelling
- Inspiration
- Body – mind connection
- Intuition
- Role models
- Etc.

3. Allowing transformation

In order to create a sustainable process, the client and especially – the client's brain, need time to allow things to sink in this is called: transformation time.
Transformation takes place when we allow ourselves to receive the positive learning from every situation.

4. Return Home and Integration

The journey of change, much like the "Hero's Journey"*, changes those who choose to embark on it as well as changing the home they return to.

As we complete it is important to address a few points:

- What learnings did the client take from the journey?
- What accomplishments need to be celebrated?
- What challenges remain and how are they different?
- Is there a new calling?

Setting an Overall Vision and Medical Coaching Goals

Reminder: in Module 1 you learned that Medical Coaching clients enter the coaching process from several points:

- Wanting to cope/better cope with an existing health/medical crisis
- Wanting to reverse a current process of deterioration in order to prevent a health/medical crisis
- Wanting to manage chronic stress/burnout in order to prevent deterioration that will cause a health/medical crisis.
- Wanting to come to terms and manage an end of life situation.

This means that clients often enter the Medical Coaching space focused on what they don't want, aren't able to do and/or can't have, rather than what they want to do, have and/or achieve.

- In addition, you learnt that the client can be either the patient, a family carer or a professional carer

Everything the client brings into the space during the 1st session, as he/she answer the question: "What do you want?" is called a **Direction**.

Direction

The Direction includes wishes, desires, hopes and dreams. The Direction is NOT coachable.

As Medical Coaches we meet the client where the client is and we listen to the Direction with empathy AND without judgment.

We explore the Overall Vision that the Direction points towards AND we help clients define coachable goals that will help them move towards the Direction which will enable them to be aligned with their vision

Examples of Directions:

- Stop being stressed
- Be more positive and optimistic
- Accept my condition
- Cope with my illness
- Have a normal life
- Be happy and balanced, despite illness
- Get my life back
- Think positive
- Be healthy

Eliciting an Overall Vision

The Overall Vision is all about the person our client wants to be in this world. It is about achieving fulfillment and purpose.

To create clarity about the vision we need to help clients take a META VIEW perspective and become curious about the possibilities that open up for them in terms of purpose and fulfilment when they follow their Direction.

The vision needs to be a short statement about the clients' state of being.

The Overall vision is that one thing that once we are aligned with it and live by it, we become our true selves - who we really are ("I am me") and our life is worth living.

These are question you can use to elicit the Life Vision:

- When you achieve (the Direction) what will your life be like?
- When you achieve (the Direction) what will become possible for you?
- When you achieve (the Direction) who will you become?
- For the sake of what is it important for you to achieve this (the Direction)?
- When you think about your life, what would you like your overall purpose to be?
- What is your sense of being?
- What will it look like when you have achieved this (the Direction)?
- What will it feel like when you have achieved (the Direction)?
- What does it mean for you to live a fulfilled life?
- If this was your last year to live, how would you like to be remembered?
- If this was your last year to live, what is the word that you would want people to connect to you that would honor/represent you?
- What is important about this (the Direction)?
- Who will you become in the world when you achieve this (the Direction)?
- What will the world receive from you when you achieve this (the Direction)?
- What would you like to give to the world through the way you live your life?

Remember that talking about an Overall Vision in the midst of a medical crisis is a radical act of choice.

A vision is a state of being, the following are examples of state of beings:

- Resilient
- Calmness
- Inner peace
- Grounded
- Wholeness
- Choice
- Peacefulness
- Open heartedness

Clients might come up with metaphors or strategies because it's the best and closest way for them to describe the vision. In this case we can ask:

- What is important about this?
- Why is this important?

Examples of metaphors:

- Confident and resilient, like a spring.
- Peaceful pool
- A nurturing tree
- An open heart

Examples of strategies:

- Freedom
- A woman of inner peace
- An instrument of God utilizing his talents
- I am a healer

Setting Medical Coaching Goals

After we have elicited the Overall Vision we ask the client to go back to the Direction in order to start setting goals and establish a coaching plan.

In order to set the coaching goals, we first need to create clarity about the objectives.

Objectives are the main themes the client wishes to address at this point in his/her life. The objectives are derived from the Direction.
Once you start creating clarity in the Direction (you can use the coaching wheels and/or clarity circles you learnt in Module 1) you will see these themes/objectives.

Examples of objectives:

- Cope better with my illness
- Decrease my anxiety and stress
- Change my thinking in order to attract more positive outcomes in my life
- Find ways to feel more positive and relaxed
- Have emotional stability
- Discover and overcome physical sensations that are happening after radiotherapy, which are not associated neither with surgery nor radiotherapy
- Get a good pace on work
- Be happy
- Lose weight

The Objectives are always important for the client but on their own, they are not coachable.
If we want to help our client achieve these objectives, we need to find out what specific things are in the client's way, what is preventing the client from achieving these objectives, and to create Medical Coaching goals around them.

We ask questions such as:

- What is stopping you?
- What is in the way?
- What is the obstacle?
- On a scale from 1 to 10 where are you in terms of achieving this objective? What do specifically need to get to the next level?
- How can I/Medical Coaching help you achieve this objective?
- What skills are you missing?
- How can I help you?

Medical Coaching Goals

Medical Coaching Goals are coaching goals that have a connection (direct or indirect) to the health/medical issue that the client has brought to the coaching space.

Medical Coaching goals have the same principles as "regular" coaching goals (which you already know how to define with clients).

They need to be:

1. Articulated in a positive language
   I will _____ instead of I won't _____

2. **Specific**
   * Tell my family how I need them to help me before, during and after my medical procedure.
   * Respectfully decline assistance when it doesn't suit my needs.
   * Create a grounding and relaxation routine that I can do before a medical procedure

3. **Measurable**
   Identify or create specific evidence that can measure the client's progress as he/she works towards the goal.
   'Will feel joy' is not measurable.
   'Will do 3 activities a week that I like such as: X, Y or Z' – is measurable.

4. **Timely**
   By the dd/mm/yy instead of next month, in 5 weeks, in the summer, the beginning of next year, Christmas etc.

5. **Pro-active**
   Coaching goals are not about the 'Being' they are about the 'Doing'. They need to include verbs.

6. **Ethical and legal**
   Coaching goals cannot be illegal or unethical from the client's point of view.

7. **Aligned with the client's belief system and values**
   The goals need to promote actions and results that are aligned with the client's belief system and values

Learning, understanding, realizing, analyzing etc. – are words that cannot be used when articulating coaching goals. Coaching goals are set around the actions the client chooses to take with what he/she has learned, understood, realized, analyzed etc.

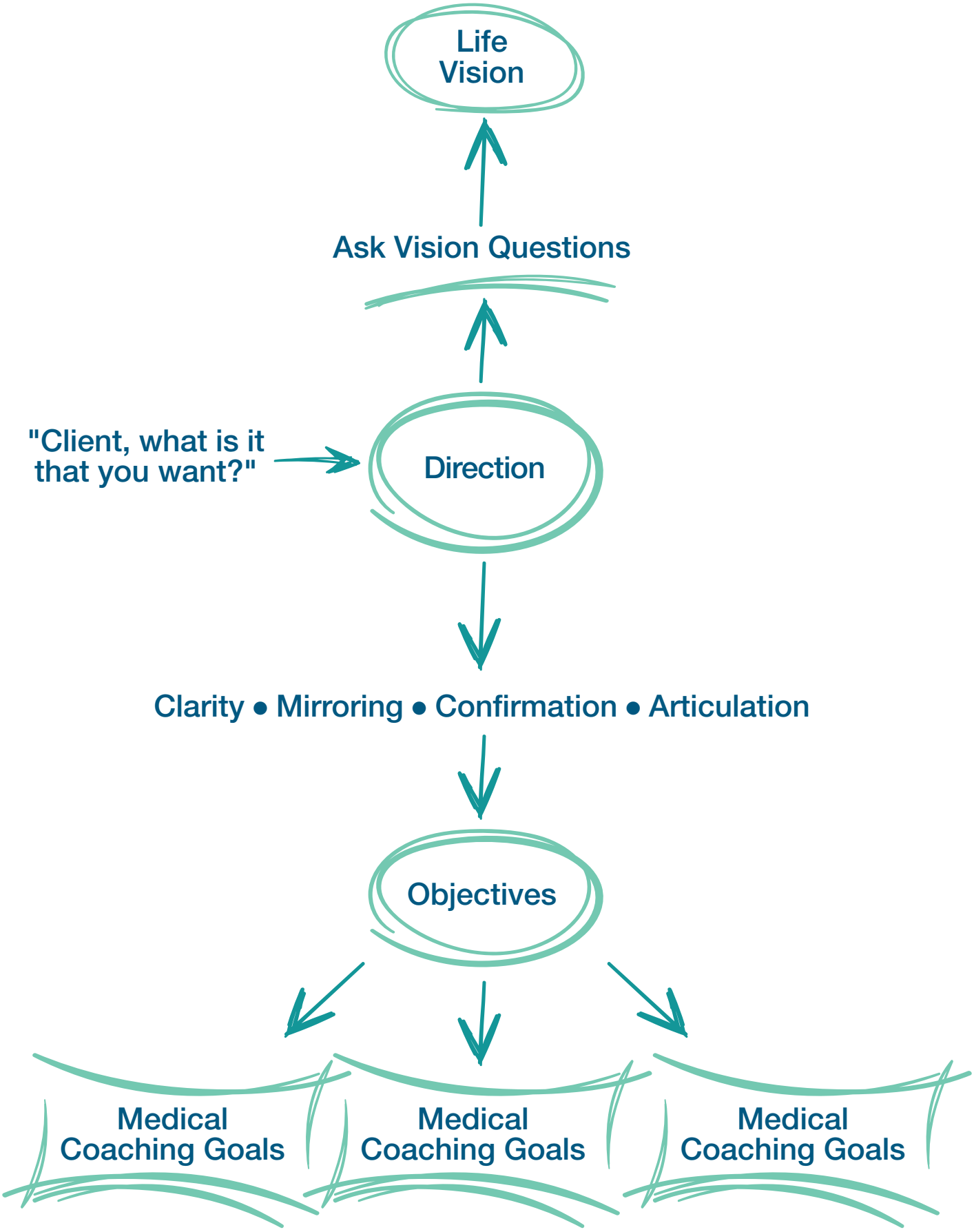
In the context of Medical Coaching it is important to make sure, with the client, that the goals are also:

1. **Responsible:** take into account the current medical condition, limitations and restrictions
2. **Realistic:** take into account the current reality of the client
3. **Resonant:** echoes with what is truly important for the client.

Examples:

1. (Using Medical Coaching sessions to) Create a strategy of being fully present and honoring self when going through the medical exam, before the 2nd of November.
2. (Using Medical Coaching sessions to) Make an empowered choice regarding a specific medical procedure within 8 sessions.
3. (Using Medical Coaching sessions to) Create an accessible self-care plan within 6 weeks.
4. (Using Medical Coaching sessions to) Have a dialog with my family around my end of life wishes by New Years.
5. (Using Medical Coaching sessions to) Establish a new belief system to help me adhere to my new medication/lifestyle within a month and a half.
6. (Using Medical Coaching sessions to) Reframe my values around food to support my weight loss goals.
7. (Using Medical Coaching sessions to) Create clarity about the type of work that will support my physical, mental and emotional needs.

Summary:


Life Vision
Ask Vision Questions
"Client, what is it that you want?"
Direction
Clarity • Mirroring • Confirmation • Articulation
Objectives
Medical Coaching Goals
Medical Coaching Goals
Medical Coaching Goals

Advanced Medical Coaching Skills

Understanding the Process of Change

There are three reasons for failure or success in trying to create change:

Success	Failure
Wanting to create change and being able to create an internal representation of it.	Lacking the ability to create an internal representation of change and the way life will be after it. Inner incongruence – there is a part that objects to change.
Knowing how to create the change.	Not knowing what is needed to create change.
Allowing the opportunity, space and resources to make the change.	Depriving opportunities and resources to make the change.

Six Logical Levels of Change

The '**Six Logical Levels**' model is a good tool for setting a goal and/or design an action plan for change.

The '**Six Logical Levels**' draw a road map of the process - a process that has a beginning, a middle, and an outcome.

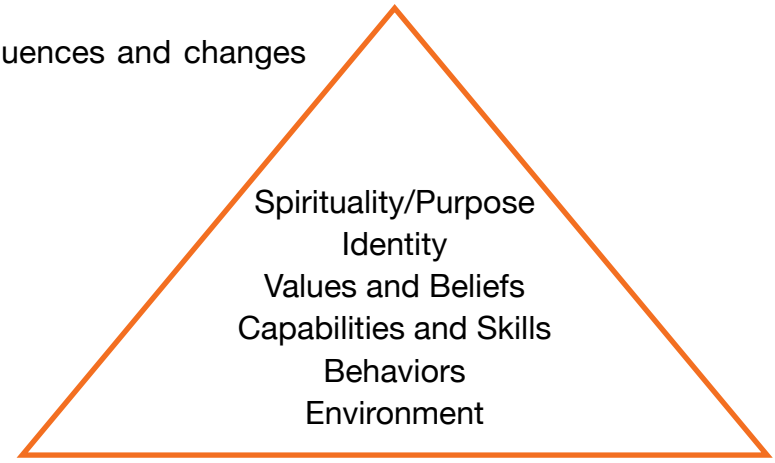
The model presents six logical levels that are arranged in an organized hierarchy:

1. ***Environment:*** *Where is the change going to take place?*
2. ***Behaviors:*** *What will be my behavior/s once this change is achieved?*
3. ***Capabilities and Skills:*** *What capabilities and skills will I use/have once this change is achieved?*
4. ***Values and Beliefs:*** *What value are being honored through this change and what do I believe about it?*
5. ***Identity:*** *Who do I become in this world when I make this change?*
6. ***Spirituality/Purpose:*** *For the sake of what am I making this change? What is the bigger picture/the bigger game?*

The '**Six Logical Levels**' is a hierarchal model.

We can move in the hierarchy from Low to High or from High to Low.

The principle is that every level influences and changes everything below and above it.



Additional ways to work with this model:

1. Creating strategies and action plans by moving up the Logical Levels' hierarchy
2. Checking for incongruence by associating our client at each level
3. Creating motivation by working with the geography of the model
4. Reflecting on a process or event
5. Creating a model from a successful process or behavior

Emotions

Emotions are an inseparable part of an illness.

Emotions are energy in motion which means that trying to stop, control or suppress them will only cause them to resurface unintentionally as mental, emotional and/or physical issues in our lives.

When working with a Medical Coaching client we introduce four premises regarding emotions:

1. There are no 'negative' to 'positive emotions', there are emotions that feel good and emotions that do not.
2. We make a distinction between balanced emotions and imbalanced emotions.
3. In the context of health and medical issues all emotions are a normal reaction to an abnormal situation.
4. We have emotions – we are not our emotions.

Research shows that attempting to minimize or ignore thoughts and emotions only serves to amplify them. *(Emotional Agility by Susan David and Christina Congleton, Harvard Business Review, Nov. 2013)*

There is no way around emotions – only through them, which means – we need to deal with them. Dealing with emotions means developing an **Emotional Agility**.

Emotional Agility

Emotional Agility is the ability to be aware of the emotions we experience, gain self-reflective learnings and create emotional shifts. These are basic to achieving a place of empowered choice.

Emotional Agility is a skill that can be taught and perfected until it becomes a natural and authentic way of navigating our emotional reality.

There are four tools that help us coach our clients around emotional agility:

1. **The 'Toe /Finger' principle**

   We use the metaphor of "dipping a toe/finger" as way of demonstrating the ability to experience an emotion at a low intensity. This creates an experience of dealing with an emotion while being safe, connected to resources and in control.

2. **The 'Transcend & Embrace' principle**

   We use an embodied Meta View by creating an experience of physically transcending above the emotional experience. From this place we can embrace the learnings.

3. **Shift from 2D to 3D**

   We start noticing the wider context of the emotional experience by consciously looking at additional aspects of the experience such as: our personal timeline, our relationships, our beliefs, our inner narrative.

4. **Expand the Emotional Language**

   We create an inner emotional vocabulary allows that us to become familiar with our emotional spectrum, distinguish between different emotions, identify specific triggers and shift between emotions.

Sadness

Sadness is a part of every illness.

Sadness tends to scare us and many times we will call it depression.

In this context it is important to understand that calling a profound state of sadness a depression is misleading because the term depression is in fact what we call clinical depression which is a mental health condition diagnosed by a mental health practitioner and needs to be medicated.

What we usually refer to as a 'depression' is called a 'depressive state' or a 'reactive depression'. Both terms refer to an emotional state of sadness as a result of a difficult emotional experience.

To be sad is to be human. Experiencing sadness it is part of what it means to be human.

It is not a 'malfunction', a mental illness, or a negative state of being. There is no need to rush and silence or suffocate it with medication.

One of the difficulties clients experience when feeling sadness is that the sadness becomes a cause of additional sadness, and can potentially create a cycle of trigger – response – trigger - response.

As medical coaches we want to help our client create emotional agility around sadness.

We introduce the concept of: 'this is how I am right now'.

Through this concept we are creating a structure for self-acceptance – 'I accept myself as I am right now', and the ability to feel the emotions without attachment.

There are a few perspectives/metaphors/myths we can offer our clients to help create a more empowering context of this process:

1. **Nature**

   The one constant about nature is that everything changes all the time.

   There are two metaphors we can use:

   - **The changing seasons**

     Looking at the cycle of seasons in nature we can see that each season has a beginning, a middle and an end. Summer will always be followed by fall and winter will always be followed by spring. All seasons are a part of the natural cycle of nature, each season has a role and a purpose and non is better than the other.

   - **Evergreen and Deciduous trees** (a beautiful metaphor I learnt from Amir Zmora, a psychotherapist who specializes in IBD illnesses)

     Evergreen trees are trees that have leaves throughout the year, they are always green. Deciduous trees are trees that seasonally shed leaves, usually in the autumn.

     There is room for both at one is not better than the other.

     We can say that deciduous trees are sad in the winter. But they do not know they are sad and therefore they are not saddened by the fact that they are shedding leaves and are perceived to be sad. They allow themselves to be the trees that they are at that moment.

     For those looking at the trees it can seem painful, like death, but for the trees there is life in this place and it might feel like a deep sleep.

     We all need sleep to re-generate. When we allow ourselves to “loose leaves” in the fall, sleep through winter we can bloom in the spring and give fruit in the summer.

2. **A Liminal Space**

   In Module 1 you learnt about the nature of a Liminal Space in the context of a health/ medical journey. You can use this concept to help the client position the emotional experience on his/her personal timeline and create a safe space to be with, process and learn from the emotion.

   You can use myths and stories of journeys to explore models of liminal spaces.

3. **Dark night of the soul**

   ‘Dark night of the soul’ is a concept that looks at what we tend to call ‘depression’ as a process of transforming emotional distress into self-reflection and growth.

   For more information about the ‘Dark Night of the Soul, go to the ‘Resources’ section.

Fear of Reoccurrence/Recurrence*

*Reoccurrence means something repeating itself.
Recurrence means something repeating itself again and again.

Fear of Reoccurrence is fear of a relapse or a new unrelated diagnosis.
Fear of Recurrence is fear of a relapse and or symptom becoming chronic and repeating itself again and again.

In this chapter I am going to address Fear of Reoccurrence. The information, approach and techniques apply to both.

We tend to think about Fear of Reoccurrence in the context of cancer, but everyone that has been through a medical crisis and/or is living with a chronic condition experiences some degree of Fear of Reoccurrence.
Whether your client is in "NED" status (No Evidence of Disease), feels less symptomatic, experiences a clinical improvement in his/her medical condition or simply feels better, there is always that fear that things might relapse again and/or there is something else going on that hasn't been diagnosed yet.

Fear of Reoccurrence can be overwhelming and crippling.
Every little pain or irregularity in the way the body behaves, an upcoming medical exam or procedure or even a thought about what might be, can send our client straight to that worst case scenario and bring on a wave of fear and panic.

The Medical Coaching immediate approach towards Fear of Reoccurrence that shows up in the coaching session includes the following steps:

1. **Acknowledge the fear**
   Create a safe coaching space for the client to name the fear and be with it.
   Remember that in western society speaking of fear is considered a weakness and talking about emotions creates vulnerability.
   Validate the client's emotions by naming this fear, being non-judgmental and remaining unattached to the content.

2. **Help the client ground him/herself**
   Grounding techniques are a way to "ground" ourselves in the present moment, balance ourselves emotionally and regain connection with present internal and/or external resources.
   Pick one technique: whether it's breathing, visualization, using the 5 senses or anything else that works for the client.

3. **Remind the client that he/she are more than the illness**
   The illness is something the client has or had in the body.
   The client also has elbows, fingers, toes.The client is more than elbows, fingers or

toes in the same way that he/she is more than the body and more than the illness.

The illness is one more thing in the client's life, it's not the only thing and it is not who he/she is.

4. **Remind the client where the true control is**

   Here is a fact of life: we have no control over things that happen to us. We have no control over the world, other people and/or our bodies.

   The most fundamental human choice we have is the meaning we choose to give to things that happen to us. Where there is choice – there is control.

   Since we see the world through the meaning we give it (our perception), when we choose the meaning – we control our subjective experience.

5. **Help the client name the real fear**

   Many times Fear of Reoccurrence is not really about the reoccurrence of the illness. Sometimes it's something else. It can be that the client is afraid of pain, of needing to be helped, of feeling helpless, of dying, of losing something … it can be one or many things.

   This doesn't necessarily make it easier but it creates clarity and clarity increases choice.

   To get to the real fear, invite the client to imagine (just for a few seconds) that there is a reoccurrence or deterioration and ask him/her to notice the first thing that comes to mind. That is where the real fear is.

   * Make sure you have set safety anchors with the client before doing this.

6. **Help the client speak his/her beliefs**

   Whether its religious, spiritual or anything else, invite the client to say out loud what he/she believes in.

   Ask the client to repeat it 5 times, loud enough for him/her to hear his/her own voice.

Once we have offered the client immediate steps to cope with the fear we can move to the long term approach that includes 4 steps:

1. Identifying Triggers
2. Clearing Triggers
3. Anchoring Resources
4. Updating the Self-Care Routine

The Neurological Aspect of Behavior and Change

An Experience

Nervous System

Pictures
Sounds/Voices
Senses
Smells
Tastes

Filters

Subjective Perception
(NOT Reality)

Thoughts & Emotions

BEHAVIOUR

We are exposed to 2 million bits of information per second via our senses.
In order to able to process this information our brain channels it through two types of filters:

Controlled Filters

- Time/Space/Matter/Energy
- Language
- Memories
- Decisions
- META Programs
- Values and Beliefs
- Attitudes

Automatic Filters

- ***Delete*** – deleting irrelevant information.
- ***Distort*** – distorting and changing sensory information regarding an experience.
- ***Generalize*** – generalizing from one event/experience to a general perception of reality.

The information processed through the filters creates a subjective internal representation of the experience/event – that is our **Subjective Perception** – the way we see the world.

Prime Directives of the Unconscious Mind

1. Stores memories (temporal - in relationship to time and A-temporal - beyond time)
2. Organizes all our memories
3. Represses memories with unresolved “negative” emotions
4. Presents repressed memories for resolution (to rationalize and release emotions)
5. May keep repressed emotion repressed for protection
6. Runs the body (and has the blueprint of perfect health)
7. Holds our high morals (the morality we were taught and accepted)
8. Generates, stores, distributes and transmits “energy”
9. Maintains instincts and generates habits
10. Needs repetition until a habit is created
11. Is symbolic (uses and responds to symbols)
12. Takes everything personally (perception is projection)
13. Works on the principle of ‘Least Effort’ (path of least resistance)
14. Does not process negatives

The conscious mind is like a pilot.
It has directions, a destination, and it gives instructions based on the changing environs.

Representational Systems

We experience the world around us using our five primary sensory modalities:
Visual (V)
Auditory (A)
Kinesthetic (K)
Gustatory (G)
Olfactory (O)

We use these to code, store and give meaning to experiences and language (verbal and non-verbal)

Usually we tend to use and work with three representational systems: visual, auditory and kinesthetic (gustatory and olfactory are often included with kinesthetic).

Of course, we use all of our senses all of the time but depending on the circumstances and preference we tend to focus on one or more representational systems in order to become more efficient and get better results.

The following are generalizations on the characteristics of people with a preference for visual, auditory or kinesthetic representational systems.

Like with all generalizations, there are always exceptions.

Visual People, will often stand or sit with their heads and/or bodies erect and eyes up. They breathe from the top of their lungs. They often sit forward in their chair and tend to be organized, neat, well- groomed and orderly. They memorize by seeing pictures and visualizing. They are more distracted by visual activity and less by noise. They often have trouble remembering verbal instructions because their minds tend to wander. Visual people tend to speak faster than the general population, they want to see the big picture of how things are done.

A visual person will be interested in how your program LOOKS. Appearances are important.

Auditory People, will often move their eyes sideways. They will breathe from the middle of their chest. They typically talk to themselves and are easily distracted by noise. They can easily repeat things they have heard or have been told. Auditory people learn by listening and asking questions. They memorize by steps, procedures and sequences. They tend to enjoy discussions and prefer to communicate through spoken language rather than the written word. Auditory people need to be heard and are easily distracted by noise.

An auditory person likes to be TOLD how they are doing and respond to a certain tone of voice or set of words. They are interested in what you have to SAY about your program.

Kinesthetic People, typically breathe from the bottom of their lungs, so their stomach goes in and out as they breathe. They often move and talk very slowly. They are more sensitive to their bodies and their feelings and respond to physical rewards and touch. They learn and memorize by doing, touching or walking through something. Kinesthetic people tend to dress and groom themselves more for comfort than for how they look. A kinesthetic person tends to decide based on feelings. A kinesthetic stands closer to other people than a visual person tends to.

Kinesthetic people are interested in your program if it "**FEELS right**".

Auditory Digital (AD) People, have a need to make sense of the world, to figure things out, to understand the matrix of things. They spend a fair amount of time talking to themselves or carrying conversations with you in their mind. They learn by working things out in their mind and memorize by steps, procedures, sequences. They tend not to be spontaneous and need to have logic. Facts and figures play a key role in their decision making process.

The auditory digital person can exhibit characteristics of the other major representational system.

The Representational System vocabulary

Visual	Auditory	Kinesthetic	Audio Digital / Unspecified
See	Listen	Feel	Sense
Look	Sound(s)	Touch	Experience
View	Make music	Grasp	Understand
Appear	Harmonize	Get hold of	Think
Show	Tune in/out	Slip through	Learn
Dawn	Be all ears	Catch on	Process
Reveal	Rings a bell	Tap into	Decide
Envision	Silence	Make contact	Motivate
Illuminate	Be heard	Throw out	Consider
Imagine	Resonate	Turn around	Change
Clear	Deaf	Hard	Perceptive
Foggy	Dissonance	Unfeeling	Insensitive
Focused	Question	Concrete	Distinct
Hazy	Unhearing	Scrape	Conceive
Crystal	Stereo	Get a handle	Know
Picture	Buzz	Solid	

List of predicate phrases:

Visual (V)	Auditory (A)	Kinesthetic (K)
An eyeful	Blabbermouth	All washed up
Appears to me	Clear as a bell	Boils down to
Beyond a shadow of a doubt	Clearly expressed	Chip of the old block
Bird's eye view	Call on	Come to grips with
Catch a glimpse of	Describe in detail	Control yourself
Clear cut	Earful	Cool/Calm/Collected
Dim view	Give an account of	Firm foundations
Flashed on	Give me your ear	Get a handle on
Get a perspective on	Grant an audience	Get a load of
Hazy idea	Heard voices	Get your goat
Horse of a different color	Hidden message	Hand in hand
In light of	Idle talk	Hang in there
In person	Inquire into	Heated argument
In view of	Keynote speaker	Hold it!
Looks like	Loud and clear	Hold on!
Make a scene	Manner of speaking	Hothead
Mental image/picture	Pay attention to	Keep your shirt on
Mind's eye	Power of speech	Know-how
Naked eye	Purrs like a kitten	Lay cards on table
Paint a picture	State your purpose	Pain in the neck
See to it	Tattle-Tale	Pull some strings
Short sighted	To tell the truth	Sharp as a tack
Showing off	Tongue-tied	Slipped my mind
Sight for sore eyes	Tuned in/Tuned out	Smooth operator
Staring off into space	Unheard of	So-so
Take a peek	Utterly	Start from scratch
Tunnel vision	Voiced an opinion	Stiff upper lip
Under your nose	Well informed	Stuffed shirt
Up front	Within hearing	Too much of a hassle
Well defined	Word for word	Topsy-turvy
If I could **SHOW** you... would you want to **LOOK**?	If I could **TELL** you... would you want to **HEAR**?	If I could **GET A HOLD OF** a way you... would you want to **GET A FEEL FOR IT**?
If this **LOOKS GOOD**, we will go ahead and **FOCUS** on the paperwork.	If this **SOUNDS GOOD**, we will go ahead and **DISCUSS** the paperwork.	If this **FEELS GOOD**, we will go ahead and **HANDLE THE PAPERWORK**.

Sub-modalities

Sub-modalities are the way we encode and give meaning to our Internal Representations. The sub- modalities comprise the sensory modalities (The Representational System): Visual (V), Auditory (A), Kinesthetic (K), Gustatory (G) and Olfactory (O).

Changing the sub-modalities changes the Internal Representation.

Working with Sub-modalities

When working with sub-modalities it is important to use the sub-modalities checklist. This adds to precision and accuracy.

As you elicit a client's sub-modalities it is crucial that you work fast!

You must elicit the sub-modalities faster than the conscious mind can keep up.

If you are too slow, your client is likely to get bored and begin analyzing what is going on.

Changing LIKE to DISLIKE

1. "Think of something that you like but wish you did not. What is it? As you think about it, do you have a picture in your mind?"

2. Elicit the sub-modalities using the worksheet and write them in column #1

3. "Think of something which is in a similar context, but which you absolutely dislike. Good, what is it?"
   As you think about it, what is the picture in your mind?"

4. Elicit the sub-modalities using the worksheet and write them in column #2.

5. Look for the differences (Polarity). Change the sub-modalities of #1 into the sub-modalities of #2 (Note: We are only changing the sub-modalities of the first picture, not the content itself. The second picture is no longer needed. It was only needed for reference purposes)

6. "Lock it with a Master Lock. Just like that"

7. Test: "Think about that old issue. Now, what comes up? How is it different now?"

The sub-modalities checklist:

Visual	1	2
B/W or Color		
Near or Far		
Bright or Dim		
Location		
Size of Picture		
Associated/ Disassociated		
Focused		
Framed or Panoramic		
Movie or Still		
Movie Speed		
3D or 2D		
Viewing Angle		
Auditory		
Location		
Direction		
Internal/External		
Volume		
Speed		
Pitch		
Tonality		
Pauses		
Duration		
Uniqueness		
Kinesthetic		
Location		
Size		
Shape		
Intensity		
Steadiness		
Movement		
Vibration		
Pressure/Heat		
Weight		

META - Programs

Meta Programs are the neurological programs, which guide and direct our thought processes. They determine how we motivate ourselves, make decisions, buy things, what we are interested in, how we manage time, our effectiveness with tasks and how we solve problems.

A person may have different Meta Programs operating simultaneously on different neurological levels.

Meta Programs are strategies we use and not who we are.

The "Key" Meta Programs used in Medical Coaching

1. ***Toward vs. Away-From***

   (Best-case vs. worst-case scenario thinking)

   Attention is directed either towards what is wanted or away from what is not wanted.

2. ***Possibility vs. Necessity***

   Attention is directed either to what is possible (expanding options, experiences, choices, paths) or to what is needed/available.

3. ***Big Chunk vs. Little Chunk***

   Attention is directed either to the big picture (Meta View) or to the details.

4. ***Self-Reference vs. Other Reference***

   Attention reference to either oneself or another.

   Self-Reference - the selection of evidence and criteria based on reference to one's own perception of the world.

   Other Reference - the selection of evidence and criteria based on reference to other's perception of the world.

   (Don't confuse "introverted" or "extroverted" with this META-Program).

5. ***Match vs. Mismatch***

   Attention is focused on what is the same or what is different.

   Whether a person notices commonality, likeness and similarities or differences, dislikes and contrasts.

Working with Resources

A resource is a means/factor required to accomplish a desired outcome.

Resources can be external (such as: money, time, labor, assistance, medication, family, possessions, tools, etc.) and internal (such as: skills, beliefs, habits, behaviors, perspectives, faith, etc.).

Emotions are not resources; they are the result of a resourceful or un- resourceful state.

Helping clients shift into a resourceful state is one of the fundamental aspects of coaching. The skill of anchoring helps the client re-access resources and shift into a resourceful state.

The principles of the anchoring are:

1. Identifying the needed resource
2. Recalling a vivid past experience where the client was fully connected to the specific resource (a resourceful state)
3. 'Importing' the specific resource (resourceful state) from the past experience to the present un-resourceful situation
4. Creating an 'Activation Button' to make the resource accessible/shift into a resourceful state at any given time

Anchoring

Anchoring is the process of creating a link between an external trigger and an internal response.

In other words: establishing an association between an external cue/stimulus and an internal experience/state.

…Or in other words: conditioning (just like Pavlov and his dogs…)

THEORY:

A. When a person experiences a specific stimulus while being in an intense emotional state, the stimulus and the emotional state will be linked neurologically
B. Anchoring can assist us in gaining access to past states and link the past state to the present and the future

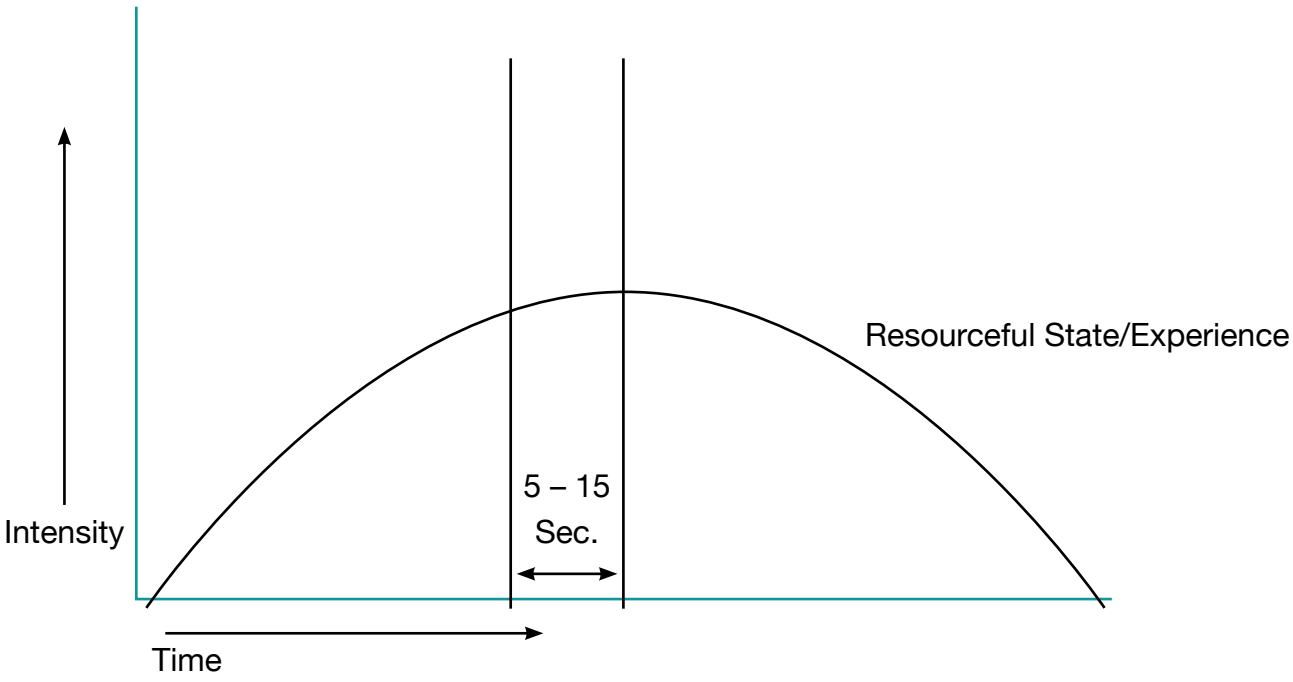
PROCESS:

The 4 steps to Anchoring:

1. Ask the client to recall a vivid past experience
2. Provide a specific stimulus at the peak (see chart)
3. Change the client's state
4. Set off the anchor and test

The 5 keys to good Anchoring:

a. The intensity and integrity of the experience.
b. The timing of the anchor
c. The uniqueness of the anchor
d. The replication of the stimulus
e. The number of repetitions (stacking)



A Timeline - is a geographical metaphor that represents the chronological events in a person's life.

Tips for working with a Timeline

1. Maintain the psycho-geographic space of the Timeline
2. Keep the directions clear
3. Use room geography
4. Check ecology

Anchoring a Goal in the Client's Future

1. Elicit a Timeline on the floor with your client.
2. Ask the client to step on the Timeline in the PRESENT, facing the FUTURE.
3. Ask the client to identify the point, on the Timeline, when the goal is to be achieved.
4. Ask the client to step off the Timeline and step on it again at the point, in the future, where the goal is achieved.
5. Connect the client to the experience of the achieved goal.
6. Ask the client to turn around, towards the present and see his/her "Present Self".
7. Ask the client to give his/her "Present Self" an important insight or advice from a place of META-View wisdom.
8. Ask the client to step off the Timeline, return to the present and step back on it, facing the future.
9. Ask the client to take in the insight or advice received from his/her "Future Self".
10 Be curious about the client's experience.
11. Ask the client "what is the next step to be taken NOW, to achieve the Goal?"

Break State

Changing the emotional state by shifting the attention from one thing to another.

A Break State is also used to break concentration and get out of un-resourceful states.

Future Pacing

Creates a future internal picture of a desired outcome occurring automatically.

Future Pacing is a technique where the client is asked to imagine him/herself in the future in a given desired situation.

In order to future pace we describe to the client a disassociated future situation in which the desired outcome is experienced successfully.

Collapsing Anchors

1. ***Choose the desired resource.***
   Ask the client to identify a situation that elicits an unwanted feeling and then ask the client to select a feeling he/she would prefer to experience in this particular situation.
2. ***Recall a vivid past experience.***
   Ask your client to remember a time when he/she was fully connected to that resource.
3. ***Create an intense association to the experience.***
   Ask your client to close his/her eyes and remember that experience in vivid detail.
   Guide your client back to the experience and enhance the desired feeling/resource by creating an intense association.
4. ***Anchor the resource.***
   Calibrate! Feeling it at its most intense – anchor it (create a physical cue). Hold for 5-15 seconds and release the 'anchor'.
5. ***Break State***
6. ***Repeat steps 3-4 two more times***
7. ***Test the anchor - 1***
   Fire off the anchor and check if the client experiences the resource.
8. ***Break State***
9. ***Test the Anchor – 2***
   Ask the client to think of the original situation, and then fire off the anchor.
10. ***Test the Anchor – 3***
    Ask the client to think of another current situation, similar to the original one (that elicits the same unwanted feeling), then fire off the anchor.
11. ***Test the Anchor – 4***
    Ask the client to think of a future situation, similar to the original one, and then fire off the anchor.
12. ***Future pace***
    Encourage the client to do this in the real world as soon as possible.

Circle of Excellence

1. Identify the desired resource.
2. Draw, with the client, an imaginary circle on the floor (large enough to step into) that contains the resource.
3. Ask the client for the sub-modalities of the resource inside the circle.
4. Ask the client to step into the circle and connect to the resource, using the sub-modalities. Calibrate.
5. Ask the client to step out of the circle and BREAK STATE.
6. Ask the client to step into the circle for the second time, associate the client with the resourceful state. Calibrate.
7. Ask the client to step out of the circle and BREAK STATE.
8. Ask the client to step into the circle for the third time and notice how quickly he/she can re-access the resourceful state.
9. Ask the client to step out of the circle and BREAK STATE.
10. Ask the client to remember a time when this resource was needed.
11. Ask the client to step into the circle (taking the memory into the circle) and connect to the resourceful state.
12. Ask the client to step out of the circle and BREAK STATE.
13. Ask the client: 'What is different now? What becomes possible? (If there is resistance go back to step 1 and update the resource).

Create an internal anchor of the resource with the client.

- Ask the client to gather the resource from the circle and let it become a symbol.
- Ask the client: 'Where in your body would you like to keep the resource?'
- Practice with the client placing the resource in the body, taking it out, spreading it on the floor, gathering it in the palm of the hand and putting it back in the body.

14. Test.
    - Ask the client to think of a future situation where the resource will be needed. Connect the client to that situation.
    - Ask the client to take out the symbol, spread it on the floor, step into the circle and connect to the resourceful state.
15. Ask the client: 'What becomes possible now?'
16. Ask the client to step out and put the symbol back in the body.
17. Future pace.

Working with Values

Values are the building stones of our identity. They are the DNA of our personality.

Values represent all that is important and essential in our lives. In order for change to be sustainable it needs to be aligned with the person's values. Each person's set of values is as unique as his/her fingerprints.

The brain organizes our values according to a hierarchy of importance. At the top we will find the CORE VALUES.

Discovering values is like mining for diamonds! Sometimes we need to dig deep and clear out a lot of dirt before we find treasure.

These questions can help 'mine' for values:

(As the client is answering, listen for values that show up in the client's answer and get curious about them)

- What do you admire in people?
- What don't you like in people? (Listening for suppressed values)
- What drives you nuts or makes you angry or frustrated?
- What are 10 things you would take to an island?
- What MUST you have in your life?
- What do the people who love you say about you?
- What were some of your low moments?
- What are you proud of?
- What is your legacy?
- What fulfills you?
- What are you obsessed by?
- What don't you have enough of?
- What is important to you?
- What is the best advice you ever received?
- What is your 5-year vision for yourself?
- What is your future self?
- Who are you when at your worst?
- Who are you when at your best?
- What is glorious about failure?
- When has life been rich, full, exhilarating, flowing? What was important about that experience? What values were you honoring?
- What is so much a part of who you that you haven't even thought to put it on this list?

Core Values – are the highest values on a person's value hierarchy. They are our most important and precious values, the ones we cannot live without and still being true to ourselves.

Core values in the context of Medical Coaching

1. **Resistance** - When a medical treatment, procedure, or strategy stands in conflict with a patient's values, that patient is more likely to resist it - physically, emotionally and mentally.
2. **Resource** - When a medical treatment, procedure, or strategy is aligned with a patient's values it becomes an additional resource of healing and empowerment.
3. Our client's values are still present and relevant in the midst of a medical crisis and chronic illness.
4. Every behavior is motivated by a positive intention. A positive intention is a core value.

The principles of a positive intention/core value

1. All behaviors serve as a positive intention/core value.
2. The behavior itself can be socially unacceptable, negative or even self-destructive.
3. Physical symptoms are behavior and serve a positive intention/core value.
4. To find the positive intention/core value we need to differentiate between the "behavior" and the "self" - *You are not your behavior*.
5. The purpose of finding the positive intention/core value is to create a change of behavior.
6. Although there is a conscious will to change, the positive intention/core value of the behavior isn't conscious, therefore the change must take place on a subconscious level.
7. Positive intentions/core values are often obscured by multiple levels of thoughts.

Revealing the positive intention/core value behind a behavior

In order to reveal a positive intention, we need to ask a series of questions to clear and reframe the multiple layers of thoughts and beliefs that cover it.

This inquiry can be done on a conscious or sub conscious level.

This form of inquiry uses the following structure:

When you have/do X – **What becomes possible?**

Who do you become?

Example # 1 -

A client has described a desire to stop taking his medication, NOW, without consulting his doctor.

Q: Why do you want to stop taking this medication?

A: It's not helping me. I'm not feeling relief.

Q: When you feel relief, what becomes possible?

A: I'll feel better.

Q: And when you feel better, what will become possible?

A: I'll be OK, I won't have to worry...

Q: And when you'll be OK and you won't have to worry, what will become possible?

A: Peace of mind.

Q: And when you'll have peace of mind, what will be possible?

A: I'll be able to live a normal life. I'll do whatever I want whenever I want.

Q: And when you'll be able to live a normal life, and do whatever you want whenever you want, what will become possible?

A: I'll be myself again.

Q: And when you'll be yourself again, what will be possible?

A: Peace of mind.

Example # 2 -

A client has described an uncomfortable pattern of "obsessive worrying about the illness getting worse".

Q: If your "obsessive worrying" about getting worse had a positive intention, what would it be?

A: I don't know. I have no idea. It doesn't help to obsess and worry. It just makes me stressed.

Q: What if you did know? What would it be?

A: I don't know. I just want to make sure everything is OK with me.

Q: And when everything is OK with you, what becomes possible?

A: I don't know. A feeling that everything is OK and nothing is going to surprise me.

Q: And when everything is OK and nothing is going to surprise you what becomes possible?

A: I can relax.

Q: And when you can relax, what becomes possible?

A: I don't know. I just know I'm going to be OK. I'm going to survive this.

Q: And when you feel you are going to be OK, you are going to survive this, what becomes possible?

A: It just means there is hope. That's all I want. Just a bit of hope.

Q: And when you have hope, what becomes possible?

A: I still have time to do things, things I didn't do…

Q: And when you have time to do things you didn't do, what becomes possible?

A: I can be important, I can make a difference, my life counts for something.

Reframing Values

1. Identify the value that the client feels is getting in the way of achieving his/her goals. Ask the client how this value manifests itself. What are the behaviors, thoughts and emotions that are attached to the value?

   Ask your client how this value manifests itself. What are the behaviors, thoughts and emotions that are attached to this value?
2. Use the attached table to explore the value (write the client's answers).

Comparing the value to…	**Similarities**	**Differences**	**Learnings (Positive Learnings)**
Another person with a similar value, today			
Another person with a different/opposite value, today			
Myself, in the past, with a similar value			
Myself, in the past, with a different/opposite value			
Myself, today, with a similar value			
Myself, today, with a different/opposite value			
Myself, in 10 years, in the same context			
Myself from a meta-view (on the moon), in the same context			

3. Read back all the learnings to the client and ask the client to give the value a new, more appropriate name

A positive learning is a learning that creates self-awareness:

1. Positive
2. Personal
3. Relevant to the client's entire life

Two useful tips:

A. A positive learning cannot have a verb in the sentence.

B. The best linguistic structure for a positive learning is: "I am _____."

REMEMBER –

A **positive intention** and a **positive learning** are 2 different things.

Relaxation

Relaxation – 1 to 4

There are many ways and techniques to help someone get into a state of relaxation.
This technique is called **'1 to 4'**. The principle is transitioning from affirmations on the given external reality to affirmations on a desired inner reality.

Examples for affirmations on the given external reality

- Take a deep breath and notice the feeling as you inhale and exhale…
- Notice that your feet are on the floor…
- Notice that your hands are on the…
- You might notice the sound of the X right now…
- You can hear my voice…
- You are sitting in the room with me…
- The chair is holding your weight…
- Notice if you are comfortable and if not, you can change the way you are sitting…

Examples for affirmations on a desired inner reality

- As you are breathing, notice the place of relaxation in your body…
- Your sub-conscious knows how to allow relaxation the exact way that works for you …
- As you inhale, feel the relaxation expanding in your body…
- As you exhale allow your body to release thoughts and tension…
- Notice how you are going deeper and deeper into relaxation, with each breath…
- You might notice thoughts coming to your attention, simply let them go now…
- You can notice the way the relaxation is following my voice…
- You can notice the way your body is getting more and more relaxed…

Working with Inner Parts/Representations

Parts Therapy

Parts Therapy is based on the concept that our personality is composed of various parts.

Parts are aspects of the subconscious, each with its respective 'jobs' or functions.

There are many variations on this concept, almost as many as the numbers of therapists working with this theory.

A "Part" can be any manifestation of any aspect of our internal maps.

We use the term **"Part"** to describe a **"Behavior"**

A **"Part"** / **"Behavior"** can be:

- A physical behavior
- An emotion
- A thought
- A thought pattern
- A value
- A belief
- A system of beliefs
- A resource
- An addiction
- A habit
- A tendency
- An illness
- A body organ

Certain parts exist on a conscious level and others on an unconscious level. Our parts make up our state of mind, our being, choices and conduct.

As Medical Coaches we create a dialogue with our client's part for the sake of resolving conflicts, updating beliefs and values, creating new behaviors, healing trauma and anchoring resources.

'Talking with Parts' – Basic Technique

This technique is the basis for all the work we do using the concept of 'Inner Parts'.

The basic technique of 'Talking with Parts' – means that we create a dialogue with the specific part that is in charge of an unwanted behavior for the sake of discovering its positive intention and then changing the behavior.

Talking with Parts

1. Identify, with the client, a specific behavior that does not serve the client.
2. Facilitate a state of relaxation.
3. Ask the client's permission to speak with the subconscious mind.
4. Ask the subconscious mind's permission to speak with the part that is the behavior.
5. Thank the part for agreeing to speak with you.
6. Explain to the part the meaning of a Positive Intention.
7. Elicit the part's Positive Intention.

   Ask the part: "What is the positive thing that you want for the client?"
8. After revealing the Positive Intention, mirror to the part the gap between the intention and the actual behavior.
9. Ask the parts permission to change the behavior and create an agreement.

   The agreement:

   The part, will become the guardian of the Positive Intention and release the old behavior

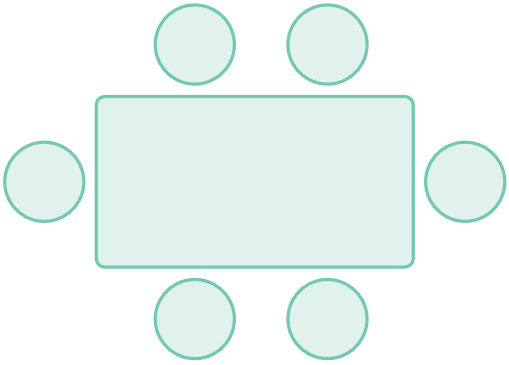
   The coach will help the client find a new behavior that is aligned with the Positive Intention
10. Thank the part for its cooperation.
11. Check ecology:

    Ask the client's subconscious if there is another part that objects to the agreement. If there is such an objecting part, return to # 4.

    If not, continue with the process.
12. Bring you client out of relaxation, debrief him/her on the process and present the agreement with the part.

* Important to remember to:
  1. Keep a respectful tone of voice and manner when speaking to a part
  2. Use the client's words, descriptions and metaphors
  3. Do NOT analyze the part and/or the behavior
  4. Write down all the details of the agreement and give a copy to the client

Parts Party



1. Establish the language for the process present the table and the chairs).
2. Facilitate a state of relaxation for the client.
3. Ask the client to go to a safe and beautiful place. Set the table and the chairs there.
4. Ask the client to invite to the table **2 parts he/she loves** and seat them at the table. Welcome them.
5. Ask the client to invite to the table **2 practical parts** and seat them at the table. Welcome them and ask them to introduce themselves to the rest of the guests.
6. Ask the client to invite to the table **2 parts he/she do not like** and seat them at the table. Welcome them and ask them to introduce themselves to the rest of the guests.
7. Ask the parts: "who among you feels the least understood?"
   - Elicit the positive intention of the part.
   - Ask the rest of the guests if the gift of the positive intention is an acceptable gift for the client.
   - If there is resistance explain the difference between a behavior and a positive intention. If there is resistance from a new part – elicit its positive intention and make sure it's acceptable to the other guests.
8. Repeat #7 for all of the parts.
9. Instruct the client: "look at all the gifts on the table" (name them).

   "As you can see the table fading, step into the center of the circle and feel how **these gifts go into your body" (keep repeating the names of the gifts). Anchor in the heart, brain, guts and organ. Allow integration**.
10. Get the client out of relaxation and future pace.

Relationships

We all have relationships in our lives.

We have a relationship with ourselves, our past, our future, our body, our organs, our family, our friends (past and present), our neighbors (past and present), our co-workers (past and present), our lovers (past and present), our homes, our cars, our "stuff", our money, our religion, our god, our government… in short - we are in a constant relationship with everything in us and around us.

Medical Coaching clients have five additional unique relationships:

1. The relationship with their illness.
2. The relationship with their treatment.
3. The relationship with their healthcare providers.
4. The relationship with their caregivers.
5. The relationship with the Medical System.

When we are coaching caregivers the additional unique relationships will be:

1. The relationship with the person they are caring for.
2. The relationship with the healthcare providers of the person they are caring for.
3. The relationship with their healthcare providers.
4. The relationships with themselves and their bodies (past, present, and future)
5. The relationship with the Medical System

All of the above relationships are emotional, un-equal and at times hierarchal and not reciprocal.

For some clients the relationship with the illness is part of the relationship with the body and vice versa.

For others these are two separate relationships that are either completely disconnected or have some form of dialog and influence between them.

As Medical Coaches we listen to the client's narrative to understand the nature of these relationship. We listen for:

- The dynamics of the relationships. Is there a dialog? What is the nature of the dialog? Is there a disconnection? What is the nature of the disconnection?
- The existence of emotional toxicity. Emotional toxicity does to the mind and spirit what chemical toxicity does to the flesh – it hurts, wounds and positions.
- The existence of abuse or neglect on an emotional or physical level
- Is this an empowering or disempowering relationship?
- Is the relationship aligned with the client's values and belief system?

Since we are coaching only 1 person in these relationships – our client we focus on changing perspective, building emotional agility, increasing resilience and creating new strategies that will allow our client to manage these relationships in an empowered way with honor and dignity.

One of the main tools we use in the context of relations ships is Perceptual Positions.

Perceptual Positions is another variation on Parts Therapy.

There are four Perceptual Positions:

First Position ("Self") – Experiencing the world from my own personal perspective.

I see and hear other people and the world around me from my own point of view, have my own feelings, etc. This is also called association.

Second Position ("Other") - Experiencing the world from or through another person's perspective.

I see, hear, recall things and hear events from another person's viewpoint, feeling his body's feelings, etc. I have an experience of being that person. It is not their experience of being them.

Third Position ("Observer") – Experiencing the world from the outside, as an observer.

I observe myself and whatever situation I am in from the outside, looking in, as if seeing someone else. This is also called dissociation.

Fourth Position ("We") - Experiencing the world from a collective perspective of the masses.

I observe myself and whatever situation I am in as part of a larger group that has a distinct identity and perspective as if I am one part in a big collective.

Each of the Perceptual Positions can be experienced in an associative or dissociative state:

	Association	Disassociation	Stuck	Notes
First Position ("Self")	I see through my eyes, I hear through my ears and feel my own sensations and feelings. I am aware of my beliefs, values, desires and boundaries. I am assertive and express myself authentically.	I see through my eyes, hear though my ears but I'm not connected to my own sensations and feelings. My beliefs, values, desires and boundaries aren't clear to me. I find it difficult to fully understand the meaning of what I'm experiencing.	My only focus is on my existing maps. I am aware only of my feelings and personal needs.	First Position is the base from where we go and explore other Perceptual Positions. When we bring information from other Perceptual Positions back to the first position, we expand our awareness in that position.
Second Position ("Other")	I see, hear and sense from your point of view. I am aware of your feelings, beliefs, values, desires and boundaries. I understand your positive intention.	I can see, hear and sense from your point of view but I'm not aware of your feelings, beliefs, values, desires and boundaries.	Over identification with another person to the point of loss of self.	Second position helps me to be empathetic, companionate, represent other people's interests, and predict another person's reaction. Second position means: I have an experience of being you, it is not your experience of being you.
Third Position ("Observer")	I can see, hear and sense from an observer's point of view (Meta View) of others in an interaction. I see the 'Big Picture'. I understand the feelings of others but I am emotionally unattached. I can notice patterns and analyze situations with empathy.	I can see, hear and sense others in the interaction from an observer's point of view. I do not understand the feelings of others and I am emotionally unattached. I cannot notice patterns and analyze situations.	Total disassociation – living like a 'Zombie', alongside life.	Third position is useful for getting a meta view perspective and creating solutions in situations that are either emotionally charged or heavily detailed.
Fourth Position ("We")	I can see and understand the values and beliefs I share with the group. I feel I belong to the group and am a part of it. I take personal responsibility for being a part of the group.	I can see and understand the values and beliefs I share with the group but I do not feel that I am a part of the group. I don't take personal responsibility for being part of the group	Total assimilation in the group to the point of loss of self.	Fourth position is useful when we want to get people inspired, motivated and engaged in action.

In Medical Coaching we work with the First, Second and Third positions.

Moving between Perceptual Positions enables us to gather valuable information about the world and our experience. It makes us flexible and enriches our inner maps.

As Medical Coaches we use Perceptual Positions to resolve conflicts and help our client heal the relationships in his/her life with others, with the body and with the illness/ill organ.

'Perceptual Positions' is NOT Transactional Analysis (TA)

From a 'Perceptual Positions' perspective all three ego states (Parent, Adult and Child) are considered Second position.

In Medical Coaching the client is responsible for defining and structuring the Second position according to his/her understanding of the narrative or the situation.

Shifting between Perceptual Positions - Resolving a Relationship with Another Person

1. Identify with the client a relationship or interaction that needs to be resolved
2. Shift geography and ask the client to go into First Position, in association, and describe the relationship and the difficulty
3. Break State
4. Ask the client who would he/she like to put in the Second Position.

   Shift geography and ask the client to go into Second Position, in association, and describe the interaction from the other person's point of view (as if he/she were that person)
5. Break State
6. Shift geography and ask the client to go into Third Position, in association, and describe the interaction from the point of view of the relationship
7. Ask the client in the Third Position:
   - What does the relationship need from the two participants in order to be balanced?
8. Ask the client to take the learnings from the Third Position, collect the learnings from the Second position and come back to the place of the First position.

   Give the client to time to integrate the new learnings
9. Ask the client: What is different now? What becomes possible?

Shifting between Perceptual Positions – Clearing the Relationship with the Body / Organ / Illness

1. Identify with the client a relationship with the body/organ/illness that needs to be resolved
2. Shift geography and ask the client to go into First Position, in association, and describe the emotions, thoughts and interactions
3. Break State
4. Ask the client what would he/she like to put in the Second Position.

   Shift geography. Ask the client to go into Second Position, and describe the interaction from the body's/organ's/illness's point of view (as if he/she were the body/organ/illness)
5. Break State
6. Shift geography and ask the client to go into Third position, in association, and describe the interaction from the point of view of the relationship between the client and the body/ organ/ illness
7. Ask the client, in the Third Position:
   - What does the relationship need from the two participants to be balanced and harmonious?
8. Ask the client to take the learnings from the Third Position, collect the learnings from the Second Position and come back to the place of the First Position.

   Give the client to time to integrate the new learnings
9. Ask the client: What is different now? What becomes possible?

   - It is possible to do this technique through visualization but having the client embody each position has a more powerful impact.

Working with Beliefs and Belief Systems

What is a Belief?

- *Richard Bandler and John Grinder:* Behavior is organized around beliefs. As long as you can fit a behavior into someone's belief system, you can get him to do anything, or stop him from doing anything. A belief tends to be much more universal and categorical than an understanding. When you already have a belief there's no room for a new one unless you weaken the old belief first.
- *Tony Robbins:* We usually think of beliefs in terms of creeds or doctrines and that's what many beliefs are. But in the most basic sense, a belief is any guiding principle, dictum, faith or passion that can provide meaning and direction in life. Beliefs are the prearranged, organized filters to our perceptions of the world. Beliefs are the compass and maps that guide us towards our goals and give us the surety and certainty to know we'll get there. Even at the level of physiology, beliefs (congruent internal representations) control reality. Belief is nothing but a state, an internal representation that governs behavior. Beliefs are preformed, programmed approaches to perception that filter our communication to ourselves in a consistent manner. Most people treat a belief as if it's a thing, when really all it is is a feeling of certainty about something.
- *Robert Dilts:* Beliefs are not necessarily based upon a logical framework of ideas. They are instead, notoriously unresponsive to logic. They are not intended to coincide with reality. Since you don't really know what is real, you have to form a belief--a matter of faith.

Abraham Maslow's story about the corpse:

A psychiatrist was treating a man who believed he was a corpse.

Despite all the psychiatrist's logical arguments, the man persisted in his belief.

In a flash of inspiration, the psychiatrist asked the man "Do corpses bleed?"

The man replied, "That's ridiculous! Of course corpses don't bleed."

After first asking for permission, the psychiatrist pricked the man's finger and a drop of

blood appeared. The man looked at his bleeding finger with astonishment and exclaimed: "I'll be damned, corpses DO bleed!"

The Medical Coaching perspective:

1. Beliefs are result of linking at least two experiences and making a generalization about the connection.
2. Beliefs are generalizations we make about ourselves and the world.
3. Beliefs exist on a conscious and a subconscious level.
4. Our lives are a printout of our beliefs.
5. Beliefs are the framework of all aspects of our lives.
6. Beliefs are the filters we view our reality through.

7. Beliefs influence all of our behaviors.
8. We attract into our lives events and people that reinforce our beliefs.
9. If we do not deal with our beliefs, our beliefs will deal with us through illness, stress, relationships, money issues…
10. A belief is like a table top that is held by many legs (Gary Craig).
11. Secondary gain issues are part of our belief system.

Although beliefs are developed through exposure to experience they are resistant to logic and "facts" because they are our subjective perceptions of the world.

When someone holds a certain belief, even if he/she comes across an event/"fact" that contradicts that belief there is a high probability that that person's mind will use perceptual filters of generalization, deletion and distortion to conform the "reality" to the belief rather than challenge and/or change the belief itself.

If a person believes that X causes Y – his/her mind will generalize, delete and distort the information in the brain so that the internal representation produced will perpetuate the belief.

Belief systems are the large frame around any change work we want to do with our clients

There are three types of beliefs:

1. **Beliefs about Cause**

   When we believe that "X" causes "Y", our behavior will be directed towards making "X" happen or preventing "X" from happening should "Y" have a negative meaning for us.
2. **Beliefs about Meaning**

   When we believe that "X" actually means that we/the world is "Y", our behavior will be congruent with the belief.
3. **Beliefs about Identity**

   Beliefs about identity include cause, meaning and boundaries.

   When "X" happens, we will ask: "what does that say about me/who does that make me?"

Trauma and the creation of beliefs

A traumatic event can cause beliefs around cause, meaning or identity. In Module 3 you will learn about traumatic events.

Examples from the Medical Coaching room:

1. *Beliefs about Cause*
    - My illness is a punishment from God
    - I'm sick because I was a bad person in a previous life
    - I'm am sick because I didn't take good care of myself
    - I'm sick because I smoked 3 packets a day

2. *Beliefs about Meaning*
    - I'm sick because I was born like this
    - I'm dying because there is no cure for this illness
    - 1 out of 3 women get this illness
    - This illness "runs" in the family's gene pool

3. *Beliefs about Identity*
    - I'm sick because I was irresponsible with my life
    - I didn't value the good things in life, so now I have this illness
    - This illness is here to teach me to let go and be myself
    - I have an addictive personality and that's why I got sick

Remember:

- Beliefs need to be re-examined on a regular base.
- Beliefs are part of our "Software". They need to be upgraded once in a while.
- When trying to identify a person's beliefs and/or belief systems you need to be mindful of The Three Traps (named by Robert Dilts):

Resistance Created by Beliefs – The Three Traps (Robert Dilts)

1. ***"The Fish in the Dreams"***

   When you (the coach) find substantiations for your own beliefs in your client's words.

2. ***"The Red Herring"***

   When a client creates logical explanations for his/her feelings or behavior because he/she is not aware of what is really causing them.

3. ***"The Smokescreen"***

   When a client blanks out, begins to discuss something irrelevant to the process or simply disassociates from the belief because he/she want to protect him/herself from the truth about the belief.

   (This often happens when working with a belief about identity that brings up pain or unpleasantness).

Placebo and the power of beliefs

What is a Placebo?

"…any therapy prescribed … for its therapeutic effect on a symptom or disease, but which is actually ineffective or not specifically effective for the symptom or disorder being treated" (Shapiro, 1997)

In other words, Placebo is a behavior, which should have no effect – and yet it does for certain people under certain conditions.

Although the Placebo Effect has been known for years many still think it has more to do with wishful thinking, superstitions or an inability to come to terms with reality.

Understanding the Placebo Effect in the context of a medical crisis is important for us, as Medical Coaches, for several reasons:

1. Raising the client's awareness regarding the importance of creating congruency between medication, procedures and therapy and his/her inner belief system.
2. Creating an understanding regarding the effect of the client's inner belief system on the effectiveness of medications and procedures.
3. Harnessing the therapeutic effects of the Placebo as a possible harmless and non-invasive alternative.

Placebo doesn't work for everyone every time.

An effective Placebo needs to have four factors:

1. The Placebo needs to be credible (for example, a large pill is more credible than a small one, an injection is more credible than a pill).
2. The Placebo is expected to deliver a specific outcome.
3. The Placebo is believable to the person administering it (this is reflected in the language, and attitude enhancing confidence and additional expectancy of success).
4. The person/authority administrating the Placebo is perceived credible and trustworthy.

Our beliefs, for better or worse, shape our picture of the world and make us relate to them as if they were scientific facts.

Secondary Gain

An advantage or benefit gained through an illness or disability.

Secondary Gain behaviors are neither good nor bad on their own, they are a normal reaction to an abnormal situation. We must look at them within the context of their content.

When working with a medical coaching client we must always search for the possibility of Secondary Gain.

To identify the Secondary Gain we need to ask two questions:

- ***What is the upside of having this problem/issue?***
- ***What is the downside of not having this problem/issue anymore?***

We can also use the ACE secondary gain questions:

- ***What is it that you ARE doing that once you let this go, you STOP doing?***
- ***What is it that you are NOT doing that once you let this go, you START doing?***

Remember #3: We need to be extremely careful when we address this issue and phrase our questions because we do not want to put any additional blame on our client.

Beliefs are divided into two categories:

- **Empowering Beliefs** – enable and encourage us to make changes
- **Limiting Beliefs** – block and prevent us from making changes

Remember:

When a client is interested in making a change, it is important to check with that client what is the belief or beliefs system around that change and if there is an inner incongruity. An inner incongruity will result in an inner conflict between beliefs.

There are two types of incongruity:

1. ***"NEED vs. WANT"***

   This incongruence originates from two sources:

   a. A person has a few significant role models who represent or hold different/conflicting beliefs

   b. A person is confused about his/her belief hierarchy

2. ***"WANT vs. CAN'T"***

   This incongruence occurs when a person expresses a desire for change but does not believe change is possible and/or that he/she deserves change.

The objective of limiting beliefs

A limiting belief is created to solve the inner incongruity between the person's desire for change and lack of an answer to the questions of "HOW to change?" and "WHY isn't change happening"?

Examples:

1. If a client does not know HOW to achieve a goal, he/she might create the belief that: "it is impossible to achieve that goal".
2. If a client does not know HOW to change a certain behavior, he/she might create the belief that: "I cannot do this".
3. If a client does not know WHY his/her body isn't responding to treatment, he/she might create the belief that: "this illness is incurable" or "I am going to die from this illness".
4. If a client does not know HOW to set boundaries for family members or medical professionals, he/ she might create the belief that: "I am not capable of setting boundaries" or "setting boundaries is dangerous for me".

To change a limiting belief, we need to answer the question of WHY.

Once we have an answer, we translate it into a resource and an action plan for our client.

Identifying limiting beliefs

There are three emotions attached to limiting beliefs. Identifying these emotions will help us identify the presence of a limiting belief:

1. **Hopelessness** – the client does not believe the goal is possible = Limiting belief regarding results
2. **Helplessness** – the client does not believe he/she can achieve the goal = Limiting belief regarding ability
3. **Low self-esteem** – the client does not feel worthy of achieving the goal = Limiting belief regarding identity

Limiting beliefs are part of our inner reality and they influence our choices, behavior and emotions.

The Health Belief Model (HBM) is a Psychological Model that attempts to explain and predict health behaviors. The Model is based on the understanding that a person will take a health related action if that person:

1. Feels that a negative health condition can be avoided
2. Expects that by taking the recommended action a negative health condition can be avoided
3. Believes he/she can successfully take the recommended health action

Principles of Working with Limiting Beliefs

1. A limiting belief is an inner behavior. It's important to remember that at the time it was created (consciously or unconsciously) it was the best strategy the client could create with the resources that were available.
2. In order to create sustainable change in the client's belief system we need to replace the limiting belief with a new empowering one.

Replacing a Belief

A process of replacing a limiting belief has 3 stages:
Stage 1 – Releasing the old limiting belief
Stage 2 - Finding a new empowering belief
Stage 3 – Anchoring the new empowering belief

Stage 1 – Releasing the Old Limiting Belief

The Belief: _____

Where is it located in my body? (Where do I feel it in my body?) _____

How does it affect my life and health today? _____

_____

What is the source (story) of this belief? _____

_____

_____

What is the reason I have this belief? _____

_____

How do I know it's true? _____

_____

What does this belief say about me? _____

_____

Do I know people who have a different belief about the same issue? What is that belief?

_____

_____

What is it that am I doing now that once I change this belief, I STOP doing?

What is it that I am NOT doing now that once I change this belief, I START doing?

Stage 2 – Finding a New Empowering Belief

The new belief: _____
(Make sure it's realistic and aligned with your values)

Where do I want to locate it in my body? _____

What impact is it going to have on my life and health once I start believing it?(write as if it is happening now) _____

For the sake of what do I want to believe this new empowering belief? _____

What actions will I do when I believe this new belief? _____

What value will I be honoring when I believe this new belief? _____

How will I be when I have this new belief? _____

_____

_____

Stage 3 – anchoring the new empowering belief

Anchor the new belief using one of the three anchoring techniques you learnt.

Core beliefs

Core beliefs are fundamental beliefs that are at the source of our belief system.

They are created between birth and the age of five when our learning is mostly unconscious.

Core beliefs can be empowering or limiting.

In order to reveal a core limiting belief we need to ask a series of questions to clear and reframe multiple layers of thoughts and beliefs that cover it.

This inquiry can be done on a conscious or sub-conscious level.

This form of inquiry is similar in structure to the positive intention inquiry but uses the following questions:

When you have/do X – What is dangerous about that?

What is the worst that can happen to you?

In Medical Coaching, core limiting beliefs are considered pain issues.

In Module 3 you will learn a technique called ACE (Advanced Clearing Energetics) to help clients clear pain issues.

Embodiment – Working with the Body

Embodiment can be defined as the bodily context of 'the way we are', our manner of being.

This is a context through which we experience, perceive, understand and interact with the world around us. Our relationship with our body is the most fundamental relationship we have in our lives. The body is more than a vessel that holds our mind. It is our history, the way we experience the world and people around us, the way we move in our surroundings, the way we explore new things and places, a source of pleasure, a way to be intimate with others and the way we become present and grounded in the moment.

We tend to go to the body to asses our capabilities as much as we tend to confuse our emotions with our bodily sensations. When the body fails us, betrays us and/or becomes a source of pain, shame and disappointment it is only natural that we disconnect from it. The comfort zone becomes talking about the body and not being with it, embodying it.

Through embodiment we learn to be fully present in the first position and expand our awareness. First – by creating awareness and attention to the subjective experience of being in the body and second – by expanding that awareness from an awareness of the body to an awareness as the body.

Embodiment is the practice of healing our relationship with the sick and wounded body.

Healing that relationship, for the sake of coming back home to the body and the authenticity of being in the world is an act of radical faith and choice. A choice to live fully and not just be alive

Since we use embodiment in a coaching setting and not a therapeutic one we avoid touch, constantly contract with our clients and follow the Medical Coaching code of ethics.

Embodiment Techniques

These are a few embodiment techniques that you can start working with in your coaching sessions.

If this resonates and you feel that you want to expand your knowledge and mastery in this field, you might want to explore additional Embodiment Coaching and Somatic Coaching training programs in the future.

Being Present in the Body

“Sit comfortably and close your eyes.

Relax your muscles.

(Our body system is designed so that the mass of the body, the muscular system, is resting in the bone skeleton.)

Take your attention to your head and start relaxing your facial muscles. Notice the tension in your forehead, chin and jaw and relax these muscles. If you are not sure they are relaxed simply tighten them and then relax.

Next, pay attention to your shoulders and neck. Bring the shoulders to the ears and then let them drop. Align your head in a way that it rests comfortably on your neck. Relax the muscles and let them rest on the skeletal system.

Next, bring your attention to your arms and hands. Let the arms rest and put your hands beside you or in your lap. Relax the muscles and allow the elbows and joints go limp.

Next, bring your attention to the abdomen. The system is designed so that breathing actually happens in the abdomen and not in the chest. Put your hand on your abdomen, below your navel and take a deep breath. As you inhale your abdomen will expand and when you exhale it will deflate (when we are breath naturally this movement is more gentle).

Next, take the attention to the pelvic area. Relax the genital and anal sphincter muscles. If you are not sure they are relaxed simply contract them and release.

Next, bring your attention to your legs. Feel your feet firmly on the floor. Relax the muscles and allow the knees to go limp.

Bring your attention back to your breathing and allow yourself to be in this place and get familiar with it.”

As a coach you want to calibrate and notice changes such as clenching teeth, tightening shoulders, changes in facial expressions, changes in breathing patterns, fidgeting etc. This is part of the way the body speaks and as a coach you will use mirroring and reflecting questions as you start creating awareness to this language.

Body Scan

The coaching body scan is different from body scan meditations. In Medical Coaching we use body scan to self-calibrate and identify where emotional issues are located in the body, practice self-compassion and non-attachment.

The technique entails methodically paying attention to each part of your body. You can choose to go from top to bottom or from bottom to top.

Once you come across a discomfort you pause and pay attention to it.

Depending on the purpose of the practice, you can address the discomfort as a behavior and talk to the part; you can use breathing and centering techniques to release; you can hold space and practice self-compassion; you can look into the submodalities and use EFT (which you will learn in Module 3) to clear the discomfort; or you can shift into a META-view and get positive learnings.

'Body Whisper - Body Shout'

'Body Whisper – Body Shout' is an approach that addresses physical intensity of pain and symptoms.

Low intensity is a 'whisper'. High intensity is a 'shout'.

The goal is to be able to recognize the pain at its 'Whisper' stage by the way the body embodies it and then create a strategy to address the underlying issue or request so that the shift into 'Shout' can be prevented/ avoided.

Embodiment of Resources

We can use embodiment to deepen the experience of anchoring resources.

We explore the embodied experience of both the resourceful state from which we want to anchor a resource and the embodied experience of becoming resourceful. We do this as the resource has been anchored by asking the client to become aware of the effect and impact the resource has on this/her posture, breathing and body language.

This creates a deeper and more profound experience of being resourceful and creates an additional layer of anchoring by embedding the resource in the physical experience of being in the body.

We can ask the client: 'what is the body of this resource?' or instruct the client to allow the resource to fill the body/echo through the body in a way that creates an embodied experience.

Survivorship

Survivorship is defined as the state of being a survivor.

The term survivorship originated from cancer.

According to the National Cancer Institute Dictionary: 'survivorship focuses on the health and life of a person with cancer post treatment until the end of life. It covers the physical, psychosocial, and economic issues of cancer, beyond the diagnosis and treatment phases.'

This implies three things:

1. Cancer has a chronic aspect.
2. End of treatment is not the end of a person's experience with cancer.
3. Survivorship is different from the diagnosis and treatment phases.

Although the term survivorship was coined in the context of cancer it is also relevant to people who have survived acute medical issues in general AS WELL AS people who are living with stabilized chronic conditions.

Medical Coaching is very relevant and effective for clients in this stage.

When coaching clients in survivorship stage we need to be aware and address the following issues:

1. A need for support system.
2. Expectations to return to "normal".
3. Fear of Reoccurrence or Fear of Recurrence.
4. Survivor's Guilt.
5. Shift to an experience of an invisible illness.
6. Limiting beliefs about survivorship.
7. Loss.
8. Changes in close relationships.
9. A need for new life skills.
10. Mortality and End of Life.
11. Life changing decisions that were made during the active phase of the illness.
12. Survivorship experience of caregivers

It's important to create a safe space for the client to process all of the above and the understanding that: 'It's OK not to be OK'.

AND there is a need to redefine what "normal" means, how its measured and how to identify and cope with abnormalities.

Resources

Emotions

Dark Night of the Soul

"The "dark night of the soul" is a term that goes back a long time. Yes, I have also experienced it. It is a term used to describe what one could call a collapse of a perceived meaning in life... an eruption into your life of a deep sense of meaninglessness. The inner state in some cases is very close to what is conventionally called depression. Nothing makes sense anymore, there's no purpose to anything. Sometimes it's triggered by some external event, some disaster perhaps, on an external level. The death of someone close to you could trigger it, especially premature death, for example if your child dies. Or you had built up your life, and given it meaning – and the meaning that you had given your life, your activities, your achievements, where you are going, what is considered important, and the meaning that you had given your life for some reason collapses." Ekhart Tolle

@ Eckhart on the Dark Night of the Soul - https://www.eckharttolle.com/eckhart-on-the-dark-night-of-the-soul/

@ Is it Depression or a Dark Night of the Soul? - https://www.everydayhealth.com/columns/therese-borchard-sanity-break/depression-dark-night-soul/

@ Sadness, Depression and the Dark Night of the Soul. Transcending the Medicalisation of Sadness. Foreword by Professor Roland Littlewood - https://www.researchgate.net/publication/313504426_Sadness_Depression_and_the_Dark_Night_of_the_Soul_Transcending_the_Medicalisation_of_Sadness_Foreword_by_Professor_Roland_Littlewood

📖 Sadness Sadness, Depression and the Dark Night of the Soul. Transcending the Medicalisation of Sadness/ Dr Glòria Durà-Vilà

📖 Sadness The Dark Night of the Soul: A Psychiatrist Explores the Connection Between Darkness and Spiritual Growth/ Gerald May

The sub-modalities checklist:

Visual	1	2
B/W or Color		
Near or Far		
Bright or Dim		
Location		
Size of Picture		
Associated/ Disassociated		
Focused		
Framed or Panoramic		
Movie or Still		
Movie Speed		
3D or 2D		
Viewing Angle		
Auditory		
Location		
Direction		
Internal/External		
Volume		
Speed		
Pitch		
Tonality		
Pauses		
Duration		
Uniqueness		
Kinesthetic		
Location		
Size		
Shape		
Intensity		
Steadiness		
Movement		
Vibration		
Pressure/Heat		
Weight		

Reframing Values

Comparing the value to…	Similarities	Differences	Learnings (Positive Learnings)
Another person with a similar value, today			
Another person with a different/opposite value, today			
Myself, in the past, with a similar value			
Myself, in the past, with a different/opposite value			
Myself, today, with a similar value			
Myself, today, with a different/opposite value			
Myself, in 10 years, in the same context			
Myself from a meta-view (on the moon), in the same context			