HMCI
Health and Medical Coaching Institute

Health and Medical Coaching Training Program

Module 2 – Process

Contents:

Health and Medical Coaching Training Program

Module 2 – Process

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

In this model, we focus on the process of change.

In the HMCI Health and Medical Coaching model, the process of change begins the moment the client decides to commit to the coaching process.

The four stages of the Health and Medical Coaching Model:

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

1. The Inner Compass

The Inner Compass is the voice of the client's soul; it is an inner calling that cannot be overheard, overlooked, or ignored.
It is a call for change, learning, growth, and purpose.
As Health and 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 to change means different things for different people.

In terms of the coaching process, this is a commitment the client makes both to their vision and to coaching.

Tools we can use to support the act of committing:

5. The Coaching Agreement
6. Setting Expectations
7. Addressing Payment
8. Addressing the Coaching Accountability
9. A "commitment scale"

3. Journey of Health

During this journey, the client meets allies, creates and discovers resources, realizes strengths, overcomes challenges, gains insights and learnings.

The Journey includes three main interactive dynamics:

1. *Overcoming Challenges*
   - 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*

To create a sustainable process, the client (and especially the client's brain) needs time to allow assimilation of all the changes – this is called: transformation time.

Transformation occurs when we allow ourselves to learn and grow from every situation

4. Return Home and Integration

The journey of change, much like the "Hero's Journey"*, transforms those who choose to embark on it and alters the way they perceive the home they return to.

As we reach the completion of the coaching process, it is important to address a few points:

- What insights and understandings 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 a Life Vision and Health & Medical Coaching Goals

Health and Medical Coaching clients enter the coaching process from several points:

- Wanting to cope with an existing health/medical crisis
- Wanting to prevent a health/medical crisis
- Wanting to manage chronic stress/burnout to prevent deterioration that will cause a health/medical crisis.
- Wanting to come to terms with and manage end-of-life challenges.

This means that clients often enter the coaching space focused on what they don't want, can't do, or can't have, rather than on what they want, can do, or can have and achieve.

During the first session, the client will bring their challenges and wishes into the coaching space. Our job is to hold a safe space for this content and listen to it with respect.
We do not coach it, because in its current form, it is NOT coachable.

Once the client has shared their challenges and wishes, we move to explore the **Life Vision.**

Life Vision

The Life Vision is a state of being that is aligned with the client's fulfillment and purpose.

It is the one thing that, once we align with it and live by it, allows us to become our true selves, who we really are ("I am me"), making our life worth living.

The Life Vision is a short one-word statement.

Examples of Life Visions:

- Joy
- Calm
- Peace
- Grounded
- Whole
- Complete
- Peacefulness
- Love

Eliciting a Life Vision:

Sometimes the client will use metaphors to describe the Life Vision.

While a metaphor can be a good step forward, it is not the Life Vision we are looking for.

These are questions that can help your client narrow the metaphor to a one-word Life Vision:
(Don't use all of the questions; pick one or two that you like, or you feel would resonate with the client)

- Who will you become in the world when you achieve your wishes/challenges?
- What is your sense of being?
- If this were your last year to live, how would you like to be remembered?
- If this were your last year to live, what is the word that you would want people to connect to you that would honor/ represent you?
- What would you like to give the world through the way you live your life?
- What will it look like when you have achieved your wish/challenge?
- What will it feel like when you have achieved your wishes/challenges?

Once you have come to a one-word Life Vision, ask the client these two questions to make sure the Life Vision is 100% being AND is about him/herself (not others):

- For the sake of what is this vision important to you?
- How will this impact/affect you?

Remember that talking about a Life Vision amid a medical crisis is a radical act of choice.

Client's Challenges and Wishes

The client's challenges and wishes are the content they bring into the coaching space in the first session. As Health and Medical coaches, we meet the client where they are and listen to their challenges and wishes with empathy, respect, and a judgment-free mindset.

Examples of challenges/wishes:

- Cope better with my illness
- Decrease my anxiety and stress
- Change my thinking to attract more optimistic/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 medical treatments
- Get a good pace at work
- Be happy
- Lose weight
- Accept my condition, cope with my illness
- Stop being stressed
- Be healthy
- Lose weight

In many other coaching disciplines, these would be considered goals, and the coaching would shift into a "doing" process, likely derailing into fixing, problem-solving, and counseling.
In Health and Medical Coaching, this content, though authentic, real, and painful, is **not** coachable in its current form. It needs to be processed into health and medical coaching goals.

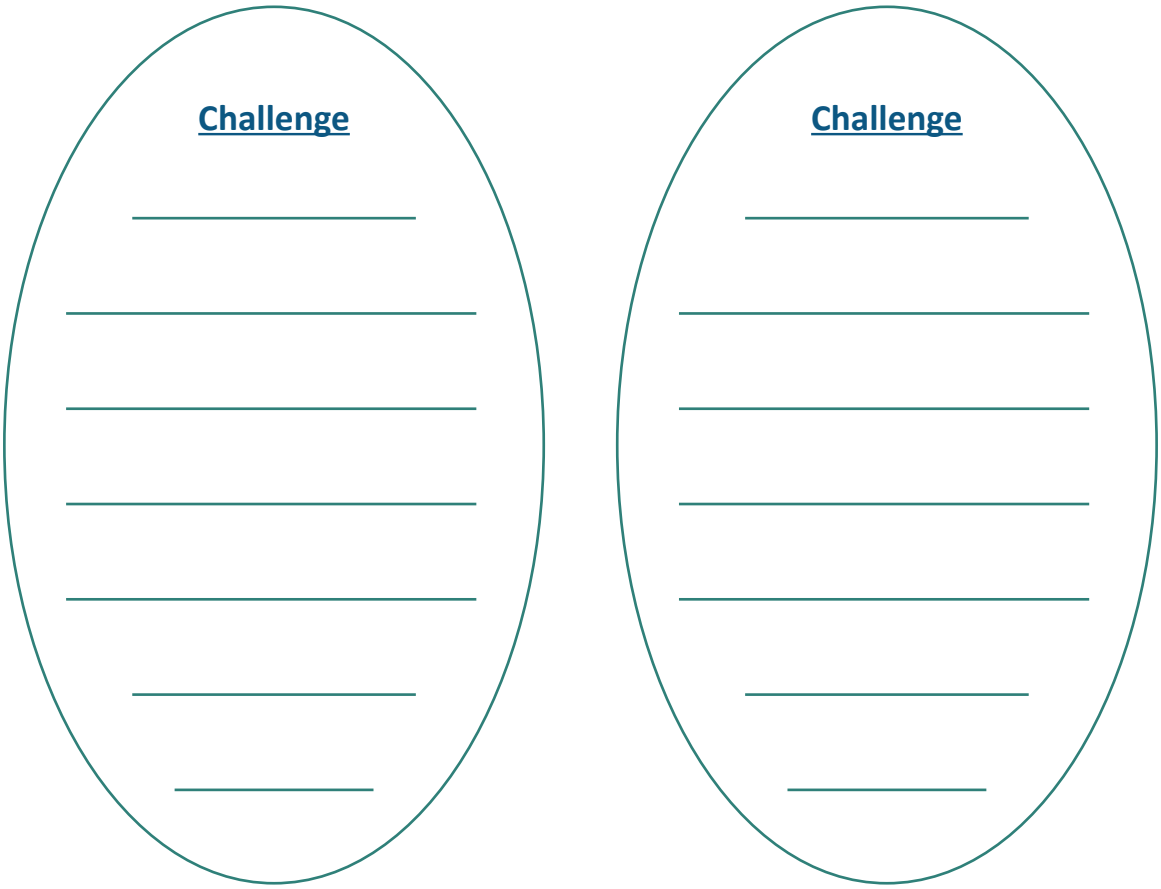
The first step in processing it is to clarify the challenges brought into the coaching space.

To this end, we can use a tool called Clarity Circles.

Clarity Circles:
Ask the client to get a piece of paper and a pen and name their challenges.
Invite the client to create a circle for each area and write inside it all the aspects of this area.

You can use one or some of these questions to help the client:

- What would you like to work on in our sessions?
- What are the challenges that you are facing right now?
- What are the challenges that you want to work through?
- What emotions are you feeling?
- What are the top three things you would like to focus on in coaching?



Once the client has created Clarity Circles for each challenge, we ask the client to rate the circles according to importance and choose 1 or 2 circles that will be the focus of the coaching process.

Once the client has chosen, we ask the client to break down each challenge.
We mirror what we hear and confirm that we understand correctly.

Once the chosen challenges have been broken down, we move to identify Themes.

Themes

The Themes are the things/obstacles that stand in the client's way of working with and resolving the challenges.

The coach's job is to listen to the themes that are coming up and mirror them to the client.

Themes can be:

- Meta-view concepts
- Assumptions
- Expectations
- Limiting Beliefs
- Generalizations
- Specific Values
- Expectations/Assumptions
- External Factors
- Emotions
- Conflicts
- Lack of skills
- Relationships

These are some questions that can bring out the Themes:

(Pick one or two that you like, or you feel would resonate with the client)

- What is getting in the way of accomplishing this wish?
- What is getting in the way of overcoming this challenge?
- What is stopping you?
- What is the obstacle?
- What do you believe about this?
- How does this honor your values?

Now, you are ready to start eliciting the Health and Medical coaching goals.

Health and Medical Coaching Goals

Health and Medical Coaching Goals are created from the client's THEMES.
The goals aim to help the client return to a resourceful state that will enable them to clear their Themes.
For a client to find solutions to their challenges, they first need to work through the emerging themes. This way, they will be able to make changes that are impactful in the long term, rather than temporary band-aid fixes that break down or create more challenges.

Health and Medical coaching goals are connected (directly or indirectly) to the health/medical challenges that the client has brought to the coaching space.
The Health and Medical coaching goals have the same principles as "regular" coaching goals.

They need to be **SMART**:

1. **Specific**
   Address the specific thing that is getting in the way of overcoming the challenge.

2. **Measurable**
   Identify or create specific evidence that can measure the client's progress as they work towards the goal.

3. **Articulated in a positive language**
   We cannot coach clients on what they don't want. Reframe statements that include the words Don't, Won't, " or " Not. Reframe- "I won't do X" into "I will do Y."
   When negative language appears, it is essential to listen to what the client is saying and calibrate (review in Module 1). Get curious about what they are looking for instead of what they don't want. It is here that you can hear many Themes in the form of beliefs, values, and emotions.

4. **Responsible**
   considering the current medical condition, limitations, and restrictions.

5. **Timely**
   Pick a specific date on the calendar or within x coaching sessions.

Additionally, they need to be **PREAR**.

1. **Pro-active**
   The goal addresses what the client can do instead of what they need others to do for them.

2. **Realistic**
   Considering the current reality of the client.

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

4. **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.

5. **Resonant**
   Echoes with what is truly important for the client.

Words such as learning, understanding, realizing, and analyzing cannot be used to articulate a Health and Medical coaching goal. These words refer to resources and strategies the client can use to achieve the goal.

The Linguistic Structure of a Health and Medical Coaching Goal

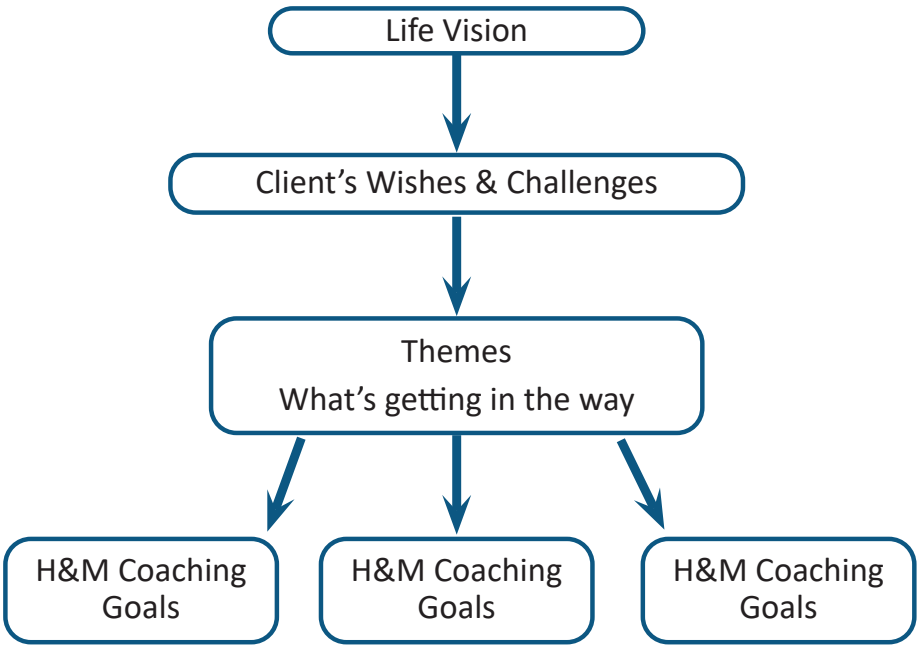
In Health and Medical coaching, we first create internal goals about the self.

This is important because when changes focus on the self, they sustainably hold other changes the client wants to make on an external level (actions, relationships, communication, strategies, etc.)

Examples:

1. Shift the limiting belief of "I'm not good enough" to an empowering belief that honors me by November 2nd
2. Build self-confidence from 4 to 8, on a scale of 1-10, within four sessions, to allow me to speak confidently when I need to get my point across or ask a question.
3. Increase my self-esteem from 5 to 7, on a scale of 1-10, within six sessions by January 7th.
4. Bring the emotional intensity of shame down, below a 4, on a scale of 1-10, by shifting to an empowering perspective within six sessions.

Summary:



Understanding the Process of Change

In this module, we will take a deep dive into what it takes to help clients create ecological and sustainable change as they work towards their goals and vision.

To fully understand the complexity of change, we will explore the process from the following angles:

- The context of change in health and medical coaching
- The framework of change
- Current professional theories regarding change
- The neurological and linguistic aspects of behavior and change
- Working with resources
- Aligning values
- Understanding and adapting the belief system
- Creating inner congruency – inner parts work
- Understanding and establishing long-term adherence

The Context of Change in Health and Medical Coaching

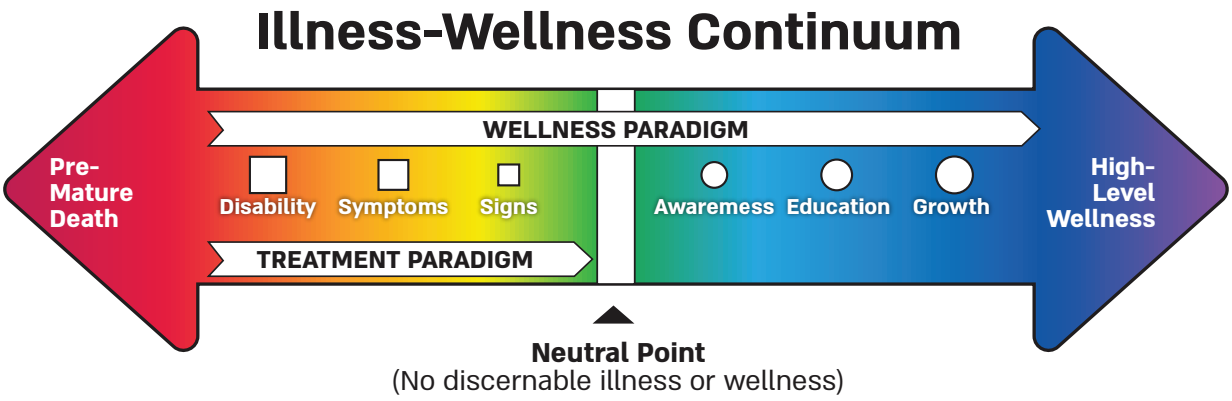
In Health and Medical Coaching, the process of change occurs on a continuum/a spectrum, ranging from health to premature death.
This continuum/spectrum is called 'The Illness-Wellness Continuum' (the term was coined by Dr. John Travis in 1972).

The Illness-Wellness Continuum, also referred to as the health-illness continuum, is a model that looks at well-being as a continuum/spectrum rather than a binary state (sick vs. healthy).
It shifts the focus from a discussion about the absence of illness and disease to an active journey of pursuing wellness and well-being.
The model emphasizes the power and choice to actively move toward better health.

The visual representation of the model depicts two back-to-back arrows: one pointing toward high-level wellness through awareness, education, and growth, and the other pointing toward premature death through signs, symptoms, and disability.

In the middle, there is the Neutral Point, which indicates a point where neither condition is prevalent (i.e., the visible absence of disease, pain, or injury).

The Illness – Wellness Continuum



The model shows two paradigms:

- The Treatment Paradigm – advocating that the responsibility of medicine and healthcare is to help people reach the neutral point where there is no visible evidence of an illness.
- The Wellness Paradigm – advocating that the responsibility of medicine and healthcare extends beyond the neutral point. This paradigm emphasizes the role of emotional and mental wellbeing in achieving high-level wellness.

Social Cognitive Theory (SCT)

Change never happens in a void; it takes place in a field that includes personal history, social interactions, emotions, relationships, behaviors, beliefs, and experiences. All of which have a dynamic interaction with any process of change we wish to initiate and implement in our lives.

The Social Cognitive Theory (SCT), developed by Albert Bandura, addresses the relationship and interaction between personal factors (beliefs and skills), behavior, and environmental influences. The theory suggests that people learn not only through their experiences but also by observing the behaviors of others and the outcomes of those behaviors.

The SCT model includes four key components:

1. **Self-efficacy:** A person's belief in their ability to successfully perform a specific behavior or task. Higher self-efficacy is associated with increased motivation, persistence, and the likelihood of achieving a goal.

2. **Observational learning:** A person's ability to acquire new behaviors, skills, or knowledge by observing others' actions and the consequences of those actions. This learning can be either direct (watching someone perform a task) or indirect (watching a video or reading about a task).

3. **Outcome expectations:** A person's beliefs about the likely consequences of their actions. Positive outcome expectations can motivate behavior change, while negative expectations can inhibit it.

4. **Reciprocal determinism:** A person's understanding of the way their behavior, personal factors, and environmental factors influence one another.

In health and medical coaching, SCT principles are used to maintain motivation for behavior change by enhancing clients' self-efficacy, creating strategy models through the observation of others' experiences, and addressing expectations about the outcomes of their actions.

Health and Medical coaches apply SCT by building client confidence through small successes, providing opportunities to observe and model healthy behaviors, helping clients manage their environment, and fostering a supportive network.

There are various ways we can do this:

- Increase awareness on how the client's environment (e.g., supportive family) can influence their behavior (e.g., eating healthy), and vice versa.
- Set small, manageable, and attainable goals.
- Create "mastery experiences" that reinforce the client's belief in their ability to change.
- Encourage clients to acknowledge their own accomplishments.
- Observe and model others who have successfully adopted similar health behaviors
- Clarify the desired outcomes and how those can lead to positive results.
- Develop internal resources and increase resourcefulness.
- Improve access to external resources.
- Expand skill set.
- Develop self-regulation and self-monitoring behaviors.
- Identify and leverage supportive environments.
- Reframe negative self-perceptions.
- Using perspective work to learn from past failures and develop more effective strategies for 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.
Knowing how to create the change.	Not knowing what is needed to create change.
Allowing the opportunity, space and resources to make the change.	Lack of opportunities and resources to make the change.

It's essential to understand and accept that change happens in stages, within a timeline that is different from one person to another.

Six Logical Levels of Change

The **'Six Logical Levels of Change'** is a framework created by Robert Dilts and George Bateson.
This framework is based on a relational concept, where some processes and behaviors are created through their relationships with other processes and behaviors.

The term "Logical Levels" refers to levels of learning and change.

In this framework, the logical levels are represented in a hierarchical form of a pyramid, demonstrating how change can occur within an individual.

These are the six levels, from bottom to top:

1. ***Environment:*** the physical and social context in which we exist and everything we interact with, including environments, places, objects, money, relationships, career, and our bodies.

   Examples of coaching questions asked on this leve: Where, when, and with whom do I do things?
   The level of the environment is where most people want to see the changes happen.

2. ***Behaviors:*** our actions in a particular environment.
   This includes actions, reactions, behaviors, language (both verbal and nonverbal), responses, routines, and habits.

   Examples of coaching questions asked on this level: What are the things I am doing? What do I need to start doing? What do I need to stop doing? What do I need to do to get started? What needs to be done differently?

3. ***Capabilities and Skills:*** the abilities, skills, competencies, qualities, and strategies we possess and can apply to create change. These include knowledge and experience, as well as cognitive, emotional, technical, communicational, and soft skills.

   Examples of coaching questions asked on this level: How do I do what I do? How can I do it better? What can I improve on? What do I need to do differently? What else can I do?

4. ***Values and Beliefs:*** the values and beliefs that shape our perception of the events we experience and the world we live in. These include our internal philosophies, assumptions, motivation, convictions, principles, and attitudes.

   Examples of coaching questions asked on this level: What's important to me? What's important about this? Why is this important? Why do I do what I do? What am I honoring?

5. ***Identity:*** our core concept and sense of self and identity. This includes how we see ourselves, our aspirations, self-worth, and self-realization.

   Examples of coaching questions asked on this level: Who am I (as a person/ professional/ family member/human being)? What do I like? What drives me? What does my journey in this lifetime/ in this place/ on this planet mean to me? Who do I want to become in this world?

6. ***Spirituality/Purpose:*** the connection to a higher/greater power, sense of purpose, or system we might be a part of. This includes spiritual beliefs and practices, creativity, and meaning.

   Examples of coaching questions asked on this level: For the sake of what? What's my highest purpose? What is the purpose of my life/this journey? What is this all for? What is the bigger picture/the bigger game?

The beauty of this framework lies in the relationship between its levels.

While we work at each level separately to identify strengths and weaknesses and understand how to make necessary changes, we use the relationship between the levels to create a more systemic shift.

Each level influences the levels beneath it.

The end goal is to align all the levels. When all levels are aligned, the change is ecological to the entire system, making it sustainable.

Additional ways to work with this model:

1. Creating an action plan for change
2. Checking for incongruence by associating with our client at each level
3. Creating motivation by embodying each fulfilled level of the model. The model can be worked on either from bottom to top or from top to bottom.
4. Reflecting on a process or event
5. Creating a model from a successful previous change

The Self-Determination Theory (SDT)

Self-determination is a key factor in our ability to initiate and implement change.

Self-determination refers to our ability to make our own choices, learn how to effectively solve problems, take control of the things within our power, and take responsibility for our choices, actions, and life.

Self-Determination Theory (SDT) seeks to explain the connection between self-determination and motivation. It holds the premise that people feel more motivated to act when they believe their actions will influence the outcome.

The Self-Determination theory suggests that people can become self-determined when these three fundamental psychological needs are fulfilled:

- **Autonomy**: having choice and control over one's own actions and decisions.
- **Competence**: being effective, capable, and able to achieve desired outcomes.
- **Connection/Relatedness**: feeling connection, belonging, and meaningful relationships with others.

In health and medical coaching, SDT principles are used to create an environment that supports clients in fostering these three universal psychological needs. This leads to more intrinsic and self-driven motivation for clients to achieve health goals, improve their well-being, and create sustainable behavior changes.

These are a few examples of various ways we can coach our clients to meet these three needs:

Autonomy:

- Foster a sense of ownership.
- Clear limiting beliefs regarding autonomy.
- Explore existing values around autonomy.
- Clear inner conflicts involving autonomy.
- Explore meaningful choices within health plans.
- Explore the rationale behind decisions.
- Create a decision-making protocol.
- Expand their medical literacy skills.

Competence:

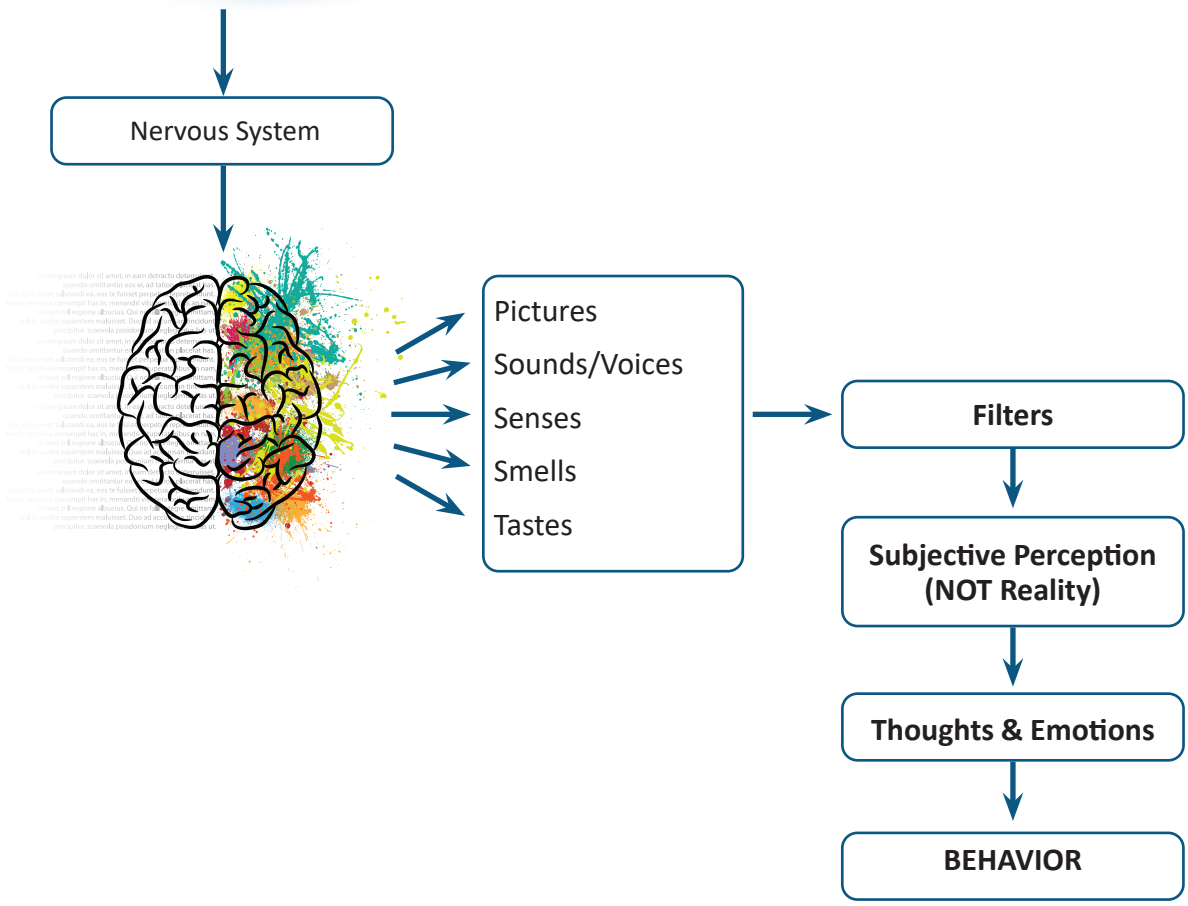
- Provide positive affirmation and constructive feedback.
- Build confidence in the clients' abilities to manage their health.
- Create strategies and protocols to cope with various challenges and needs.
- Identify and anchor resources.
- Clear limiting beliefs regarding competency in general and specific abilities.
- Expand skill set.

Connection/Relatedness:

- Identify, enhance, and create medical, social, and emotional support systems.
- Address the relationships with professional and family caregivers.
- Foster a sense of belonging.
- Address communication skills.
- Clear limiting beliefs regarding connection, belonging, and trust.
- Address the narrative on past painful experiences regarding connection, belonging, and trust.

The Neurological Aspect of Behavior and Change

An Experience



We are exposed to 2 million bits of information per second via our senses.
To be 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.

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. Still, depending on the circumstances and preference, we tend to focus on one or more representational systems to become more efficient and achieve better results.

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

As 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, and 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 often move their eyes to the side. 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 spoken communication over written. 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 specific 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 rises and fall as they breathe. They often move and talk very slowly. They are more sensitive to their bodies and feelings, responding 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 appearance. A kinesthetic person tends to decide based on feelings. A kinesthetic person tends to stand closer to others than a visual person does.

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

Auditory Digital (AD) People 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 on conversations with you in their mind. They learn by working things out in their mind and memorize by steps, procedures, and sequences. They tend not to be spontaneous and need to follow a logical approach. 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 the 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 this **LOOKS GOOD**, we will go ahead and **FOCUS** on the paperwork.	If I could **TELL** you … would you want to **HEAR**? If this **SOUNDS GOOD**, we will go ahead and **DISCUSS** the paperwork.	If I could **GET A HOLD OF** a way you … would you want to **GET A FEEL FOR IT**? If this **FEELS GOOD**, we will go ahead and **HANDLE THE PAPERWORK**.

Submodalities

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, you must 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 start analyzing what is happening.

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 neurological programs that guide and direct our thought processes. They determine how we motivate ourselves, make decisions, buy things, express our interests, manage time, perform tasks effectively, and 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 Health and 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 refers 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 others' 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 result from a resourceful or un-resourceful state.

Helping clients shift into a resourceful state is a fundamental aspect of coaching in general and Health and Medical Coaching in particular.

Living with a health or medical condition means finding new ways to address both new and old challenges.

Addressing old challenges involves:

1. Recognizing the gap between existing challenges and the scope of abilities
2. Assessing the efficacy of existing resources and releasing the ones that are not effective or relevant
3. Identifying resources that are missing or need updating
4. Coping with the loss of abilities
5. Updating the inner sense of self-agency
6. Learning new ways to use existing resources
7. Learning to use new resources

Addressing new challenges involves:

1. Identifying the new challenges
2. Assessing which of the existing resources can still be used as is and what needs to be updated and adapted
3. Learning to use new resources
4. Updating the inner sense of self-agency

The skill of anchoring resources helps the client sustainably embed both resources and resourceful states, ensuring they remain available and easily accessible.

The principles of anchoring are:

1. Identifying the needed resource
2. Recalling a vivid experience where the client was fully connected to the specific resource (a resourceful state)
3. 'Importing' the specific resource (resourceful state) from a 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, it establishes 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 linking the past state to the present and the future.

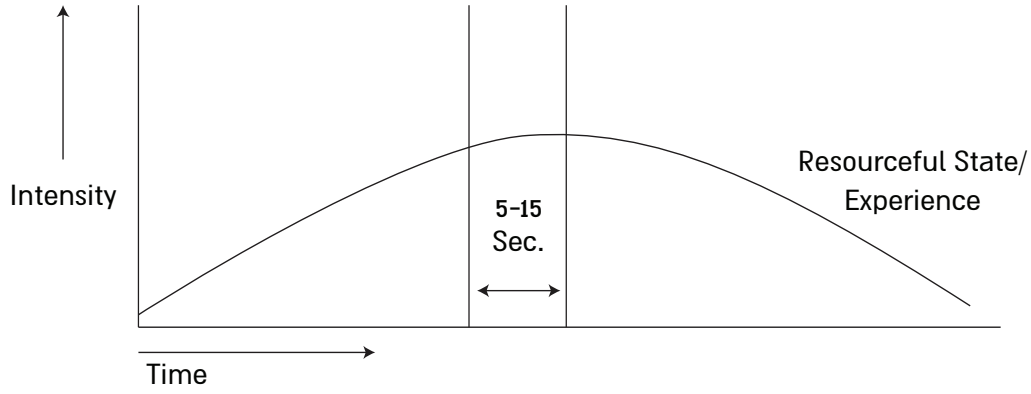
PROCESS:

The 4 steps to Anchoring:

1. Ask the client to recall a vivid 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:

1. The intensity and integrity of the experience.
2. The timing of the anchor
3. The uniqueness of the anchor
4. The replication of the stimulus
5. 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 their "Present Self".
7. Ask the client to give their "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 their "Future Self". Be curious about the client's experience.
10. Ask the client: "What is the next step to be taken NOW, to achieve the Goal?"

Break State

A Breck State changes the emotional state by shifting the attention from one thing to another.

A Break State is used to break concentration and step out of unresourceful states.

Future Pacing

Future Pacing creates an internal picture of a desired outcome occurring in the future.

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

To future pace, we describe to the client a dissociated future situation where the desired outcome is successfully experienced.

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, and 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, 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 clie nt 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 essential in our lives. 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 their 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 with?
- 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 are that you haven't even thought of putting 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, the ones we need to remain true to ourselves.

Core values in the context of Health and 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 amid a medical crisis and chronic illness.

4. Every behavior is motivated by a positive intent. A positive intent is a core value.

The principles of a positive intention/core value

1. All behaviors serve as a positive intent /core value.

2. The behavior itself can be socially unacceptable, negative, or even self-destructive.

3. Physical symptoms are behaviors and serve a positive intent/core value.

4. To find the positive intent/core value, we need to differentiate between the "behavior" and the "self"

5. The purpose of finding the positive intent/core value is to create a change of behavior.

6. Although there is a conscious will to change, the positive intent/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 thought.

Revealing the positive intention/core value behind a behavior

To reveal a positive intention, we need to ask a series of questions to clarify and reframe the multiple layers of thoughts and beliefs that obscure it.

This inquiry can be done on a conscious or subconscious 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, with the client, a value the client feels is getting in the way of achieving his/her goals.

   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 this value further (it's important to write down 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.

A positive learning has 3 principles:

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 two different things.

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 through which we perceive the world. Beliefs are the compass and maps that guide us towards our goals, providing the surety and certainty that 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 performed, 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 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.

The Health and Medical Coaching Perspective:

1. Beliefs are the 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 subconscious level.
4. Our belief system is the blueprint of our lives.
5. Beliefs are the framework of all aspects of our lives.
6. Beliefs are the filters through which we view our reality.
7. Our beliefs influence all our behaviors.
8. We attract events and people that reinforce our beliefs into our lives.
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 tabletop 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 they come across an event or a" 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, their 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 overarching framework for 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" 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?"

Examples from Health and Medical Coaching:

1. *Beliefs about Cause*
    - My illness is a punishment from God
    - I'm sick because I was a bad person in my previous life
    - I'm sick because I didn't take good care of myself
    - I'm sick because I smoked 3 packs 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 gets 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 regularly.
- Beliefs are part of our "Software". They need to be updated 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 to Change 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 their feelings or behavior, it is because they are not aware of what is really causing them.

3. **"The Smokescreen"**

   When a client begins to discuss something irrelevant to the process or disassociates from the belief to protect themselves from the truth about it.

   (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, a Placebo is a behavior that 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.

Placebos don'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 administering the Placebo is perceived as 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 am I gaining and what am I losing by having this problem/issue?***
- ***What am I gaining and what am I losing by not having this problem/issue anymore?***

We can also use these secondary gain questions, created by Richard Flook:

- ***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 addressing this issue and phrasing our questions, as we do not want to place any additional blame or shame 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 the client what the belief or belief system is 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 that change is possible or that they deserve it.

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: 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, influencing our choices, behavior, and emotions.

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 available resources.

2. To create sustainable change in the client's belief system, we need to replace the limiting belief with a new empowering one.

The Health Belief Model (HBM)

The Health Belief Model (HBM) explains and predicts health-related behaviors by focusing on the individuals' beliefs about health threats and the potential benefits of action.

The model includes six key components:

1. Perceived Susceptibility – the person's belief about their risk of contracting a particular illness or condition.
2. Perceived Severity – a person's belief about the seriousness of the illness, and the possible medical and clinical consequences.
3. Perceived Benefits - a person's belief in the potential positive outcomes of a particular health action.
4. Perceived Barriers (negative aspects of action) – a person's perception of the negative aspects of taking a health action.
5. Self-efficacy - a person's belief in their ability to successfully perform a specific health-related behavior.
6. Cues to Action – internal or external factors that cause a person to respond and take action.

As coaches, we use the Health Belief Model (HBM) to help our clients understand their perceptions of health risks, benefits, and barriers, enabling us to replace these perceptions with beliefs that can help them shift their behaviors and achieve the change they want.

Applying the HBM in Health and Medical Coaching

- **Assessing Perceived Susceptibility and Perceived Severity** - using open-ended questions to understand the client's perception of their risk of a health problem and the severity of the consequences that problem might have.
- **Exploring Perceived Benefits** - helping the client identify the potential benefits and advantages, as well as the possible positive outcomes of changing their behavior.
- **Reduce Perceived Barriers** - working with clients to identify obstacles that prevent them from taking action and creating an action plan involving relevant resources to help them overcome these obstacles.
- **Boost Self-Efficacy** - helping clients build confidence in their ability to act by setting achievable goals and celebrating small wins.
- **Cues to Action -** helping clients create internal and external motivators and triggers that would help them take action.

The Theory of Planned Behavior

The Theory of Planned Behavior (also known as the Theory of Reasoned Action) suggests that three types of beliefs affect an individual's intention to perform a specific behavior:

1. Behavioral beliefs – the attitude the person has toward the specific behavior
2. Normative beliefs - the perceived attitudes of peers and respected figures (social pressure) toward the behavior
3. Control beliefs – the perceived ability to perform the behavior with ease or difficulty

The TPB provides a framework for understanding how rational thought processes influence choices. Our behavioral, normative, and control beliefs come together and form our behavioral intention – our commitment to act.

A strong intention to perform a behavior, driven by a positive attitude, supportive social norms, and high perceived control, leads to a higher likelihood of performing the behavior.
In other words, people are more likely to act if they have positive attitudes, perceive support from others, and believe they can successfully execute the behavior.

Applying the Theory of Planned Behavior in Health and Medical Coaching

As coaches, we can address these three beliefs to help clients strengthen their behavioral intentions to perform a specific health-related action by:

Attitudes

- Inviting the client to become more educated about the results of this behavior.
- Focusing on the behavior's positive outcomes.
- Inviting the client to examine their belief system and explore more perspectives

Subjective Norms

- Addressing social influences that affect a client's perception of what their peers or family think they should do.
- Encouraging the client to expand the existing support system and involve more people with various perspectives.
- Encouraging the client to build a supportive social network of like-minded individuals who can encourage healthy behaviors.
- Inviting the client to examine their belief system and explore more perspectives about social norms.

Perceived Behavioral Control

- Helping the client improve their confidence in their ability to perform the behavior successfully.
- Helping the client develop skills and strategies to overcome potential obstacles and challenges.

This theory provides a framework for designing coaching interventions that are tailored to a client's personal beliefs and social environment, increasing the likelihood of long-term behavior change.

The Common Sense Model of Self-Regulatory (CSM)

The Common-Sense Model of Self-Regulation (also referred to as the "Common-Sense Model", or CSM), developed by Howard Leventhal and colleagues, is a widely used theoretical psychological framework that explicates the processes by which patients become aware of a health threat, navigate affective responses to the threat, formulate perceptions of the threat and potential treatment actions, create action plans for addressing the threat, and integrate continuous feedback on action plan efficacy and threat-progression.

In other words, the model explains how individuals construct perceptions of their health threat/ illness, based on cognitive and emotional representations of their condition, and manage their thoughts, emotions, and behaviors to achieve their health goals.

The model proposes that individuals develop a "common-sense" understanding of their health threat based on six dimensions (five cognitive dimensions and one emotional dimension):

- **Identity:** The label or name given to the condition, including the symptoms and signs associated with it.
- **Timeline:** The belief about the duration of the illness, such as whether it is acute, chronic, recurring, or terminal.
- **Consequences:** The perceived physical, social, and economic impact of the condition.
- **Cause:** The belief about what caused the condition.
- **Control/Cure:** The perception of whether the condition can be cured or controlled, either by oneself or through medical intervention.
- **Emotions:** The emotions evoked by the condition, such as fear, anxiety, or anger. and it interacts with cognitive beliefs.

These dimensions guide their coping actions, which are then assessed and evaluated to update future beliefs and behaviors.

Example:

A person with a headache, exhibiting no additional symptoms.

- **Identity**:
  The person labels the headache a 'regular headache' and recognizes that this is something that occasionally happens.
- **Timeline:**
  The person believes it is non-threatening and chooses to take a mild painkiller and wait 30 minutes.
- **Consequences:**
  The person perceives the consequences as minor—perhaps a bit of discomfort while they are waiting for the pain to subside.
- **Cause:**
  The person believes the headache was caused by a common factor, like mild dehydration.
- **Control/Cure:**
  The person believes they can manage it with simple actions like taking a mild painkiller and drinking fluids.
- **Emotions:** The person feels confident that the actions will resolve the temporary discomfort.

After 30 minutes, the person assesses the situation.

Scenario A: If the symptoms dissipate, the strategy of taking a mild painkiller, drinking more fluids, and waiting 30 minutes is assessed as effective, leading the person to confirm their original belief that this was a minor headache. The experience will further reinforce the person's internal representation of a mild headache and the associated successful coping strategy.

Scenario B: If the symptoms persist, the strategy of taking a mild painkiller, drinking more fluids, and waiting 30 minutes is assessed as ineffective, prompting the person to modify and update the original strategy.

- **Identity**:
  The person labels the headache a 'moderate headache' and recognizes that this is something that occasionally happens.
- **Timeline:**

  The person believes they did not give the medication enough time to work, did not wait long enough for it to work, and that there are additional mitigating factors like moderate dehydration and stress.
- **Consequences:**

  The person chooses to wait another hour and proceeds to drink more fluid and do breathing exercises.
- **Cause:**

  The person believes that a combination of moderate dehydration and stress caused the headache.
- **Control/Cure:**

  The person believes they can manage it with additional drinking, stress management techniques, and additional waiting.
- **Emotions:** The person feels annoyed but still confident that the actions will resolve the temporary discomfort.

An hour later, the person assesses the situation.

Scenario A: If the symptoms dissipate, the strategy is assessed as effective, leading the person to confirm their original belief that it was a moderate headache caused by dehydration and stress. The experience will further reinforce the person's internal representation of a moderate headache and the associated successful coping strategy.

Scenario B: If the symptoms persist, the strategy is assessed as ineffective, prompting the person to modify and update it.

If, after several assessments where the coping strategy is updated, applied, and found ineffective in reducing headache symptoms, the person may conclude that their internal representation of the headache was initially incorrect. They may then seek to update it by searching for other illness prototypes that match the representation.

This may, in turn, lead them to seek an alternative coping procedure for dealing with a health threat whose cause is uncertain, such as seeking medical attention.

The assessments are dynamic feedback that permits the updating of internal representations and coping strategies.

The coaching process supports the client in creating clarity around each dimension, structuring a coherent assessment process, and updating the strategy.

Replacing a Belief

A process of replacing a limiting belief has three 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 different beliefs about the same issue? What is that belief? _____

_____

_____

_____

What is it that I am 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 take when I believe this new belief?

What value will I be honoring when I believe in 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 two anchoring techniques you learnt.

Core beliefs

Core beliefs are fundamental to our belief system.
They are formed between birth and age five, when our learning is mostly unconscious.

Core beliefs can be empowering or limiting.

To reveal a core limiting belief, we need to ask a series of questions to clarify and reframe the multiple layers of thoughts and beliefs that encompass it.

This inquiry can be done on a conscious or subconscious 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 thing that can happen to you?

Trauma and the creation of beliefs

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

Prime Directives of the Subconscious Mind

1. Stores memories (temporal - in relationship to time and Atemporal - 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 subconcious mind is like a pilot.

It has directions, a destination, and it gives instructions based on the changing environment.

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 involves transitioning from affirmations about the given external reality to affirmations about a desired inner reality.

It "looks" like this:

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…

Exemplos de afirmações sobre uma realidade interna desejada

- As you are breathing, notice the place of relaxation in your body…
- Your subconscious 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, and you can simply let them go…
- You can notice the way the relaxation is following my voice…
- You can notice the way your body is getting more and more relaxed…

Creating Inner Congruency – Working with Inner Parts/ Representations

Parts Therapy

The concept of working with inner parts is based partly on a systemic approach and partly on Parts Therapy, which posits 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 number 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 a subconscious level. Our parts make up our state of mind, our being, choices, and conduct.

As Health and Medical Coaches, we help our clients have a dialogue with their inner system and its parts to resolve conflicts, update beliefs and values, create new behaviors, heal trauma, and anchor 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' involves creating a dialogue with the specific part responsible for the unwanted behavior to discover 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 responsible for 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.

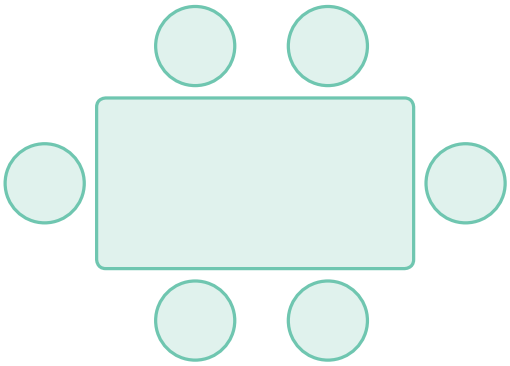
   Ask the part: "What is the positive thing that you want for the client?"
8. After revealing the Positive Intention, mirror to the part the gap between the intention and the actual behavior.
9. Ask the part's permission to change the behavior and create an agreement.
   The agreement:
   The part will 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 your client out of relaxation, debrief them on the process, and present the agreement with the party.

*** 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 they love** 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 they 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 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 (in that order). Allow integration.
10. Guide the client out of relaxation and then 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.

Health and 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.

For some clients, the relationship with their 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 Health and Medical Coaches, we listen to the client's narrative to understand the nature of these relationships.

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 poisons.
- 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 one person in the relationship – 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 relationships is Perceptual Positions.

Perceptual Positions is another variation of 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, feel, and sense things from another person's viewpoint. I am not becoming this person, but having an experience of being that person in a specific context, as if I have temporarily 'stepped into their shoes'.

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 the situation I am in as part of a larger group with a distinct identity and perspective, as if I am one part of 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 emotions. I am aware of my beliefs, values, desires, and boundaries. I am assertive and express myself authentically.	I see through my eyes, hear through 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 can lead to a loss of self.	Second position helps me to be empathetic, compassionate, and 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. 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 Health and 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 creates flexibility and the enrichment of inner maps.

We use Perceptual Positions to help our client heal relationships in their life with others, the body, illness, or a specific organ.

'Perceptual Positions' is NOT Transactional Analysis (TA)

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

In Health and 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 they would/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 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 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 they would/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 the 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 time to integrate the new learnings

9. Ask the client: What is different now? What becomes possible?

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

Adherence to Change

Clients come for coaching to create sustainable changes in their lives.

To understand sustainability in the context of health and illness, we need to familiarize ourselves with the following professional terms:

Compliance is a patient's passive act of meeting external expectations and following instructions, often without the patient's input or a shared decision-making process.

Examples:

- A patient is given a prescription for medical treatment and is instructed to fill it out in the pharmacy and take it as prescribed.
- A patient receives written guidelines regarding nutrition and exercise and is told to follow them.

From a Health and Medical Coaching perspective, coaching a client on compliance is based on a behavior approach.

Adherence is a patient's active and mutual agreement with a healthcare provider to follow a treatment plan. This is a proactive and positive partnership that emphasizes shared responsibility, patient autonomy, and empowerment.
Adherence ensures internal alignment with values, beliefs, and behaviors,

Examples:

- A patient has a discussion with the doctor about relevant treatment options. They address clinical pros and cons, the client's lifestyle, the client's support system, questions, and concerns. They agree on treatment, follow-up, and accountability.
- A patient works with their doctor to make lifestyle changes around nutrition and exercise, and they both agree on health goals and a plan.

From a Health and Medical Coaching perspective, coaching a client on adherence is based on a relationship approach.

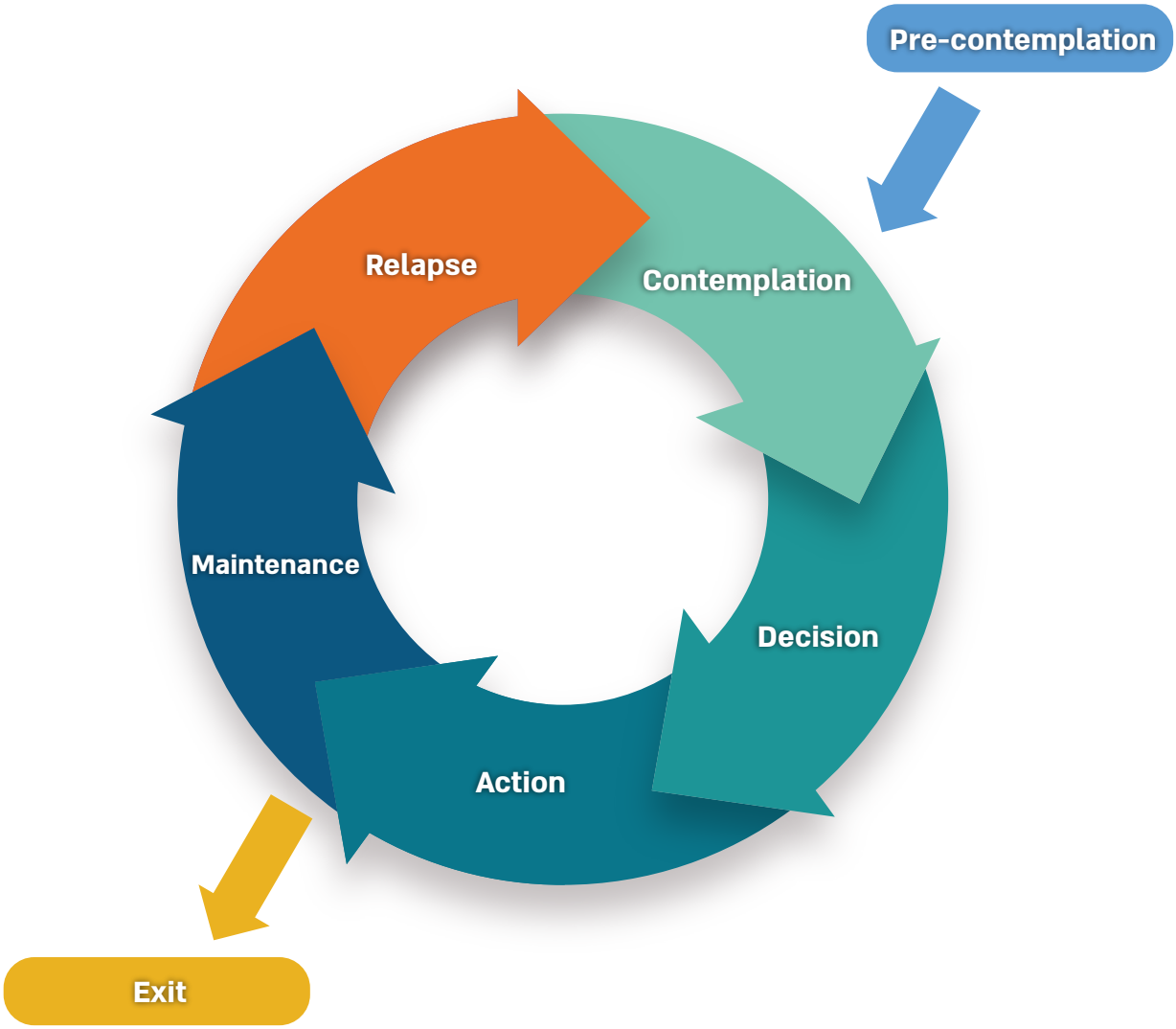
The medical field is shifting away from the term "compliance" because it suggests a one-sided authority dynamic and places blame on the patient if they don't follow instructions. This is part of a bigger shift to a more patient-centered approach, acknowledging that successful treatment depends on a partnership in which the patient feels involved and invested in the plan, hence an active participant in their own health.

The Transtheoretical Model (TTM)

The Transtheoretical Model (TTM), also known as the Stages of Change Model, is a theory describing behavioral change as an intentional process that unfolds over time and involves progress through a series of stages: precontemplation, contemplation, preparation, action, maintenance, relapse, and exit.

It was developed by psychologists James O. Prochaska and Carlo DiClemente in the late 1970s and is used to tailor interventions based on an individual's readiness to change.

Since then, it has been endorsed by the World Health Organization and widely used across different sectors of healthcare to assess people's motivation and adherence to change, as well as to develop intervention programs addressing various health concerns, from smoking to diet, alcohol consumption, and physical activity.



Stages of the Transtheoretical Model:

Precontemplation (I'm not ready yet)

People in the Precontemplation stage do not intend to take action in the foreseeable future, usually measured as the next six months.

Reasons for being in the Precontemplation stage:

- Being uninformed or underinformed about the consequences of one's behavior.
- Multiple unsuccessful attempts at change can lead to limiting beliefs about the ability to change.

Many times, people in Precontemplation are labeled as stuck, resistant, unmotivated, noncompliant, or unready for help.

Key coaching and behavioral strategies:

1. Address and focus on the positive aspects (the Pros)
2. Educate yourself about the facts
3. Pay attention to the emotions and the emotional state
4. Notice social trends
5. Start building confidence through small steps

Contemplation (I'm getting ready)

People in the Contemplation stage intend to start the process of change in the next six months.

They are aware of the pros and cons of starting the process and of not starting it.

At times, this can create ambivalence that causes people to remain in this stage for long periods.

Oftentimes, this is labeled as procrastination.

People in the Contemplation stage are not ready for traditional action-oriented programs that expect participants to act immediately.

Key coaching and behavioral strategies:

1. Address Pros and Cons and focus on the Pros
2. Educate yourself about the facts
3. Address self-confidence and agility
4. Pay attention to the emotions and the emotional state
5. Notice the effect on others
6. Notice social trends
7. Start building confidence through small steps

Decision (I'm preparing to take action)

People in the Decision stage intend to take action in the immediate future, typically within the next month.

They have an action plan in place and benefit from action-oriented programs.

Key coaching and behavioral strategies:

1. Continue building confidence by planning ahead.
2. Address self-image
3. Make a commitment
4. Create an action plan
5. Pay attention to the emotions and the emotional state
6. Clear limiting beliefs and negative self-talk
7. Address support systems

Action (Here I go…)

People in the Action stage are making specific overt modifications in their lifestyles.

Key coaching and behavioral strategies:

1. Increase confidence
2. Address support
3. Create rewards
4. Clear limiting beliefs and negative self-talk

Maintenance (I'm good…)

People in the Maintenance stage are enjoying the results of their behavioral changes and are working to prevent relapses.

At this stage, we typically observe increased confidence in the ability to continue the change, alongside a decrease in the application of processes compared to the Action stage.

Based on self-efficacy data, researchers have estimated that Maintenance lasts from six months to about five years.

Key coaching and behavioral strategies:

1. Keep confidence high by planning for unexpected situations
2. Address support
3. Use rewards
4. Clear limiting beliefs, negative self-talk, and triggers

Relapse (I failed)

People in the Relapse stage experience failure as the process has stopped.

Many times, people in this stage will internalize the experience and will give up altogether.

This stage is normal and should be expected and accepted as part of the process.

Key coaching and behavioral strategies:

1. Pay attention to the emotions and the emotional state
2. Use emotional and nervous system regulation techniques when needed
3. Reframe the relapse from failure to a learning opportunity
4. Clear limiting beliefs, negative self-talk
5. Address and focus on the positive aspects (the Pros)
6. Educate yourself about the facts
7. Notice social trends
8. Start building confidence through small steps

Exit/Termination (I don't need this anymore)

This is a less commonly used stage.

People in the Exit/Termination stage have completed the process and successfully changed their behavior. They no longer have the temptation to revert to old habits.

In this stage, the new behavior is stable and ingrained in the person's life.

Relapse is no longer a risk, and there is no need to maintain adherence actively.

Key coaching and behavioral strategies:

1. Celebrate wins
2. Reflect on the process and create a model for the future
3. Address self-confidence and agency

Clients' Narratives and TTM

1. Client narratives help us extract the self-defeating stories and limiting beliefs that ultimately prevent them from moving to the next stage.
2. Client narratives help us uncover and overcome the "Perception Gap Phenomena" – the gap between the healthcare practitioners' perspectives and the patient's perspectives about the medical condition and the process of change.

The Relapse Prevention (RP) Model

The Relapse Prevention (RP) Model is a cognitive-behavioral (CBT) model designed to help people identify and cope with high-risk situations and triggers to prevent them from relapsing to problematic behaviors.

The model was developed by G. Alan Marlatt and Judith Gordon in 1985 and is regarded as an essential innovation in the field of addiction recovery.

The Relapse Prevention Model relies on the idea that relapse is a gradual process. It begins before stopping the new behavior and ends after the person returns to the old one.

Principles of the Relapse Prevention Model

1. Enhancing self-efficacy by celebrating developmental milestones
2. Boosting confidence and agency
3. Changing internal and external factors, such as the environment, fulfillment, social connections, and emotional coping skills
4. Incorporating self-care
5. Establishing support systems
6. Promoting lifestyle changes
7. Nurturing personal growth

In Health and Medical coaching, this model is used to understand the broader concept of relapse. It supports clients who continue to struggle with adherence, whether as a single event or over time, by identifying high-risk situations and developing personalized coping strategies and action plans.

This involves helping clients anticipate triggers, understand the early warning signs of a relapse, and build the skills and self-efficacy to manage those situations. A key component is normalizing the idea that a relapse is not a failure or a cause for shame, but a setback and a learning opportunity.

The key principles of the model are:

- Identify high-risk situations:
- Develop coping strategies
- Change thinking patterns
- Increase self-efficacy
- Understand relapse as a process
- Create a personalized plan

How health and medical coaching applies the model

- **Identifying triggers and high-risk situations:**

  Coaches work with clients to recognize internal and external cues that might lead to a relapse, such as specific emotions, thoughts, people, or places.

- **Developing coping strategies:**

  Coaches help clients create personalized protocols that include cognitive, emotional, communicational, and behavioral skills to manage triggers.

- **Building self-efficacy:**
  Coaches help clients build confidence in their ability to cope with challenges by creating and executing action plans.

- **Promoting a holistic lifestyle:**
  Coaches help clients incorporate healthy behaviors that promote overall wellness.

- **Normalizing and learning from lapses and relapses:**

  Coaches help reduce shame and guilt, through the reframing of the experience so that it can serve as a learning opportunity.

- **Focusing on maintenance:**

  Coaches help clients focus on the long-term benefits of their new behaviors, how these align with the client's values, and how they serve the client's vision.