# Health and Medical Coaching Training Program

## Module 3 – Advanced

# Contents:


**Mind – Body Connection from a Health and Medical Coaching Perspective 4**

- Embodiment – Working with the Body 5
- EFT - Emotional Freedom Technique 6
- Felt Sense 18
- Somatic Core Dimensions of Body Movement 20

**Emotions 21**

- The Relationship between Emotions and the Body 21
- The Biochemistry of Emotions 23
- Coaching Clients Through Emotional States 25
- Emotional Agility 30
- Deep Dive into Specific Emotions and Emotional States 32
- Emotional First Aid in the Coaching Space 36

**Trauma and Post-Traumatic Growth 39**

- The 6 Trauma Responses 42
- The Tearless Trauma Technique (EFT) 43
- Rotating in Space Technique 44
- Breaking Space Technique 45
- Post-Traumatic Stress Disorder – PTSD 46
- Diagnostic Shock 47
- Post -Traumatic Growth (PTG) 48

**Grief and Loss 50**

- Loss 50
- Grief 51
- The Theory of Grieving/ The Five Stages of Grief - Dr. Elizabeth Kubler-Ross 51
- The Two-Track Model of Bereavement – Shimon Shimshon Rubin 54
- The Dual Process Model of Grief/Margaret Stoebe and Henk Schut (DPM) 55
- Anticipatory Grief 58
- Coaching grieving clients 59
- Writing a Loss History 61
- End-of-life 62
- Dying 63

**Stress 64**

- Introduction to Stress 64
- The Relationship Between Stress, Health, and Illness 66
- The Connection Between Stress and the 6 Trauma Responses 70
- Burnout 73
- Compassion Fatigue 75
- The B.T.R.S. model 76

**Self-care** 77

- Obstacles to self-care 77
- The Health and Medical Coaching Self-Care Matrix 79
- Self-care for Coaches 81

**Pain** 82

- **Emotional Pain** **82**
- Conflicts 83
- **Physical Pain** **88**
- Coaching Clients Through Acute Pain 88
- Coaching Clients Through Chronic Pain 89

**Survivorship** 93

**Health Literacy** 94

- The Health Literacy Pathway Model 95

**The Bio-Psychosocial–Spiritual (BPSS) model** 96

**Health and Medical Coaching in Clinical Settings** 97

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**Health and Medical Coaching Training Program**

**Module 3 – Advanced**

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

In this model, we focus on advanced aspects of coaching in a health and medical context.

# Mind – Body Connection from a Health and Medical Coaching Perspective

We are all living, organic, biological, chemical, emotional, and energetic systems that exist and function within larger social, energetic systems that we share with other living, organic, biological, chemical, emotional, and energetic systems.

This means that we are not coaching a health or medical problem, challenge, or issue; we are coaching a human system with one. For this reason, Health and Medical Coaching needs to be holistic and integrative in both its approach and its practice.

A holistic approach and its practice are more than seeking answers in alternative medicine; they are a way of life.

To fully understand the holistic approach to life and medicine, we need to understand its opposite—the Reductionist Approach.

**The Reductionist Approach** – seeks to understand how each part of the system works to comprehend the system as a whole.

**Reductionist medicine** – looks at organs and systems separately.

Reductionist medicine asks: How is each symptom unique and different from others?

**The Holistic Approach** seeks to understand the synergy among all parts of the system to comprehend the system as a whole.

**Holistic medicine** views the body as an integrated system that depends on reciprocal relationships among all its parts to function fully. When one part fails, the entire system is affected.

Holistic medicine asks: what do all the symptoms have in common?

When looking at human experience from a holistic perspective, we can identify four aspects of the human body that co-exist:

**The Physical Body** – holds the anatomical, physiological, pathological, chemical, mechanical, and biochemical aspects of our being.

**The Emotional Body** – holds the emotional aspects of our being.

**The Mental Body** – holds our opinions, perceptions, thoughts, and values through patterns, meta-programs, and beliefs.

**The Energetic Body** – holds our energetic system and our relationship with a higher being (however we choose to name or define it).

From a holistic perspective, the physical body mirrors the emotional, mental, and energetic bodies.

## Embodiment – Working with the Body

Embodiment is an approach through which we relate to, focus on, and work with the body as more than a physical form, but as a "whole person", a system of wisdom, emotion, and action.

In simple words. Embodiment is the bodily context of 'the way we are, our manner of being.

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*"We are our body… we perceive the world with our body…we are in the world through our body."*

*- Merleau Ponty*

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When we incorporate embodiment into coaching, we move beyond a talk-based interaction to working directly with the nervous system, treating the body as the primary site of lasting transformation.

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

We tend to go to the body to assess our capabilities, just as we tend to confuse our emotions with bodily sensations. When the body fails us, betrays us, and/or becomes a source of pain, shame, and disappointment, it is only natural that we disconnect from it. Often, talking about the body without being with it, embodying it.

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

In Health and Medical Coaching, we use embodiment as a practice of healing the relationship with the sick and wounded body for the sake of 'coming back home' to the body and the authenticity of being in the world. This is an act of radical faith and choice. It is a choice to live fully, not just to be alive.

Since we use embodiment in a coaching, not a therapeutic, setting, we avoid touch, we contract with our clients, and follow the HMCI – Health and Medical Coaching Code of Ethics.

## EFT - Emotional Freedom Technique

EFT (Emotional Freedom Technique), also referred to as Tapping, is considered a form of Energy Psychology or Psychological Acupressure.

EFT uses the same Chi energy and meridians as traditional acupuncture has for over 3,000 years.

We gently tap with our fingertips on acupuncture points, stimulating the body's energy system, while thinking about a specific issue

As we do that, energy moves, emotions shift, and we experience a clearing or release.

The combination of stimulating our body's bioenergy system and voicing our thoughts – while feeling the emotions – helps clear a previously stuck energetic pattern and restores our mind and body to balance.

This allows new, empowering, resourceful, creative, healthy, loving, joyful, and peaceful thoughts and emotions to emerge.

The modern version of EFT, as we know it today, was created by Gary Craig.

There is a lot of information online about EFT and many demonstrations on YouTube.

As you go deeper into EFT and look at other practitioners' work (which I highly recommend you do), you will notice that practitioners have different styles of tapping and preferences for tapping points.

When you become more competent and more experienced with EFT, you will find your own style.

My personal belief is that the actual points you tap on aren't nearly as important as stimulating the energy system and feeling the emotions.

Feelings that are "buried" do not die; they get trapped in our system, and when triggered, they express themselves emotionally, mentally, and/or physically.

*When tapping – speak the truth about what you feel.*

# The Scientific Aspect of EFT

*Quotations from the article: 'Breakthroughs in Energy Psychology:* ***A New Way to Heal the Body and Mind'****, , by Nick Ortner. Posted on the Huffington Post, 03/17/2012*

*http://www.huffingtonpost.com/nick-ortner/emotional-freedom-technique_b_1349223.html*

Dr. Dawson Church, Ph.D., from the Foundation for Epigenetic Medicine, Santa Rosa, California, has been researching and using EFT since 2002. Because EFT simultaneously accesses stress on physical and emotional levels, he adds, "EFT gives you the best of both worlds, body and mind, like getting a massage during a psychotherapy session."

In fact, it's EFT's ability to access the amygdala, an almond-shaped part of your brain that initiates your body's negative reaction to fear, a process we often refer to as the "fight or flight" response, that makes it so powerful. "By reducing stress," adds Church, "EFT helps with many problems. When you reduce stress in one area of your life, there's often a beneficial effect in other areas."

In partnership with Dr. David Feinstein, Dr. Church has confirmed that tapping specific meridian points has a positive effect on cortisol levels. Cortisol, known as the "stress hormone," is integral to our body's "fight or flight" response.

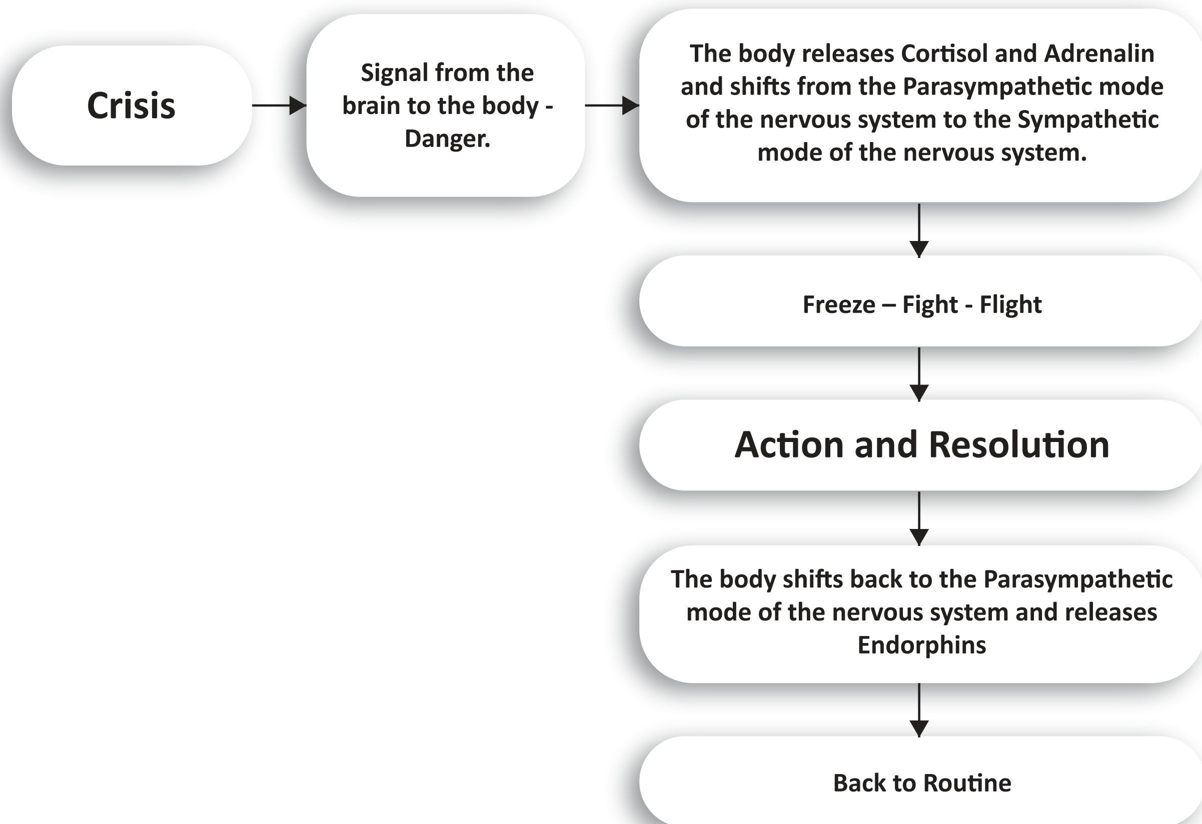
In Dr. Church's study, 83 participants were separated into three groups. One group was guided through an hour-long EFT session; the second group received an hour of talk therapy, while the third, the control group, received no treatment. The group that did an hour of EFT demonstrated a 24% decrease in cortisol levels, while the other two groups showed no significant change. The EFT group also exhibited lower levels of psychological symptoms, including anxiety, depression, and others, as measured by the Symptom Assessment-45 (SA-45), a standard psychological assessment tool.

Research suggests that EFT may be so effective because of its perceived ability to balance out the nervous system, levelling off the activity of the parasympathetic and sympathetic regions. Responsible for promoting cell regeneration and relaxation, the parasympathetic region helps to slow your heartbeat, support digestion, and more. The sympathetic system, on the other hand, prepares you for vigorous physical activity by speeding up your heart, constricting your pupils, and so on. As noted in Church's study, an imbalance between these two regions is associated with a long list of health issues, from high blood pressure and heart problems (most often seen in those with an overactive sympathetic region) to depression, fatigue, and weakened immune response (in those with excessive parasympathetic activity).

In his study findings, Church asserts that EFT, which he refers to as "acupoint treatments," produces "a neutral emotional state," which, biologically speaking, is the gold standard of health and wellness.

(For full study, go to - *http://www.eftuniverse.com/images/stories/epimechpaper.pdf*)

**In conclusion**, from a physiological perspective, EFT helps the body balance the nervous system by reducing high cortisol levels associated with sympathetic activation, thereby shifting the nervous system from sympathetic to parasympathetic, allowing us to return to a balanced state.




## What can we use EFT for?

- Cravings
- Any emotional upset
- Repetitive thoughts
- Haunting memories
- Procrastination
- Overwhelm
- Pain
- Insomnia
- Goal setting
- Headaches
- Fatigue

As Gary Craig (the originator of EFT) said, ***"Try it on everything!***

*Let's be honest, this stuff can look silly!*

*Some people are put off by the look of emotional tapping; others find it unscientific.*

*The bottom line is that the positive effects of EFT are undeniable, and... we can always tap on feeling silly.* ☺

## A few points before we start tapping...

- We tap using several fingers
- It is best to tap with the fingertips (this way we also stimulate the energy meridians on the fingertips)
- We tap as hard as we might tap on a table

## The 4 C's of tapping

There are 4 principles to a good tapping session. Gwyneth Moss calls them the 4 C's.

1. **Calming** – bringing down the level of emotional intensity
2. **Connecting** – maintaining the emotional connection to the topic
3. **Clearing** – clearing emotions to reveal deeper issues
4. **Completing** – making sure all aspects of the topic have been cleared and the change is ecological and applicable to the client'slife

## Basic EFT

***1. TUNE IN AND ASSESS***

- Get the topic/issue.

  The first step in EFT tapping is to assess the intensity of the emotion. Since we have no scale to stand on, the assessment is subjective.

- Tune in to what your inner voice is saying about the issue.

  Get the intensity of the related emotions right now. Get an intensity number from 0 to 10.

  Zero means there is no emotion about the issue. Ten signifies the maximum emotional intensity.

- Note the starting number on paper. This will be your baseline. You will continually reassess it as you go through the process

***2. THE SET UP***

This part of the process is designed to pacify the subconscious gatekeepers who want to keep you safe in your familiar patterns.

Start tapping on the side of the hand and say,

Even though I have ____________(name the issue), I love and accept myself.

Make this statement three times, while tapping continuously on the side of the hand.

In the first part of the setup phrase, you fill in the blank with a short description of the problem or the issue.

**Examples:**

*Even though I feel overwhelmed... Even though I'm sad right now...*

*Even though I have this throbbing headache...*

*Even though I have this craving for______________...*

The second part of the setup phrase is an affirmation or a positive statement about yourself. The most basic affirmation we use is: 'I love and accept myself'.

If that doesn't sit well or feel authentic, there are other possible affirmations you can use, such as:

*Even though I have _(the issue)_, I accept myself and all my feelings.*

*Even though I have _(the issue)_, I accept myself right now.*

*Even though I have _(the issue)_, I'd like to accept myself just as I am.*

*Even though I have_(the issue)_, I know I'm ok.*

Examples, with the whole setup statement:

*Even though I feel overwhelmed, I love and accept myself.*

*Even though I'm feeling depressed, I accept myself and all my feelings.*

*Even though I am terrified about the operation I need to do, I'd like to accept myself just as I am. Even though I have this throbbing pain in my leg, I know deep down I'm ok.*

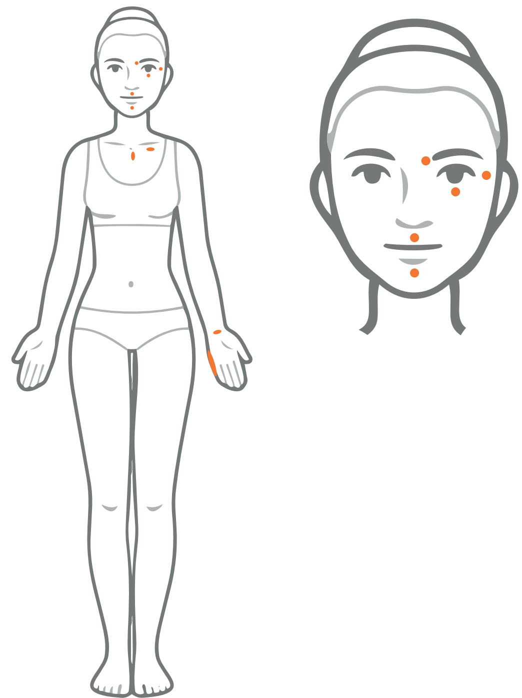
*Even though I have this craving for a cigarette, I'm ok.*

***3. <u>TAPPING</u>***

After the Tapping set-up, start 2-3 tapping "rounds" on the meridian points.

At each point, you name the issue.

The tapping round begins and ends at the side of the hand.



These are the tapping points:

- Eyebrow
- Side of Eye
- Under Eye
- Under Nose
- Chin
- Collarbone
- Thymus
- Under Arm
- Wrist

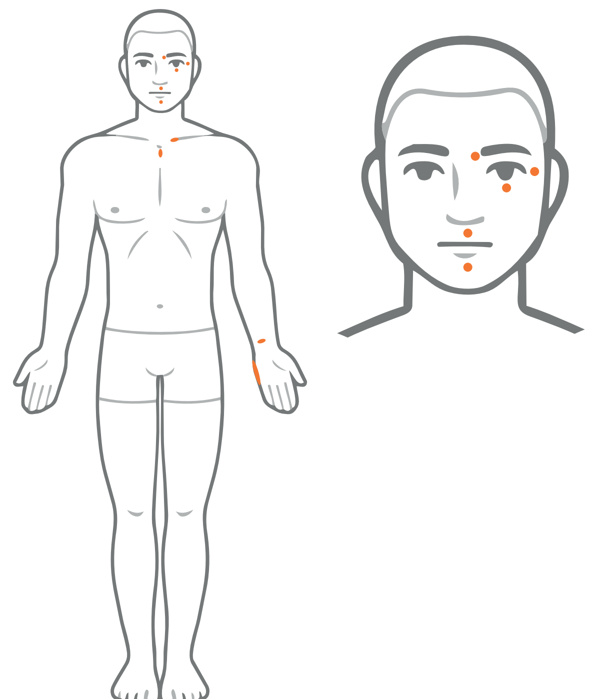
That is one round.

Repeat at least two more times

**<u>Example</u>**:

Let's say the problem is that you are feeling overwhelmed.

At each point, you can repeat the statement: "This overwhelm."



Eyebrow: This overwhelm

Side of Eye: This overwhelm

Under Eye: This overwhelm

Under Nose: This overwhelm

Chin: This overwhelm

Collarbone: This overwhelm

Thymus: This overwhelm

Under Arm: This overwhelm

Wrist: This overwhelm

That is one round. Repeat at least two more times.

### *4. DEEP BREATH*

Take a deep breath.

This helps move energy, oxygenates the mind and body, and helps bring mental clarity. It's also recommended to drink water at this point.

### *5. REASSESS INTENSITY*

Tune in and reassess the issue's intensity level on a scale of 0-10. Ideally, you will keep tapping until the intensity reaches zero.
Notice if a new issue arises and start a new set of tapping.

## Using EFT with Clients

When we use EFT with clients, we become the facilitators of the tapping process.

1. We do not tap on the client. We mirror the tapping points by tapping on ourselves.

2. Client names the issue and the intensity.

3. We lead the tapping by speaking out loud about the issue, and the client repeats after us.

4. During the process, we check new intensity levels and get curious about new issues that may have come up.

5. We integrate tapping into the coaching process.

# Advanced EFT

Basic EFT is great for simple daily issues and upsets, such as irritation, hurt feelings, anxiety, worry, frustration, or overwhelm.

But there are times when basic tapping isn't enough, and you need a tapping technique that goes deeper – an advanced tapping technique.

Advanced tapping is similar to the basic tapping technique, with a few additions.

1. We make a list of all the information that comes up as the client connects emotionally to the issue
2. We elicit the sub-modalities of the information
3. We use that list as tapping phrases

### *1. TUNE IN AND ASSESS*

- Get the topic/issue and its emotional intensity
- Tune in and write down the related emotions, their intensity level from 0 – 10
- Explore relevant sub- modalities
- This information is your baseline

### *2. THE SET UP*

Even though I have (name the issue), I love and accept myself.

Make this statement three times, while tapping continuously on the side of the hand.

Tap continuously on the karate chop point, state the problem, and affirmation three times

### *3. START TAPPING*

- Start tapping on the tapping point using the information (emotions and sub-modalities) you explored with the client
- Encourage the client to vent anything else that comes up as you are both tapping together

### *4. DEEP BREATH AND REASSESS*

* Tap for 3 rounds

- Take a deep breath and reassess all the information on the list
- Notice if there are any new emotions or submodalities. If there are, add them to the list.

### *5. NEW SET UP*

* Start a new setup and keep tapping until you have brought all the intensities down to the lowest level the client can bring them to, at that point in time.

Although, as Health and Medical Coaches, we strive to bring the intensity down to zero, we need to ensure this aligns with the client's belief system and values.

When practicing advanced tapping, we can consider which emotion and body function are associated with each tapping point according to Chinese Medicine.

This is a list of emotions and body functions connected to the tapping points we use:

- *Side of the hand (KC) – Small Intestine Meridian*

  Releases: Psychological reversal (feeling stuck or frozen), inability to let go, resistance to change, sorrow, feeling vulnerable, worry, obsession, compulsive behavior.

  Allows: Ability to move forward, letting go of the old, healing from grief, finding happiness in, and connecting to the present moment.

- *Eyebrow (EB) - Bladder Meridian*

  Releases: Trauma, hurt, sadness, restlessness, frustration, impatience, and dread.

  Allows: Peace and emotional healing.

- *Side of Eye (SE) - Gall Bladder Meridian*

  Releases: Rage, anger, resentment, fear of change, and muddled thinking.

  Allows: Clarity and compassion.

- *Under Eye (UE) - Stomach Meridian*

  Releases: Fear, anxiety, emptiness, worry, nervousness, and disappointment.

  Allows: Contentment, calmness, and a sense of safety. “All is well.”

- *Under Nose (UN) - Governing Meridian*

  Releases: Embarrassment, powerlessness, shame, guilt, grief, fear of failure.

  Allows: Self-acceptance, self-empowerment, and compassion for self and others.

- *Chin (CH) - Central Meridian*

  Releases: Confusion, uncertainty, shame, embarrassment.

  Allows: Clarity, certainty, confidence, and self-acceptance.

- *Collarbone (CB) - Kidney Meridian - Adrenal Gland Function*

  Releases: Psychological reversal, feeling stuck, indecision, worry, and general stress.

  Allows: Ease in moving forward, confidence, clarity, and elevating Qi levels.

- *Thymus*

  Releases: Trauma, stress.

  Allows: Adaptation of the immune system.

- *Under Arm (UA) - Spleen Meridian*

  Releases: Guilt, worry, obsession, hopelessness, insecurity, and poor self-esteem.

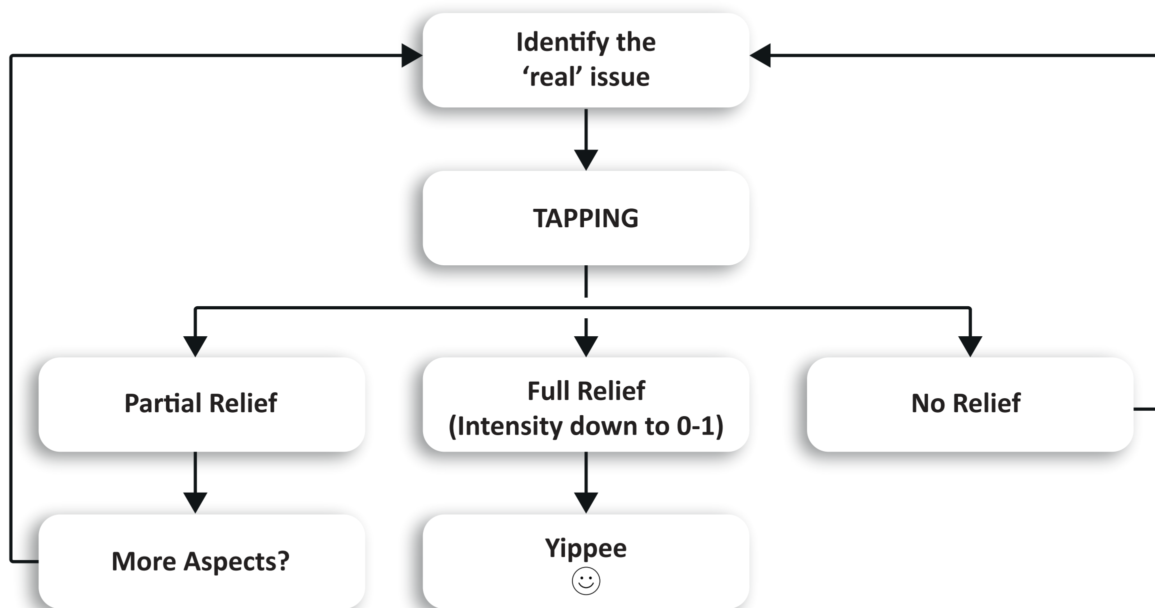
  Allows: Clarity, confidence, relaxation, and compassion for self and others.

- *Wrist – replaces the Top of the Head point (‘Hundred Meeting Points’ Meridian)*

  Releases: Inner critic, ‘gerbil wheel’ thinking, lack of focus.

  Allows: Spiritual connection, insight, intuition, focus, wisdom, clarity.

## The EFT process flow chart:




### *A few important tips:*

- Venting is good when doing EFT!
  We tend to ignore those childish, whining parts of us that want to be cuddled, want approval, feel insecure, and just want to be heard. Devoting a few rounds to express those thoughts and emotions can help release emotional 'garbage', integrate all our parts, and heal (and it really feels good!)
- After each one or several rounds of tapping, stop and take a deep breath. This helps move more energy and clear your thoughts
- After taking a deep breath, tune in again and notice what you are feeling and thinking about the issue
- You can say the words out loud or to yourself – as long as you stay focused on the issue you are tapping on

**What if 'I love and accept myself' doesn't work for the client?**

The 'I love and accept myself' affirmation is just one option among many. If it doesn't feel 100% sincere and authentic, find one that does.

Here are some alternatives to the "I love and accept myself" statement:

Even though I__________________, I accept myself and all my feelings. Even though I____, I accept myself no matter what.

Even though I__________________, I accept myself right now. Even though I_____, I accept myself just as I am. Even though I_______________, I know deep down I am good. Even though I_, I'm ok.

Even though I__________________, deep down I know I'm ok. Even though I_____, God loves me.

Even though I__________________, I would like to accept myself.

Even though I__________________, it would be great if I could accept myself no matter what. Even though I , I'd like to be able to accept myself.

Even though I__________________, I can imagine the possibility of beginning to accept myself someday.
Even though I__________________, I'm tapping on it.

Even though I__________________, that's ok. Even though I_____, I'm alive.

## Things that can sabotage tapping or make it ineffective:

1. Alcohol, drugs, or chemical toxins
2. Inadequate water in the system. If you haven't drunk enough water, or have consumed only drinks like coffee, tea, juice, or soda, drink water and begin EFT again
3. You are not tuned in emotionally to the issue. You are tapping, but not really feeling it
4. There is a conscious or unconscious secondary gain
5. There is a conflict
6. You are not tapping on the real issue

You began tapping, and suddenly the client feels ***worse…***

**Option # 1** - You have probably tapped into a greater well of emotion than the client realized was there.

This is a good sign, because that deep emotion has been affecting the client without him/her being aware of it.

Continue tapping and remember that the work you are doing is life-transforming.

**Option # 2** – the client feels a new unsettling emotion that wasn't present when you began tapping.

This is also a good sign, as our thoughts, feelings, and beliefs around the events of our lives can have many layers. Like the layers of an onion, we need to peel those layers to get to the core issue so that we can release it.

Continue tapping. Remember that the work you are doing is life-transforming.

***EFT and serious/chronic illness***

- To appropriately approach an issue that concerns a chronic illness, we must first dispose of the "one-minute wonder" misconception about EFT
- Even though applying EFT to health issues may result in "one-minute wonders" on some of the symptoms, one cannot assume that EFT will dispose of the broader underlying causes so easily
- The idea of a "one-session wonder" is a perception; in reality, it is the exception to the rule

## Tapping with Children

EFT is a great tool to use with children.

When tapping with children, remember to use age-appropriate language AND keep it simple and playful.

## When is it time to work with a Professional and not on your own?

1. When the issue is highly emotionally charged - like trauma, death, abuse, horror, and violence
2. When you feel you need change NOW!
3. When you can't seem to get to the root of the issue
4. When you feel it's too difficult to tap on the issue while maintaining distance and perspective

*Acknowledgments:*

I would like to acknowledge and thank my wonderful EFT teachers: Gary Craig, Natalie Hill, Masha Bennet, Nick Ortner, Brad Yates, Gwyneth Moss, Ilana Weiler & Aya Hod.

# Felt Sense

The term Felt Sense was coined by Dr. Eugene Gendlin, the creator of the Focusing method.

Felt Sense refers to the bodily-held sense of a situation, relationship, or issue. It is a holistic body experience that encompasses emotions, memories, bodily sensations (usually, in the throat, chest, stomach, and belly), and knowing beyond words.

Because Felt Sense is a subjective experience, it can be hard to describe - and harder still to grasp from just reading about it.

Here are three exercises to help you experience Felt Sense

In the student portal, you will find a video of these exercises to help you practice and experience them.

You may find it feels familiar and easy, or you may not get much at first. Either way, it's okay.

Take 2-3 minutes, and give yourself permission to be open, curious, playful, and unattached to results.

**Exercise 1**

1. Sit somewhere quietly
2. Take a few nice breaths and, for a few minutes, set aside the day's worries and concerns.
3. Invite yourself to be present in this moment (It can help to notice how your body is being supported, and the contact between your body and the chair and/or floor.)
4. Close your eyes. Think about someone you know and love – a friend, family member, even a pet. Imagine that person is with you now, in the room with you.
5. Notice - what is coming up in you and in your body? (Thoughts, memories, emotions, and/or sensations like warmth, an expansive feeling, or something else). Don't focus on anything specific.
6. Notice the holistic sense of this person and your relationship with them that feels more than just the sum of the details.

This is a "felt sense".

**Exercise Part 2**

1. Open your eyes and give yourself a shake to reset your body (a kinaesthetic Break State 😊 ) and repeat Step 1 from Part 1.
2. This time, think about someone with whom you don't get along or find challenging to deal with. Imagine that this person is in the room with you.
3. Notice - what is coming up in you and in the body? (Thoughts, memories, emotions, and/or sensations like warmth, an expansive feeling, or something else). Don't focus on anything specific.
4. Notice how this "felt sense" is different from the felt sense you experienced in Part 1.

**Exercise 3**

1. Try going back and forth from the person in part 1 to the person in part 2 a few times.
2. Notice how your body has a clear and definite felt sense of each person and how they are different.

**Using Felt Sense in Coaching**

We use Felt Sense in coaching to help the client access information and wisdom about experiences, memories, and relationships stored in the body.

As we invite the client to safely connect with these experiences, we also invite them to explore the Felt Sense in the body. This will provide us with information about existing values, beliefs, and triggers.

We can also use Felt Sense to discover resources and to validate new resourceful states.

**To discover resources**, we invite the client to connect to an embodied experience, a resourceful state. We invite the client to explore the Felt Sense of the experience, one or more specific resources, and the experience of becoming resourceful as a result.

To validate resourceful states, we invite the client to explore the Felt Sense of a previously challenging experience. After activating an anchored resource, we ask the client to notice the new Felt Sense and how different it is from the previous one.

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

# Somatic Core Dimensions of Body Movement

Somatic Core Dimensions of Body Movement refer to movements that mirror sensation, consciousness, and the body's neurological organization.

We look at three primary core dimensions to deepen our awareness of the current experience and to decode the path to balance and nervous system regulation.

| Core Dimension | Anatomic Perspective | Embodiment Perspective |
|---|---|---|
| Top-Bottom/Up-Down | Involves the relationship between the upper and lower body, focusing on gravity and the core (pelvis and torso). | <u>Push up – Sink Down</u><br><br>Push up – assertively respond through acting/action<br><br>Sink Down – respectively respond through sensing |
| Front-Back/Forward-Backward | Relates to the coordination of movement in front of and behind the body. | <u>Advance Forward – Draw Back</u><br><br>Advance Forward – compassionately focus on others<br><br>Draw Back – authentically focus on self |
| Expansion-Retraction/ Wide-Narrow | Involves organizing spaces and defining boundaries. | <u>Open - Close</u><br><br>Open -adaptively open to the content/ the field<br><br>Close – stably distance from the content |

# Emotions

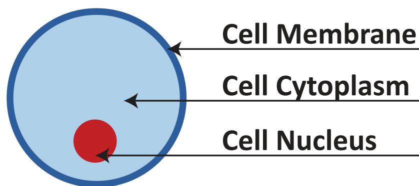
Emotions are an inseparable part of an illness, and they "show up" regularly in the coaching room as well. There is no way around them – only through them, which means we need to deal with them!

## The Relationship between Emotions and the Body

To understand the relationship between emotions and the body, in a health and medical context, we need to understand how medication works at the cellular level.

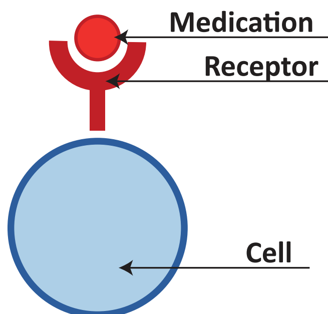
Cells are the smallest biological unit of life.

Cells consist of a nucleus (containing the cell's genome), the cytoplasm (containing the material within a cell), and a membrane (containing biomolecules such as proteins and nucleic acids)




The cell communicates with the environment through receptors on its membrane.

As a medication binds to a receptor, it affects the cell's function.




Medication can bind to a receptor only if it is biochemically similar to the material already present in the cell. If the medication does not biochemically fit the receptor, it will not work.

In 1973, Dr. Candace Pert and Dr. Solomon Snyder published the first detailed study of what would turn out to be the Opioid Receptors – receptors that bind with opioids (substances that, when binding with the opioid receptors, produce morphine-like effects).

The discovery of Opioid Receptors meant that our cells already have material that operates in a similar way to opioids, and this later led to the discovery of Endorphins. Endorphins are endogenous opioid neuropeptides (Neuropeptides are peptides - small protein-like molecules, used by neurons - nerve cells, to communicate with each other. Neuropeptides are also called messenger hormones).

Endorphins are naturally produced in response to pain, but they have also been studied for their roles in pleasure, happiness, and well-being. Research shows that endorphin release produces a euphoric state, suggesting that endorphins affect both our state of mind and our level of awareness.

The discovery of endorphins was the first evidence that emotions have a biochemical aspect.

From this came five conclusions, revolutionary for the time (early 1980's):

1. Emotions are biochemical reactions
2. Emotions affect our immune system
3. Emotions affect our awareness
4. The body is an extension of the subconscious
5. Repressed emotions are stored in the body and disrupt the way the cells' function

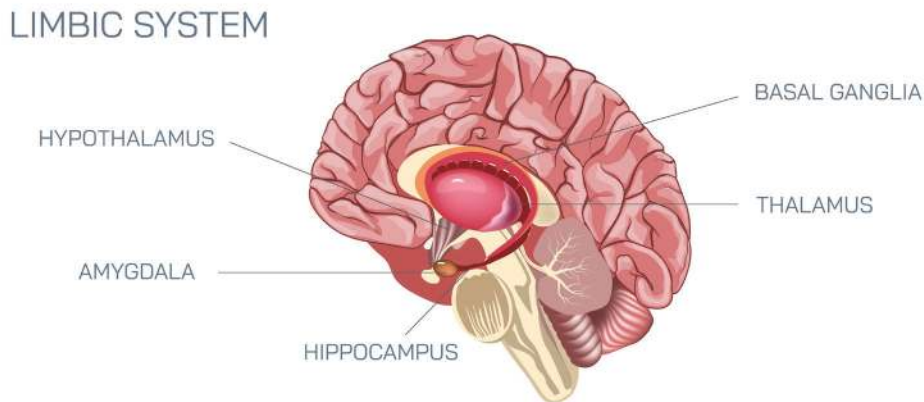
This means two VERY important things for us, Health and Medical Coaches:

1. Our cells are experiencing our emotions.
2. Emotions create bodily sensations:
   Anger often feels like something hot coming up to the surface. It has a distinct vibration.
   Love usually feels like something warm spreading inside of us.
   Emotional pain usually feels like physical pain.

## The Biochemistry of Emotions:

Emotions have a biological basis rooted in a complex, integrated system involving specific brain regions (primarily the limbic system), neurotransmitters, and physiological responses from the autonomic nervous system. Key structures like the amygdala (fear/threat), hypothalamus (arousal), and hippocampus (memory) process stimuli, while hormones like cortisol and adrenaline trigger physical reactions.

**The Limbic system**, also known as the paleomammalian cortex or the "emotional brain," is a network of brain structures that work together to generate and interpret emotional responses, especially in behaviors essential to survival: feeding, reproduction, caring for the young, and fight-or-flight responses.




The Key structures of the limbic system are: the amygdala, hippocampus, hypothalamus, thalamus, and basal ganglia

- **The amygdala** serves as the central sentinel for detecting emotional significance, particularly fear and threat, often triggering immediate, subconscious reactions.
- **The hypothalamus** mediates the autonomic nervous system, triggering physiological changes like increased heart rate, sweat, or adrenaline release.
- **The hippocampus** plays a major role in learning, long-term memory formation**,** and memory retrieval. It also plays a role in spatial memory, allowing individuals to track the location of objects and the position of their bodies relative to them.
- **The thalamus** interprets information from the body's senses, other than smell, which sends the information differently, and processes it before being sent to the brain's cerebral cortex for interpretation.
- **The basal ganglia** are a group of interconnected nuclei crucial for motor control (initiating, stopping, and modulating movement). They are also involved in reward processing, cognition, and emotion, acting as gatekeepers for voluntary actions and learning.

## Physiological and Chemical Drivers

- **Neurotransmitters:** chemicals that allow neurons to communicate with each other throughout the body. They enable the brain to perform a variety of functions through chemical synaptic transmission. Neurotransmitters, such as serotonin, dopamine, and norepinephrine, are critical in modulating mood, impulsiveness, and aggression. For example, lower serotonin is associated with higher aggression and impulsivity.
- **Autonomic Nervous System (ANS)**: the part of the nervous system that supplies the internal organs, including the blood vessels, stomach, intestine, liver, kidneys, bladder, genitals, lungs, pupils, heart, and sweat, salivary, and digestive glands. In addition, the ANS controls physical reactions, such as "fight-or-flight" (sympathetic) responses or calming (parasympathetic) actions, and regulates involuntary physiological processes, including heart rate, blood pressure, respiration, digestion, and sexual arousal. The autonomic nervous system is also referred to as the visceral nervous system
- **Hormones:** chemical messengers produced by glands that travel through the bloodstream to coordinate functions like growth, metabolism, mood, and reproduction, working slowly over time to regulate nearly every process in the body by signaling specific cells to act. They are vital for maintaining homeostasis (internal balance) and are part of the endocrine system, which includes glands like the pituitary, thyroid, and pancreas, along with testicles and ovaries. Hormones such as cortisol (stress) and oxytocin (bonding) are physically manifested in bodily sensations.

## Current Biological Theories About Emotions

- **Physiological Response:** suggests emotions arise from the brain's interpretation of bodily reactions to specific environmental stimuli.
- **Brain Circuitry:** suggests that emotions are generated by neurobiological networks, rather than one specific center.

From a biological perspective, emotions function as survival mechanisms, enabling organisms to assess their surroundings and respond rapidly to events and stimuli, whether threats or rewards.

## Emotions and the Body - Summary:

- Information gets to the brain through the senses.
- The brain filters and processes sensory information, giving it meaning
- The meaning of the information creates both a thought process and an emotional reaction
- The emotions (being biochemical reactions) – affect our cells.
- The effect on the function of the cells affects the function of the body.

## Coaching Clients Through Emotional States

To coach clients through emotional states, we need to start by establishing a language.

The first step is differentiating between emotions and sensations.

**Emotions**: psychological experience described by an emotional vocabulary

**Sensations**: physical experiences described via metaphors. Feels like…

The second step is creating an emotional vocabulary with our clients, so they gain clarity and articulate their emotional state.

“Feeling Wheels” is a good tool for raising awareness about emotions and expanding one’s emotional vocabulary.

There are many “Feeling Wheels” you can use; they differ slightly in their core emotions, yet the principles remain the same.

Here are two that we recommend.

**Gloria Wilcox's "The Feelings Wheel"**

- Happy
  - Playful: Aroused, Cheeky
  - Content: Free, Joyful
  - Interested: Curious, Inquisitive
  - Proud: Successful, Confident
  - Accepted: Respected, Valued
  - Powerful: Courageous, Creative
  - Peaceful: Loving, Thankful
  - Trusting: Sensitive, Intimate
  - Optimistic: Hopeful, Inspired
- Sad
  - Lonely: Isolated, Abandoned
  - Vulnerable: Victimised, Fragile
  - Despair: Grief, Powerless
  - Guilty: Ashamed, Remorseful
  - Depressed: Empty, Inferior
  - Hurt: Dissapointed, Embarrassed
- Disgusted
  - Repelled: Hesitant, Horrified
  - Awful: Detestable, Nauseated
  - Disappointed: Revolted, Appalled
  - Dissaproving: Embarrassed, Judgmental
- Angry
  - Critical: Dismissive, Sceptical
  - Distant: Numb, Withdrawn
  - Frustrated: Annoyed, Infuriated
  - Aggressive: Hostile, Provoked
  - Mad: Jealous, Furious
  - Bitter: Violated, Indignant
  - Humiliated: Ridiculed, Disrespected
  - Let down: Resentful, Betrayed
- Fearful
  - Threatened: Exposed, Nervous
  - Rejected: Persecuted, Excluded
  - Weak: Insignificant, Worthless
  - Insecure: Inferior, Inadequate
  - Anxious: Worried, Overwhelmed
  - Scared: Frightened, Helpless
- Bad
  - Bored: Indifferent, Apathetic
  - Busy: Pressured, Rushed
  - Stressed: Overwhelmed, Out of control
  - Tired: Sleepy, Unfocussed
- Surprised
  - Startled: Shocked, Dismayed
  - Confused: Disillusioned, Perplexed
  - Amazed: Astonished, Awe
  - Excited: Eager, Energetic

**The Junto Institute “Emotion & Feeling Wheel”**

Anger
Rage, Exasperated, Irritable, Envy, Disgust
Hate, Hostile, Agitated, Frustrated, Annoyed, Aggravated, Resentful, Jealous, Contempt, Revolted

Sadness
Suffering, Sadness, Disappointed, Shameful, Neglected, Despair
Agony, Hurt, Depressed, Sorrow, Dismayed, Displeased, Regretful, Guilty, Isolated, Lonely, Grief, Powerless

Surprise
Stunned, Confused, Amazed, Overcome, Moved
Shocked, Dismayed, Disillusioned, Perplexed, Astonished, Awe-struck, Speechless, Astounded, Stimulated, Touched

Joy
Content, Happy, Cheerful, Proud, Optimistic, Enthusiastic, Elation, Enthralled
Pleased, Satisfied, Amused, Delighted, Jovial, Blissful, Triumphant, Illustrious, Eager, Hopeful, Excited, Zeal, Euphoric, Jubilation, Enchanted, Rapture

Love
Affectionate, Longing, Desire, Tenderness, Peaceful
Romantic, Fondness, Sentimental, Attracted, Passion, Infatuation, Caring, Compassionate, Relieved, Satisfied

Fear
Scared, Terror, Insecure, Nervous, Horror
Frightened, Helpless, Panic, Hysterical, Inferior, Inadequate, Worried, Anxious, Mortified, Dread

Coaching clients through emotional states means helping them create a way to authentically process their emotions, whether they are connected to an acute event or an ongoing one.

Processing emotions means consciously acknowledging, experiencing, and understanding a subjective experience of an event or stimulus. It does not mean consciously or actively suppressing or ignoring them.

Research shows that attempting to minimize or ignore thoughts and emotions only serves to amplify them. *(Emotional Agility by Susan David and Christina Congleton, Harvard Business Review, Nov. 2013 - https://hbr.org/2013/11/emotional-agility )*

To help clients process the emotions they bring into the coaching space in a way that will empower them AND contribute to the success of the coaching process, we need to remember the following:

1. Emotions exist in a context.
2. Every illness expresses itself emotionally as well as physically
3. The more the client can articulate their emotions, the more emotionally agile they become.
4. People have emotions, they are not their emotions
5. People define emotions in different and subjective ways
6. Emotions are not sensations
7. In the context of health and medical issues, all emotions are a normal reaction to an abnormal situation.
8. When we allow ourselves "to be" with them and express them without attachment, emotions become less unpleasant
9. Our emotions help us survive in the world
10. We have more unpleasant emotions than pleasant ones
11. There are no "good/positive" or "bad/negative" emotions; there are only "balanced" and "imbalanced" emotions.

| **Balanced** | **Imbalanced** |
|---|---|
| Happiness | Euphoria |
| Anger | Rage |
| Fear | Anxiety |
| Confusion | Disorientation |
| Sadness | Despair |

As already mentioned, there is no way around emotions – only through them.

This means we need to process them. Processing emotions means developing emotional agility.

**Creating Emotional Clarity**

Emotions can feel very messy, and this messiness can create an experience of overwhelm.

It's important to remember that:

1. Certain emotions arise from other emotions. E.g., **loneliness** can arise from sadness, **frustration** from anger, **anxiety** from shame, and **anger** from fear.
2. Sometimes we unconsciously cover one emotion with another emotion. E.g., we react in anger when we feel sad and vulnerable.
3. Sometimes we use an emotional strategy to get what we want. E.g., we use anger to communicate boundaries.
4. Sometimes our real emotions are so messed up that they get us into trouble. E.g., if I have experienced a lot of fear as a child, I might grow up to be an adult who needs to feel safe, loved, and accepted, and/or I might choose to behave in an overprotective way and end up driving people away from me

One way of creating emotional clarity is by curiously examining an emotion through three dimensions:

- The Narrative Dimension - the narrative/story of the chain of events that led to this emotion and the context in which it occurred.
- The Action Dimension – the way the person acts or reacts when the emotion is triggered.
- The Positive Intention Dimension – the "good thing" this emotion wants for the person, in other words the values that are asking to be honored.

**Example:**

| ***Emotion*** | ***Narrative*** | ***Action*** | ***Positive Intention*** |
|---|---|---|---|
| Anger | I have been wronged, and I" know who/what is responsi-".ble | To confront the perceived source of the injustice | Fairness/justice |
| Fear | I believe something may" harm me, and no one/noth-".ing will be able to save me | To avoid the things that may harm me | Safety/protection |
| Sadness | I have lost something im-" portant to me, and I know ".what/who took it from me | To seek ways to regain what has been lost | Connection |
| Hope | I believe things can change" for the better and my condi-".tion can improve | To work for change | Growth |

The value of creating emotional clarity is that it allows the client to recognize their ability to understand their experience and identify which narrative, belief, or action needs to change to shift the emotion.

Creating emotional clarity is key to emotional processing and emotional agility.

When we know how to be with our emotions and listen to them rather than trying to cover them up or silence them, they become tools for growth.

## Emotional Agility

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

**Emotional Agility** is a skill that can be taught and perfected until it becomes a natural, authentic way to navigate our emotional reality.

**Emotional Agility consists of 6 parts**:

1. Identifying the present emotion
2. Identifying the context in which the emotion was triggered and is present
3. Evoking self-compassion and agreeing to create a safe space and to be with an emotion
4. Active self-regulation or co-regulation
5. Gaining insights and personal learnings
6. Turning learning into growth

**Self-Regulation**

Self-regulation is the ability to observe, balance, and shift our attention, thoughts, emotions, and behaviors to achieve short-term and long-term goals and adapt to changing circumstances. It plays a fundamental role in decision making, information processing, emotional agility, resilience, stress management, goal pursuit, and impulse control. It also impacts well-being and success.

The ability to self-regulate emerges during childhood, but we can develop these skills as adults by practicing techniques, becoming more aware of our emotions, and reframing how we view situations.

**Practices to develop and use to self-regulate:**

1. Becoming aware of the present emotion/s
2. Centering techniques
3. Grounding techniques
4. Breathing techniques
5. Reframing
6. Affirmations
7. Gratitude practices
8. Establishing routines & habits
9. Small wins
10. Goal setting
11. Visualization techniques
12. Activation of anchored resources
13. EFT
14. Mindfulness

**Co-regulation**

Co-regulation in coaching is the interactive process in which a coach helps a client manage their emotions and behaviors, particularly during stressful or challenging situations. This is done by offering support, modelling self-regulation, and guiding the client through emotional regulation practices.

Co-regulation is about creating a safe and trusting environment where the client feels secure enough to explore their emotions and develop self-regulation skills.

Key aspects of co-regulation in coaching:

- **Creating a safe and trusting environment:** through presence, empathy, and the ability to attune to the client's emotional state.
- **Attuning to the client's emotional state:** through active listening, mirroring, and validating, the emotional experience, creating a sense of being "seen", "heard", "felt", and understood
- **Modelling and coaching:** through the modelling of healthy emotional regulation strategies, guidance, information, and practice when needed.
- **Building rapport:** through the fostering of connection and facilitating open communication.

Co-regulation in coaching is a collaborative process where the coach and client work together to build the client's emotional resilience and self-regulation skills.

Example: A client is feeling anxious before a medical procedure. The coach, through empathetic listening, helps the client identify their physical and emotional responses. The coach might then guide the client in practicing deep-breathing techniques or visualization exercises to calm their nervous system. The coach's presence and support help the client feel more grounded and confident, enabling them to navigate the procedure more calmly. Over time, the client learns to apply these techniques independently in situations that trigger similar emotions.

# Deep Dive into Specific Emotions and Emotional States

## Sadness

Sadness is a part of every illness.

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

In this context, it is important to understand that calling a profound state of sadness - depression is misleading. The term depression is, in fact, clinical depression. Clinical depression is a mental health condition diagnosed by a mental health practitioner and needs to be medicated.

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

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

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

One of the difficulties people experience when feeling sadness is that it can become a trigger for further sadness, potentially creating a cycle of trigger–response–trigger-response.

As Health and Medical Coaches, we want to help our clients create emotional agility around sadness.

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

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

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

1. **Nature**
   The one constant about nature is that everything changes constantly.
   Here are two metaphors we can use:

   - **The changing seasons**
     Looking at the cycle of seasons, we can see that each season has a beginning, a middle, and an end. Summer will always be followed by fall, and winter will always be followed by spring. All seasons are a part of the natural cycle of nature; each season has a role and a purpose, and none is better than the other.

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

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

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

     We can say that deciduous trees are sad in the winter. But they do not know they are sad; therefore, they are not saddened by shedding leaves and being perceived as sad. They allow

themselves to be the trees that they are at that moment.
For those looking at the trees, it can seem painful, like death, but for the trees, there is life in this place, and it might feel like a deep sleep.
We all need sleep to regenerate. When we allow ourselves to “lose leaves” in the fall, sleep through winter, we can bloom in the spring and give fruit in the summer.

2. **A Liminal Space**
In Module 1, you learnt about the nature of a Liminal Space in the context of a health/medical journey. You can use this concept to help the client place an emotional experience on their personal timeline and create a safe space to be with, process, and learn from it.
You can use myths and stories of journeys to explore models of liminal spaces.

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

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

You can find more information about the ‘Dark Night of the Soul ‘ online.

## Fear

Fear is ultimately about self-preservation.

When clients bring up fear, avoid trying to “fix it” or offer solutions; instead, get curious and inquire about it.

What are the facts?

Are there gaps in the information that are being filled with assumptions?

What are the beliefs?

Fear is a concrete and manageable reaction to a specific source of perceived danger. It has coherent content and logic that can be addressed and processed.

When fear becomes unbalanced, it turns into anxiety.

The shift from fear to anxiety is like the shift from acute to chronic. When an acute situation is not addressed and resolved at its core, it often becomes a chronic issue, continually presenting itself for resolution.

Anxiety is a generalized reaction to a vague source of perceived danger. Often it feels like been flooded or overrun. It lacks coherent content or logic that can be addressed and processed.

Anxiety tends to draw attention away from other emotions.

## Fear of Reoccurrence/Recurrence*

*Reoccurrence means something repeating itself.

Recurrence means something repeating itself again and again.

Fear of Reoccurrence is the fear of a relapse or a new, unrelated diagnosis.

Fear of Recurrence is the fear of a relapse and or symptom becoming chronic and repeating itself again and again.

We tend to think about Fear of Reoccurrence in the context of cancer, but everyone who has been through a medical crisis and/or is living with a chronic condition experience some degree of Fear of Reoccurrence.

Whether your client is in "NED" status (No Evidence of Disease), feels less symptomatic, experiences a clinical improvement in his/her medical condition, or simply feels better, there is always that fear that things might relapse again and/or there is something else going on that hasn't been diagnosed yet.

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

The Health and Medical Coaching approach towards Fear of Reoccurrence includes the following steps:

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

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

3. **Remind the client that they are more than the illness**
   The illness is something the client has.
   The client also has elbows, fingers, and toes.

   The client is more than elbows, fingers, or toes, just as he or she is more than the body and more than the illness.
   The illness is one more thing in the client's life; it's not the only thing, and it is not who he/she is

4. **Reframe the concept of control**
   Here is a fact of life: we have no control over what happens to us. We have no control over the world, other people, and/or our bodies.

   The most fundamental human choice we make is the meaning we give to what happens to us. Where there is choice – there is control.
   Since we see the world through the meaning we give it (our perception), when we choose the meaning, we control our subjective experience.

5. **Help the client name the real fear**
   Fear of reoccurrence is not always about the reoccurrence of the illness. Sometimes it's something else. It can be that the client is afraid of pain, of needing to be helped, of feeling helpless, of dying, of losing something … it can be one or many things.
   This doesn't necessarily make it easier, but it creates clarity, and clarity increases choice.

   To get to the real fear, invite the client to imagine (just for a few seconds) that there is a reoccurrence or deterioration and ask him/her to notice the first thing that comes to mind. That is where the real fear is.
   * Make sure you have set safety anchors, such as affirmations, anchored secure states, and emotional regulation practices with the client before doing this.

6. **Help the client speak his/her beliefs**
   Whether it's religious, spiritual, or anything else, invite the client to say out loud what he/she believes in.

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

Once we offer the client immediate steps to cope with the fear, we can move to the long-term approach that includes 4 steps:

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

## Desperation/Hopelessness

Desperation/hopelessness is a state of having little to no hope. Often, it is accompanied by uncertainty, a lack of control, helplessness, and even anxiety.

Desperation/hopelessness ultimately stems from the loss of emotional anchors, and it can feel overwhelming for both the client and the coach.

The best indicator of the client's coachability at this point is their willingness to consider that there is something they are not yet seeing and to take action with you to find it.

It is vital that we do not try to "fix it" or offer solutions.

Our job is to hold a safe space, help the client set a vision and goals, and start with nervous system and emotional co-regulation.

At this point, it is very important to check if the client is still coachable.

# Emotional First Aid in the Coaching Space

Emotional First Aid includes immediate nervous system-regulation techniques to help the individual shift back to a resilient state during an acute crisis or distress.

> This is critical when a person needs to make quick decisions, cope with a crisis, and create an action plan.

You already have at least three powerful tools in your toolbox:

1. Rapport
2. Empathy
3. Emotional regulation

Here are a few additional tools:

## RAIN model –

R - Recognize. *Recognize what is going on around you, name the emotions, and speak the inner narrative.*

A - Allow. *Allow yourself to be with what is present now without judgment.*

I - Investigate. *Investigate what you need right now to center and balance yourself.*

N - Non-Identification (Non-Attachment). You are not your emotions AND you are more than your circumstances.

## Centering

The term "Centering" refers to an approach that seeks to create a shift in state of mind by focusing on the body.

My favorite definition for centering is by Mark Walsh: "…any body-mind techniques used for self-regulation that bring us back into holistic balance."

Centering techniques include those that reduce arousal and those that increase alertness and stimulation (up-regulation).

The centering approach has three principles, called the **A – B – C of Centering:**

A - Awareness of the body and breathing.

B - Balance yourself by feeling connected to where you are right now.

C - Center yourself by locating your physical center of gravity.

Here are three basic and effective breathing techniques that are very effective:

## Conscious breathing

1. Look around you and notice where you are right now. Notice what you see and hear.
2. Breathe into your lower abdomen as if you are inflating a balloon that is located underneath your belly button.
3. Release your jaw.
4. Take your attention to your breathing.
5. Continue until you feel an inner shift.

## The Square Breath Technique:

INHALE: 4 seconds,
HOLD: 4 seconds,
EXHALE: 4 seconds,
HOLD: 4 seconds.

## 4-7-8 Breathing Technique:

INHALE: 4 seconds,
HOLD: 7 seconds,
EXHALE: 8 seconds,

# Emotional First Aid outside the Coaching Space

There may be situations in which you come across a person in distress outside the coaching room.

This means that there is no coach-client relationship between you and this person.

**The principles for Emotional First Aid outside the coaching space:**

1. Introduce yourself by name
2. Establish rapport
3. Ask what happened and what the person needs
4. Help the person regain emotional balance (by using fast relief techniques, grounding, and connection)

The British Ministry of Health developed 4 rules for providing emotional first aid, called NO FEAR (an acronym for Focus, Encourage, Ask, and Render understandable).

**This is an adaptation of the NO FEAR model for Health and Medical Coaches:**

1. **Focus** – create a connection with the person you are assisting by using the principles of rapport. This will focus the person's attention on communicating with you and help them reduce feelings of loneliness.
2. **Encourage** – use simple action instructions to help the person start shifting from a passive state to a more active state.
   For example: ask the person to tell you his/her name, phone number, and means of contact with relatives
3. **Ask** – start asking simple open questions to increase cognitive processing and choice.
   For example:
   - Where are you from?
   - Where do you need to go?
   - Are you hungry/thirsty?

* Avoid questions about emotions, as a flood of emotions heightens distress.

4. **Render understandable** – start reducing confusion and increasing comprehension by helping the person make the sequence of events. Use the timeline principle to describe the sequence of events that have occurred. Stick to the facts, avoid metaphors, and keep your language clear and simple.

# Trauma and Post-Traumatic Growth

Many people experience trauma in some shape or form in the context of their illness or medical condition.

**What is Trauma?**

***The DSM-5*** (DSM – Diagnostic Statistical Manual of Mental Disorders) defines trauma (Criterion A for PTSD) as exposure to actual or threatened death, serious injury, or sexual violence. This exposure must result from directly experiencing, witnessing, learning of such events to a close relative/friend, or extreme indirect exposure to aversive details.

***The APA*** (American Psychological Association) defines trauma as any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning.

Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes, wild fires) and often challenge an individual's view of the world as a just, safe, and predictable place.

The threat of trauma lies in its power to disrupt an individual's sense of safety, causing lasting physical, emotional, and psychological harm. It keeps the nervous system trapped in a chronic "fight-flight-freeze" state, leading to severe health issues like cardiovascular disease, immune system dysfunction, depression, and PTSD.

It's important to be aware that trauma can be caused by the way a person experiences their illness, a medical procedure, interaction with a healthcare professional, interaction with the medical system, and/or witnessing another person experience a traumatic event.

In Health and Medical Coaching, we address traumatic events and memories directly linked to the illness/ medical condition.

If a client is actively coping with the aftermath of another traumatic issue and/or a past traumatic issue is being triggered by the current illness/medical issue, the coaching must be paused, and three questions MUST be addressed:

1. Is this client coachable?
2. Is Health and Medical Coaching the right modality at this point?
3. Am I the right coach (personally and professionally) for this client?

**It is highly recommended to take supervision at this point.**

Traditionally, the word TRAUMA has been used within medical contexts to describe life or limb-threatening physical injuries caused by an external source.

The recognition of the presence and importance of psychological trauma has grown steadily since the 19th century.

Today, health and medical-related trauma is considered an experience and not an event.

It has physical, emotional, mental, social, and spiritual aspects.

There is little theoretical or empirical work published on the topic of coaching through and beyond trauma, which is a complex field that belongs in the capable hands of trained and experienced therapists and psychotherapists.

Trauma-informed coaching is a specialized approach that helps clients address the impact of past trauma on their current lives, focusing on safety, resilience, and growth rather than therapeutic treatment.

Unlike therapy, this type of coaching does not diagnose or treat trauma.

It ensures the coaching practice is sensitive to a client's history and helps the client manage triggers, rebuild relationships, and find purpose.

In Health and Medical Coaching, we work with events related to the client's health, medical condition, and challenges.

Our job is to create a supportive, nonjudgmental coaching environment to help our clients develop self-regulation strategies, understand their trauma, process their emotions and memories related to traumatic events connected to their health and medical condition, identify triggers to avoid future re-traumatization, connect to resources of safety and trust, reclaim their clinical and personal narrative, shift into a pro-active state of choice, and move toward their goals.

According to Prof. Mooli Lahad (Israeli psychologist and psycho trauma specialist), a traumatic event interrupts four life sequences:

**1.** The cognitive sequence – "What just happened?"

**2.** The functional sequence – "What do I do now?"

**3.** The social sequence – "No one can understand what I'm going through."

**4.** The historical sequence – "Something happened to me, it changed me."

Since there is a tendency to use the term "Trauma" to describe a variety of emotional events, it is important that we, as Health and Medical Coaches, understand the difference between a traumatic event and a dramatic one.

A dramatic event is one that causes us to experience intense emotions.

Every dramatic event affects us, but not every dramatic event is a trauma.

## There are five elements that turn a dramatic event into a traumatic one:

**Unexpected** – feeling a deep sense of surprise (and shock) in the fact that things have occurred in the way they did.

**Chaotic** – Nervous system dysregulation, shifting into sympathetic mode.

**Dramatic** – Intense emotions (especially fear, powerlessness, and uncertainty) and a perceived threat to the physical, emotional, or mental wholeness.

**Isolating** – feeling separated, different, and unseen.

**Resourceless** - feeling disconnected from resources (internal and external).

At the time of its occurrence, we feel shocked by its unexpectedness, dysregulated, overwhelmed by intense emotions, isolated in the moment, powerless, and without resources in the face of a force greater than ours.

After a traumatic event, our mind and body are still in a state of shock.

Over time, we begin to make sense of what happened to us, process our emotions, create meaning by learning from the event, and eventually heal the pain and psychological injury of the traumatic event.

Trauma can affect those who personally experience the event. Those who witness it, such as the caregivers, friends, and family members of those who went through the actual trauma experience what is called SECONDARY TRAUMA.

To clear the emotions from a traumatic event or memory, we use EFT.

## The 6 Trauma Responses

When discussing trauma, most of us have heard about the fight-or-flight responses, and some of us even know the fight-or-flight-freeze responses.

But as trauma research grows, so does the understanding of trauma responses.

There are many theories, and none is correct or incorrect. We view them as tools to help us and our clients better understand their responses to triggers.

As Health and Medical Coaches, we look at 6 trauma responses:

**Fight** - Confronting the perceived threat

**Flight** - Fleeing the perceived threat

**Freeze** - Immobilizing in light of the perceived threat

**Faun** - Appeasing the perceived threat

**Faint/Fatigue/Flop** - Feeling tired or sleepy in response to a perceived threat

**Fraternize** – Negotiating, bribing, or pleading in response to a perceived threat

Two additional Trauma strategies that are considered trauma responses:

**Flood** - an intense surge of emotions in response to a perceived threat (Emotional flooding, emotional dysregulation). This response is increasingly more common for autistic and neurodivergent people. Other people who may experience emotional flooding include people with bipolar disorder, borderline personality disorder, ADHD, and Rejection Sensitive Dysphoria.

**Fine**: the fine response can occur in the aftermath of a traumatic event. The person is in denial about the trauma. They might play it down, question whether it happened, pretend it didn't, or act as if everything is okay. This often happens because the trauma is too big to process, or because of social pressure to appear to be okay.

Our response to trauma is unique to each of us, and what we've been through – while you may recognize similarities amongst the 6 trauma responses listed here, the reality is that people usually experience a combination and variety of thoughts and feelings that correspond to different trauma responses.

# The Tearless Trauma Technique (EFT)

This specific EFT technique IS USED to clear emotionally charged, painful, stressful, and/or traumatic events or memories.

In this technique, we DO NOT go into the event's content.

We address the event as if it were energy, give it a code name, and elicit its submodalities.

The above creates a disassociation that helps our client clear this issue without re-experiencing it.

It's important to remember that this technique will not erase the memory of the event; it will help the client reduce and adjust their emotional experience of it.

This change will increase the client's ability to regain balance and resilience.

***Tearless Trauma Technique***

Identify a specific event or memory that still triggers intense and painful emotions. Make sure that the event is in the client's past and has ended!

Assess the emotions and the intensity and write them down.

**It's important that the client does not recreate the event in his/her mind!**

- Give the event/memory a code name
- Write down all emotions and thoughts that the event triggers

  Elicit the sub-modalities of the emotions and thoughts, and assess the intensity
- Tap on the event using ONLY the code name and sub-modality of the emotions and thoughts
- Do 3-4 rounds
- Reassess the intensity and elicit new sub-modalities
- Keep tapping until you have brought the intensity down to less than 2
- Ask the client to **TRY** to remember "that old event" and notice what has changed
- Ask the client 'what becomes possible now'

When clearing a memory of a traumatic event, it is important to remember that trauma impacts and changes a person's belief system.

To make our work sustainable, we need to update beliefs that were formed or altered by the traumatic event.

The following question will point us in the right direction: In that specific trauma/event, what do you do to survive?

## Rotating in Space Technique

*(Adapted from Zivorad M. Slavinski's P.E.A.T methodology)*

1. Identify the challenging image (a still picture - not a moving picture)

2. Ask the client:
   - What is the image?
   - What thoughts are coming up?
   - What is coming up in the body?

3. Ask the client to turn the image into a Black and White image AND put a frame around it

4. Ask the client to reach out and touch the frame with the fingertip

5. Ask the client to close his/her eyes and drag the picture as he/she turns 3.5 turns counterclockwise (keep reminding the client to drag the picture with the finger tip)

6. Ask the client to open his/her eyes AND release the old image.

7. Break State

8. Ask the client to try to bring up the old image and notice what has changed

9. Ask: "What becomes possible now?"

# Breaking Space Technique

*(Adapted from Zivorad M. Slavinski's P.E.A.T methodology)*

Identify the challenging image (a still picture and not a moving picture)

**1.** Ask the client: Where is the image in your space?
- What is the image?
- What thoughts are coming up?
- What is coming up in the body?

**2.** Ask the client to turn the image into a black-and-white image AND put a frame around it

**3.** Ask the client to reach out and touch the frame with the fingertip

**4.** Ask the client to close his/her eyes and drag the picture while he/she turns 90° to the left

**5.** Ask the client to estimate the following:
- The distance from the fingertip to the ceiling
- The distance from the fingertip to the floor
- The distance from the fingertip to the wall in front
- The distance from the fingertip to the wall behind
- The distance from the fingertip to the wall on the right
- The distance from the fingertip to the wall on the left

**6.** Turn your client back and remind him/her to drag the picture with their fingertip

**7.** Ask the client to open his/her eyes AND release the old image

**8.** Break State

**9.** Ask the client to **try** to bring up the old image and notice what has changed

**10.** Ask: "What has become possible, now?"

# Post-Traumatic Stress Disorder - PTSD

PTSD is an **anxiety** disorder caused by exposure to a traumatic event.

After going through a traumatic experience, it is natural to feel frightened, overwhelmed, sad, anxious, disconnected, and numb.

**These are normal reactions to abnormal events.**

- Almost anyone who has been through trauma experiences has at least some PTSD symptoms
- For most people, these symptoms last for several days or even weeks, but they gradually fade
- PTSD symptoms develop in the hours or days following the event
- Sometimes it takes weeks, months, or even years before they appear
- Living with PTSD damages every aspect of life
- *PTSD can be treated*

## Symptoms of PTSD:

| ***Re-experiencing the traumatic event*** | **Avoidance and numbing** |
|---|---|
| • Intrusive, upsetting memories of the event<br>• Flashbacks<br>• Nightmares<br>• Feelings of intense distress when reminded of the trauma<br>• Intense physical reactions to reminders of the event | • Avoiding activities, places, thoughts, or feelings that remind you of the trauma<br>• Inability to remember important aspects of the trauma<br>• Loss of interest in activities and life in general<br>• Feeling detached from others and emotionally numb<br>• Sense of a limited future |
| **Increased anxiety and emotional arousal** | **Obsessive interest in the trauma** |
| • Difficulty falling or staying asleep<br>• Irritability or outbursts of anger<br>• Difficulty concentrating<br>• Hyper vigilance<br>• Feeling jumpy and easily startled | • Feelings of intense guilt and responsibility regarding the outcome of the trauma<br>• Obsessive thoughts about the traumatic event<br>• Reduction in interest in anything that does not have to do with the trauma<br>• Attempts to recreate the chain of events leading to the trauma |

Not everyone who has PTSD will exhibit all the symptoms, but even one is enough to cause pain and suffering in one's life.

## Can anyone suffer from PTSD?

Generally speaking, yes, because a person's inner maps give meaning to every event in that person's life. Nevertheless, there are a few factors that increase the probability of PTSD:

- The type of event
- The severity of the consequences
- The duration of the exposure
- The richness of a person's inner maps
- The availability of resources around the time of the event
- The level to which control was lost
- Prior emotional and mental issues
- The level of support from family/community

## Diagnostic Shock

A Diagnostic Shock is a traumatic shock that arises from the act of giving or receiving medical information.

It can occur following an initial diagnosis, a second opinion, test results, a change in medical therapy, a change in diagnosis, or online medical information.

Like any other traumatic event, a diagnostic shock is an unexpected, dramatic, isolating event that evokes a sense of powerlessness and lack of strategy in the face of danger.

# Post -Traumatic Growth (PTG)

The concept of post-traumatic growth was introduced by psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in 1996.2

Tedeschi and Calhoun published a paper titled "The post-traumatic growth inventory: Measuring the positive legacy of trauma," in which they explained that someone who has experienced traumatic events may experience positive changes and growth.

### The Tedeschi and Calhoun PTG Framework

The Tedeschi and Calhoun PTG Framework is widely regarded as the foundational model of PTG. It proposes that while trauma shatters a person's core assumptions about the world, it can be navigated to produce growth in five key domains:

- **Appreciation of life:** A greater sense of gratitude and appreciation for things that might have previously been taken for granted.
- **Relationships with others:** Deeper, more meaningful connections, bonds, and relationships.
- **New possibilities in life:** Shifting perspectives to identify, adapt, and innovate new opportunities and paths.
- **Personal strength:** A deeper sense of resilience, agility, and empowerment.
- **Spiritual/Existential change:** A better understanding of one's core beliefs, core values, and purpose.

## PTG Coaching

The **Expert Companion Model**, developed by Tedeschi and Calhoun, defines the role of the coach as an "expert companion" who works alongside the client, guiding them through the "shattered assumptions" caused by trauma by fostering:

**Emotional Regulation:** Helping clients manage distressing emotions.

**Disclosure**: Encouraging the sharing of their stories.

**Narrative Construction:** Re-authoring their life stories to include strength and purpose.

**The Ten Key Components of Health and Medical PTG Coaching:**

1. Clearing emotional triggers.
2. Clearing the emotional intensity of memories associated with the traumatic event.
3. Creating self-regulation protocols.
4. Identifying and adapting internal resources.
5. Reconstructing the personal narrative and finding authentic ways of self-expression around it.
6. Re-claiming the clinical narrative.
7. Reflecting on and re-evaluating the belief system.
8. Reflecting on and re-evaluating the value hierarchy.
9. Establishing a "Compassionate Self".
10. Finding purpose and meaning in life.

Post-traumatic growth is a process that takes time.

As coaches, we use strength-based and forward-looking approaches to help our clients leverage their experiences to build a more meaningful, purposeful, and resilient present and future.

We introduce the concept of PTG mindfully and intentionally, work at the client's pace, and resist any urge to rush the process by "pushing" a growth agenda.

# Grief and Loss

"Not all grief has trauma. But all trauma has grief."

**- David Kessler**

**Terminology:**
**Loss** is an event.

**Grief** is the internal emotional response to loss. of coming to terms with it.

**Mourning** is the external behavioral expression of grief.

**Bereavement** is the period of grief and mourning after the death of a loved one.

## Loss

A chronic illness /medical crisis is, among other things, an experience of loss.

Because it is an ongoing, ever-changing experience, the loss takes on many shapes and forms: losing a job, physical abilities, the ability to do certain things on your own, social status, friends, mobility, dreams, privacy, sexuality, etc.

Unlike a permanent loss, such as death, chronic illness invites a constant flow of “small” losses into one’s life.

This challenges one to find a way to make space to grieve while still maintaining daily functioning and responsibilities.

As Health and Medical coaches, we encourage our clients to identify their authentic way of grieving these losses and to create spaces where grief can be heard, acknowledged and processed.

Coaching a client through issues of loss requires us to examine our own beliefs, values, thought patterns, and emotions around loss.

## Grief

Grief helps us process the loss and create new meaning in life. Grieving is an unavoidable, painful, and difficult phase and process.

In Health and Medical Coaching, grief is not just associated with death; it is an inherent part of processing the change that has been onset by the illness or medical crisis.

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"Grief is not a feeling it is a capacity. It is not something that disables you, we are not on the receiving end of grief, we are on the practicing end of grief."
— **Stephen Jenkinson**

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These are the three main models we lean into to help to support and coach our clients through their grief:

1. The Five Stages of Grief - Dr. Elizabeth Kubler-Ross
2. The Two-Track Model of Bereavement – Simon Shimshon Rubin
3. The Dual Process Model of Grief/Margaret Stoebe and Henk Schut

## The Theory of Grieving/ The Five Stages of Grief - Dr. Elizabeth Kubler-Ross

Dr. Kubler- Ross' theory about the stages of grief, described in her 1969 book "On Death and Dying," was initially developed through her observations of terminally ill patients and their families.

However, this 5-stage model can be applied to help people understand, cope, and even predict their emotional reactions to a range of events involving life with a chronic illness.

In this model, the Five Stages of Grief are:

- Denial and Isolation
- Anger
- Bargaining
- Depression
- Acceptance

## Denial and Isolation– “This can’t be happening to me”

In this stage, you are in denial about your diagnosis – you do not believe it’s true.

You might feel numb, “in shock” or simply de-personalized, as though “it’s not happening to me but to someone else.” You feel nothing at all - for a while.

> Denial is a natural coping mechanism - it helps us cope with feelings that are overwhelming at the time and protects us from feeling out of control and helpless.

## Anger – “Why me? It’s not fair!”

> As the shock wears off, you begin to accept the truth of your diagnosis, and you start feeling angry about it.

The anger can be generated by various things: the unfairness of being ill, the “betrayal” of your body, a sense of helplessness you might feel, and more.

> Anger is a strong and difficult feeling to cope with. You might find yourself lashing out at friends and family members, finding it difficult to contain your anger, or even trying to “medicate” the anger with alcohol, drugs, or other behaviors.

You might be preoccupied with what could have been done to prevent the illness and/or experience feelings of guilt as you struggle with the idea that you may somehow have caused the disease.

## Bargaining – “I promise to X from now on…”/”I just want to Y before…”

> As the anger subsides, you may find yourself trying to “make deals” with God/yourself/the body to make your illness go away. You might find yourself questioning and doubting your personal and/or spiritual beliefs.

If this doesn’t work, you may find yourself going through the anger stage again.

## Depression – “Why bother?”/ “There is no point…”

As the bargaining subsides, the truth of your situation begins to “sink in,” and you begin to experience profound feelings of sadness and loss.

Sleep disturbance, loss of appetite, lack of energy, poor concentration, and crying spells are common outward manifestations of depression.

This is a normal part of the grieving process.

Although this model uses the term “depression”, it’s important to keep in mind that it is used as a general term to describe a range of sadness-based emotions from profound sadness to reactive depressions and depressive states, all the way to clinical depression.

In cases of significant interference with basic activities (eating, bathing, dressing, etc.) or thoughts of suicide, self-injury, or danger to others, there is a need to involve additional medical and mental health practitioners.

## Acceptance – “I can be Okay.”

Acceptance doesn’t mean that everything is ok and everyone is experiencing a “happy ending”.

Acceptance means you have gained enough strength and support to move forward in your life. By moving forward, you don’t necessarily live the life you would like (without illness), but you have reached a point where you can lead a life of happiness and new ways of self-fulfillment, a life without crippling emotional reactions or self-destructive coping behaviors.

Not everyone manages acceptance, but Kübler-Ross writes that if communication occurs early in the process, even though the process is incomplete before death, the transitions through the stages will be experienced as therapeutic, and the process will continue after death.

> Some Thanatologists say there is a sixth stage – Euphoria.
>
> It “looks” like this: “I’m going to die/I’ve been through the worst; nothing can hurt me anymore – I am untouchable”.
>
> Don’t confuse this stage with denial, they are very different.

## Important to remember when working with this model:

1. This is not a linear process. It’s a spiral model.
2. There is no “right way” or a timetable for this.
3. Some people skip stages, and some repeat stages.
4. It is important to create a safe space and allow self-expression at every stage, without judgment, offering advice, or instant solutions.
5. Create a context for the emotions and reframe what is happening by connecting it to the model and the different stages.

# The Two-Track Model of Bereavement – Shimon Shimshon Rubin

The Two-Track Model of Bereavement was developed by Simon Shimshon Rubin in 1981 and has been further elaborated on in subsequent publications and research.

The model proposes that grief following a loss can be understood by examining two distinct but interrelated dimensions, called tracks:

**Track I: Biopsychosocial Functioning**

- Focuses on the individual's overall well-being, including their biological, psychological, and social functioning.
- Examines the impact of loss on the person's physical health, mental health (anxiety, depression, etc.), and social interactions.
- Evaluates the impact of any significant life stressors.

**Track II: Relationship to who/what has been lost**

- Focuses on the individual's ongoing emotional attachment and relationship with who/what has been lost.
- Explores how the person continues to relate to who/what has been lost, including their memories, thoughts, and feelings associated with the loss.
- Acknowledges that the relationship with who/what has been lost doesn't simply end with the loss but continues in a new form.

***Important things to remember about this model:***

1. The grieving experience is unique to each individual, with varying degrees of focus on each track.
2. The tracks are not isolated but rather interact and influence one another.

This model suggests that grieving is not solely an emotional experience but a dynamic, holistic one that encompasses the individual's overall well-being and their ongoing connection to the person or thing that has been lost.

## The Dual Process Model of Grief/Margaret Stoebe and Henk Schut (DPM)

The Dual Process Model of Grief presents a dynamic approach to grieving. It recognizes that grieving individuals navigate and oscillate between two distinct yet interconnected processes:

1. **Loss-Oriented Coping** – This involves confronting and processing grief-related emotions, such as sadness, longing, anger, or despair. It includes mourning actions such as reminiscing about the deceased, talking about the loss, or engaging in rituals such as funerals and memorials.
2. **Restoration-Oriented Coping** – This focuses on adapting to life without the deceased. It includes activities such as adjusting to new roles and responsibilities, returning to work, socializing, attending to daily tasks, and seeking personal growth.

People may have moments of deep sorrow, followed by periods of respite during which they engage in activities unrelated to their loss. This dynamic approach allows for a more individualized grieving process, accommodating the complexities of each person's journey.

Unlike linear models, where people follow a fixed sequence, the Dual Process Model recognizes that grief is not a straightforward path but a fluctuating experience.

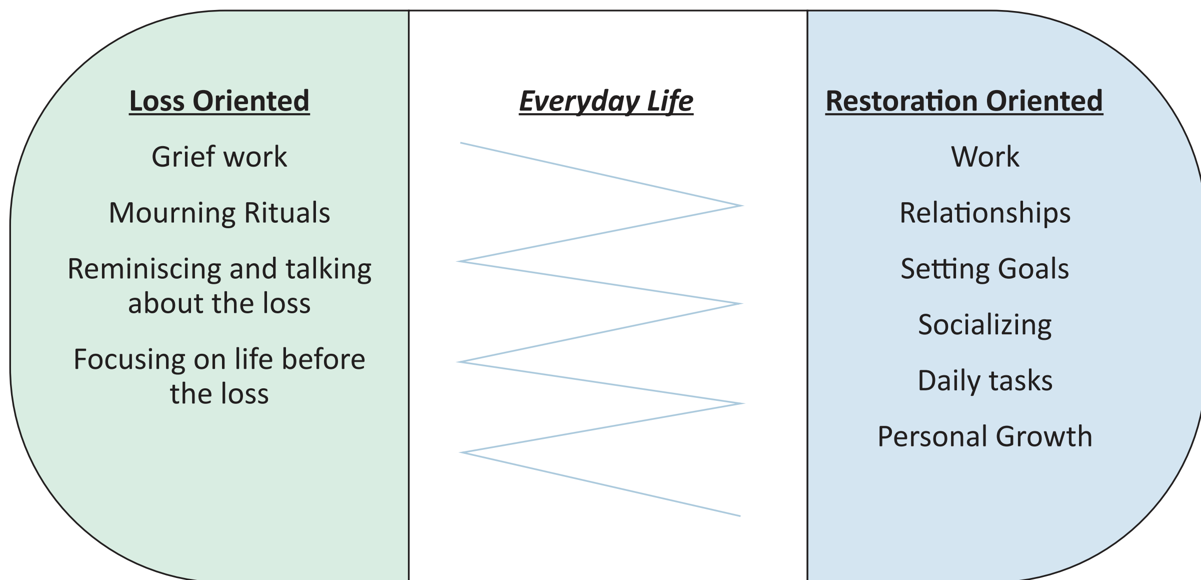
The uniqueness of this model is in its ability to acknowledge two important things:

1. **The necessity of distraction and avoidance**. The model validates the need to take breaks from grief-related emotions by engaging in daily life activities.
2. **Gender and Cultural Differences**. Research suggests that men and women often grieve differently, with men leaning more toward restoration-oriented coping and women engaging more in loss-oriented coping. The model accommodates these differences, making it more inclusive.

A major strength of the Dual Process Model is its emphasis on **oscillation**, or the movement between confronting loss and focusing on restoration. This helps cope with the overwhelm of grief while maintaining a space and context for processing emotions in meaningful ways.

The movement acknowledges that loss and restoration coexist, allowing individuals to integrate grief into their lives without being consumed by it.

By embracing this approach, people can honor their loss while finding new meaning and purpose.




## Applying the DPM in Health and Medical Coaching

1. **Awareness of the nature of grief:** Grief is not about reaching a clear endpoint. Instead, it is a lifelong journey of moving on—with love, memories, and hope, that evolve over time.
2. **Awareness of the Two Processes:** awareness that both loss-oriented and restoration-oriented coping are essential.
3. **Permission to Oscillate:** inner permission to shift between grief and daily activities. It's okay to mourn and to seek comfort in routines or distractions.
4. **Self-Care:** Taking care of physical and mental health through exercise, proper nutrition, mindfulness, and activities that bring peace.
5. **Support Systems:** friends, family, or professionals can navigate both aspects of grief.
6. **Self-compassion:** There is no "right" way to grieve; each grief journey is unique. There is no pressure to "move on" quickly or stay "stuck" in one phase.

***Emotions that come up during the grieving process:***

1. **Shock** – even when the loss is expected, we're still stunned by the fact that it really happened
2. **Denial**– we are not yet prepared to accept the reality of the loss
3. **Relief** – when the dying process was a painful one, accompanied by the suffering of our loved one, we feel relief. In some cases, this will be accompanied by guilt
4. **Guilt** – for things that were and were not said or done
5. **Fear** – How will life continue now? What will happen to us?
6. **Numbness** – a feeling that can last from several hours to several weeks and even months
7. **Anger** – at the deceased, the family, the doctor, the medical system…
8. **Longing** – for what has been lost and what will never be possible
9. **Loneliness** - difficulty adjusting to life without the person/thing that is lost
10. **Sorrow** – for the loss of connection

It is important to remember that grief takes time, and the best thing that we can give our clients is our time.

## Anticipatory Grief

Anticipatory grief relates to grief that occurs in expectation of one's death or that of a loved one.

*Anticipatory grief differs from unanticipated grief in a few ways:*

**1.** There is time to "look forward" to death

**2.** There is chronic stress

**3.** There are characteristics of a Liminal Phase

Therese Rando (Clinical Psychologist, Thanatologist, Traumatologist) detailed the many aspects of anticipatory grief and the factors that influence it in individuals.

We will address the points relevant to our work as Health and Medical Coaches.

### Anticipatory grief is affected by:

1. The duration and nature of the illness
2. The secondary losses
3. Existing level of resilience and emotional agility
4. The person's previous experience with/or personal expectations regarding illness, loss, and death
5. The person's knowledge and response to the illness
6. The griever's perception of the preventability of the illness
7. The griever's evaluation of the quality of care, treatment, and resources provided
8. The quality of the person's life after the diagnosis
9. The family's support and participation in the patient's care
10. The person's support system.
11. The person's sociocultural, ethnic, and religious-philosophical background
12. Family and community rituals for illness, loss, dying, and death

Our role as Health Medical Coaches is to help our clients create a separation and grieving process aligned with their values and beliefs.

## Coaching grieving clients:

Grief can be an overwhelming process. People are often unsure when and how grieving begins and when and how it ends.

Cultural and/or familial rites of mourning provide a structure to help a person reframe and process the loss, but many times this does not feel authentic or enough.

In the context of illness, many of the losses the person feels due to the loss of health are "invisible" to their social circles and therefore are not witnessed and acknowledged.

Our job, as Health and Medical coaches, is to name, validate, and normalize this loss and grief, and to help the client create authentic coping strategies that allow their grief to be heard and processed.

**Principles of supporting a grieving client and holding a safe, professional, and ethical coaching space:**

1. Meet the clients where they are without an agenda.
2. Ask about what or who has been lost, or is being lost, and listen without judgment.
3. Be willing to be a "kind witness" to the client's experience, narrative, and emotions.
4. Be fully present with the client and whatever they bring to the space.
5. Invite the client to express their emotions.
6. Support the client in releasing guilt.
7. Help the client integrate the pain of loss and love.
8. Support the client in finding new meaning after the loss.
9. Be aware of bias – yours and the client's.

**Important things to remember about grief (that can be used as reframes):**

- Grief comes in waves
- There is no right or wrong way to do grief. People are doing grief perfectly, all the time.
- Grief is not a linear process but a spiral one.
- Grief doesn't have an agenda or a linear timeline.
- If clients say they are lost, we meet them there - at the "lost."
- Mourning and grief are not the same. Grief is the emotional reaction to loss, and Mourning is the social "doing" of grief.
- It is essential to create a safe space and allow self-expression, without judgment, offering advice, or instant solutions.

There are four additional aspects we address in Health and Medical Coaching to support a grieving process:

**1.** *Maintaining function and health*

- Regular meals and healthy nutrition
- Sleep and rest
- Physical activity
- Keeping the GP informed and updated

**2.** *Social support*

- Maintaining connection with current social circles
- Support groups
- Maintaining a calendar of community events

**3.** *Emotional process*

- Giving permission to feel and be with what is currently present
- Sharing and processing emotions
- Giving permission to begin memorialization
- Documenting the emotional process
- Creating a wider context

**4.** *Family and close relationships*

- Allowing the loss to be familial as well as personal
- Giving permission to various ways of mourning and bereavement (releasing judgment)
- Maintaining familiar roles and events
- Authentically expressing wishes and setting boundaries

## Writing a Loss History

A loss history is a great tool for clients to reveal how they view loss. It helps them understand the coping mechanisms they use.

The information included should address various events of loss (not only deaths), such as divorces, job losses, illnesses, major moves, etc.

These are examples of questions that could be used:

- Was an illness or deformity something to be ashamed of or talked about openly in your family?
- Was it okay to show sadness or pain in the family? Or were they considered weaknesses?
- When you were young, was loss, either physical or not, discussed, or did you know not to ask?
- What are your family mottos regarding loss?
- What are some stories told in the family regarding the “right way” to deal with loss?
- How do you think your family wants you to deal with your loss based on the messages you received?
- How do you think your friends/community want you to deal with your loss based on the messages you received?
- What cultural rituals for sickness, old age, death, burial, and bereavement does your family/community practice?
- What kind of beliefs regarding sickness and loss did you hear in your family/community?

# End-of-life

*" It's not that I'm afraid to die, I just don't want to be there when it happens."*

***- Woody Allen***

Death is the ultimate, most frightening form of loss. In this context, it is important to remember:

1. Death is a part of life

2. We are all going to die

When the topic of Death comes up in the coaching process, we, as Health and Medical coaches, need to hold a safe space while balancing between letting the client set the pace and calling the client forth.

As human beings, talking about our death or planning for it goes against every instinct we have. Yet in the context of a medical coaching process, talking about death is just another way of "walking our talk".

## "The Talk"

Talking about death in a coaching way means addressing the topic in a way that aligns with the client's values.

Like with everything else that comes up in coaching, we want to design an alliance around this talk and ask our client for permission to be curious, "blurt out" our intuition, and challenge.

*There are certain topics that need to be addressed:*

- Type of palliative or end-of-life care
- Preferred place of death
- Resuscitation or DNR
- Preferred way of dealing with the bodily remains
- Funeral arrangements
- Care of dependents
- Organ donation
- Legacy
- Farewells
- Having "The Talk" with family and loved ones
- Worries and unresolved issues
- Online assets and legacies (Digital Dust)
- Closure

# Dying

*"Dying is active. Dying is not what happens to you. Dying is what you do."*

***- Stephen Jenkinson***

***Things we need to remember about the process of dying:***

1. Dying can be a traumatic process for the person and his/her community (family, friends, caregivers, and colleagues)

2. The dying are grieving as well

3. Not everyone has a religious faith to lean back on, but everyone has resources that bring comfort and closure

4. The process of dying holds a lot of fear and uncertainty:

- Fear of being and/or dying alone
- Fear of becoming a burden
- Fear of pain
- Fear of losing one's dignity
- Fear of the unknown

## Things we need to remember about holding space for a dying client:

1. Our presence is the most empowering and valuable thing in the stage of the coaching process

2. We come from a place of empathy and not sympathy

3. Listen carefully to everything - verbal and non-verbal

4. It is crucial at this point to lower the level of fear and stress as much as possible

Our job is not to prevent the pain of loss or the loss itself.

***Our job is to hold a safe space that is aligned with our client's values and beliefs and honors how our client wishes to live until they die.***

# Stress

## Introduction to Stress

Stress is a physiological response to a stressor that disrupts how we normally think and behave.
Hans Selye, known as the "father of stress research," defined stress as the "non-specific response of the body to any demand for change". He viewed stress as a biological mechanism that focuses on how the body reacts to, resists, and adapts to stressors.

Selye believed that stress was necessary for life and only became harmful when experienced in excess. One of his famous quotes stated, "Stress is the spice of life; the absence of stress is death."

**Stressors**

Stressors are triggers of stress.
They can be short-lived, long-lasting, recurring, external, internal, physical, emotional, and mental.
Stressors are both universal, personal, and subjective.

From Hans Selye's perspective, diverse stressors trigger a universal and non-specific set of physiological responses.

From an NLP perspective, stress is a sense of distress caused by a lack of balance between demands/ challenges and available resources.

From this perspective, a stressor is a demand that reveals the gap between challenges and resources.

## Acute Stress

Acute Stress is short-lived and results from exposure to an emotionally dramatic event/situation (stressor) such as a deadline, financial issue, marriage, divorce, childbirth, trip, promotion, etc.
On the one hand, Acute Stress can be beneficial and create motivation. On the other hand, it can cause physical symptoms such as:

- Headaches
- Stomach aches or indigestion
- Sweating
- Heart palpitations
- Shortness of breath
- Dizziness
- Chest pain

During an Acute Stress event, our body releases stress hormones (adrenaline and cortisol), which flood the body to get the heart pumping and boost energy levels. Once the crisis has passed, the body balances adrenaline and cortisol levels, stress diminishes, and we start to recover.

## Chronic Stress

Chronic, or long-term, Stress results from ongoing exposure to one or more unresolved stressors.
The long-term high level of cortisol in the body causes various health problems:

1. Memory and reasoning impairment
2. High blood pressure due to the narrowing of blood vessels
3. Bruxism - clenching and grinding the teeth, a condition afflicting the jaw and surrounding muscles
4. Suppression of neurotransmission in the brain, causing depression
5. A weakening of the immune system and increased risk of infections and stress-related diseases
6. Excessive hair loss
7. Aggravation of existing skin problems, including psoriasis, rosacea, acne, and eczema
8. Muscular pain, mostly in the back, neck, and shoulders
9. High risk of cardiovascular disease and hypertension
10. Aggravation of existing medical conditions and illnesses
11. Aggravation of the digestive system that results in irritable bowel, nausea, or diarrhea
12. Weight gain
13. Impact on sex drive, vaginal infections, impotence, sexual dysfunction, and infertility
14. Mental and emotional problems, including insomnia, headaches, irritability, anxiety, and personality changes

# The Relationship Between Stress, Health, and Illness

The relationship between stress and disease is now well established
The word 'stress' comes from physics and refers to the interaction between a force and the opposing resistance to that force.

The first step in understanding the relationship between stress, health, and illness is that stress is not a "stand-alone" reaction to a stressor. Stress is the outcome of four systems acting in unison:

- Cognitive system
- Nervous system
- Endocrine system
- Immune system

Here are six theoretical models that address this relationship from a scientific perspective:

1. **The Borysenko Model**
   Dr. Joan Borysenko's model is widely regarded as the most accurate description of the immune system. When the brain perceives a stimulus as a threat, it triggers the autonomic nervous system (ANS) to release stress hormones, which affect how the body and organs function to better cope with the threat. According to Borysenko, when the brain is frequently stimulated, it elicits heightened neural responses that accelerate the metabolic rate of organs. This creates autonomic dysregulation, in which the autonomic nervous system becomes hypersensitive and overresponsive to perceived threats, leading to elevated stress hormone levels. This, in turn, can lead to migraines, ulcers, irritable bowel syndrome, coronary heart disease, and hypertension.
   As the body becomes "flooded" with stress hormones, the immune system's various functions are suppressed, leading to lower T cell levels and reduced ability to locate and destroy harmful pathogens. This, in turn, can lead to infections, allergies, cancer, lupus, arthritis, and AIDS.
   (Read more about Dr. Borysenko - https://www.joanborysenko.com/)

2. **The Pert Model**
   After discovering opioid receptors, Dr. Candace Pert identified the link between the nervous and immune systems.
   She discovered that neuropeptides (messenger hormones) can bind to receptors on lymphocytes (white blood cells, including T and B cells, both of which are natural cells that eliminate or prevent the growth of pathogens). Neuropeptides carry a biochemical 'code' that is like a language influenced by emotional response.
   Pert discovered two additional things:
   1. Immune cells can manufacture neuropeptides while being able to adapt to emotions.
   2. Various cell tissues comprising the immune system can synthesize neuropeptides to alter immune function.

   This led to the belief that neuropeptides mediate communication between the brain, T cells, and B cells, suggesting that emotions can suppress or enhance immune function via these neuropeptides.
   (Read more about Dr. Pert - http://candacepert.com/)

3. **<u>The Lipton Model</u>**

Dr. Bruce Lipton is an advocate of the 'epigenetic theory'. This is the study of molecular mechanisms by which the environment controls gene activity.

Lipton studied the cell's environment and suggested that the cell's brain is not in the nucleus but in the membrane. The membrane encodes the information that enables the cell to translate environmental signals into behavior. Lipton's research revealed that cells can promote growth as well as the production of their integrity. They can't do both simultaneously.

Looking at cells' physiological systems, Lipton noted that stress hormones strongly affect the immune system, to the point that organ transplant patients are often given high doses of these hormones to suppress immune rejection of the new organ. Lipton examined the correlation between stress and aging. His studies show that telomeres (a DNA-protein complex involved in cell division) are significantly shortened by age and/or by chronic physiological stress, indicating a link between stress and aging.

4. **<u>The Gerber Model</u>**

Dr. Richard Gerber's model suggests that the mind, through conscious and unconscious thoughts, exists as a subtle energy field surrounding the body and influencing biochemical reactions. Gerber names four layers that compose this energy field:

- The etheric layer – closest to the body
- The astral layer – emotional thought
- The mental layer – instinct, intellect, and intuition
- The casual layer - soul

A disruption or disturbance in this subtle energy field cascades through the four layers via the chakras and meridians thus leading to illness and disease.

Thoughts, perceptions, and emotions that originate in various layers of subtle energy cascade through the mind-body interface and are decoded at the molecular level, potentially causing biological changes in the body.

From Gerber's perspective, stress-related symptoms that appear in the physical body are the manifestation of problems that occurred earlier because of disturbances at higher energy levels.

* The study of subtle energy and energy medicine has led to a new field called Energy Psychology. This is a term used to describe the relationship between subtle energy, psychological issues, and trauma involving certain aspects of stress.

5. **<u>The Pelletier Model</u>**

Dr. Kenneth Pelletier believed several issues must be studied and understood before a stress-disease model can be developed.

These include:

1. Manifestation of disease states in people with Multiple Personality Disorder: people who have different personalities manifest different illnesses.
2. Spontaneous remission: the sudden disappearance of diseased tissue – most often observed with terminally ill cancer patients but acknowledged with other illnesses as well.
3. Hypnosis: when the power of the unconscious mind is used to induce physiological changes. There have been documented cures for warts, asthma, hay fever, contact dermatitis, and some animal allergies using hypnosis.
4. Placebos/Nocebos:

   Placebo - the phenomenon where a medication that has no proven efficacy is believed to be effective by the person receiving it, and it is.

   Nocebo - the phenomenon where a medication that has been proven to be ext

5. remely effective is believed to be ineffective by the person receiving it, and it is.
6. Cell memory: cells of various organ tissues hold an energetic memory pattern that transfers to the next recipient. This has been discovered as medical technology has enabled organ transplants.
7. Subtle energy: “mind-body interaction clearly involves subtle energy or subtle information exchange… given that mind-body interactions involve an exchange in subtle energy, principles of physics may be appropriately applied to issues of health and disease”. Pelletier
8. Immune enhancement: if a suppressed immune system can, by way of thought, influence the progression of tumors and other disease processes, physiological factors may also be able to enhance the immune system to create an environment conducive to spontaneous remission and other healing effects.

After reviewing the medical literature at the time, Pelletier believed that the only logical approach to understanding the stress-disease/mind-body phenomenon is to consider the individual to be more than the sum of their physiological parts.

(Read more about Dr. Pelletier - https://drpelletier.com/)

6. **The Selye Syndrome (General Adaptation Syndrome)**

Hans Selye (who first incorporated this term into the medical lexicon to describe the “nonspecific response of the body to any demand “) rejected the study of specific disease signs and symptoms and instead focused on universal patient reactions to illness.
He was the first scientist to identify ‘stress’ as underpinning the nonspecific signs and symptoms of illness.
Selye states that stress is present in an individual throughout the entire period of exposure to a nonspecific demand.

He made two important distinctions:

1. The distinction between Eustress (positive stress) and Distress (negative stress)
2. The distinction between acute stress and the total response to chronically applied stressors

Selye termed the second distinction the General Adaptation Syndrome (GAS), which is also known as Selye’s Syndrome. The syndrome divides the stress response into three phases:

- Alarm Reaction: The body defends itself using an immediate “freeze, fight or flight” response.
- Resistance: The body attempts to maintain homeostasis by resisting the change or adapting to the ongoing stressor.
- Exhaustion: As the body’s exposure to long-term stress continues, it becomes exhausted and reaches a state of depleted energy, this leads to changes in the body’s function or disease.

From Selye’s perspective, stress is a choreographed state of events, not merely a psychological term, and is experienced by all individuals during illness.
It differs fundamentally from the fight-or-flight or acute stress response that occurs when facing a perceived threat.

Hans Selye’s concept of stress influenced scientific and lay communities alike across fields as diverse as endocrinology, complementary medicine, animal breeding, and social psychology.

## Psychosomatic Illnesses

Another step in understanding the relationship between stress, health, and illness is understanding the concept of **Psychosomatic illnesses**.

**Psychosomatic** mind (psyche), body (soma) – refers to the psychological functioning of the brain (mind) on the physiological functions of the body.

**Psychosomatic Illness** – a physical illness, disease, or disorder in which the physical symptoms are caused, triggered, or worsened by emotional and mental factors.
It is now recognized that emotional factors play a role in the development of nearly all organic illnesses. The physical manifestation of an illness, unless caused by mechanical trauma, cannot be separated from a person's emotional life. There is an emotional and mental aspect to every physical disease.
To an extent, most illnesses are psychosomatic as they involve both mind and body.
Experts estimate that 75-80% of all health-related issues and problems are either precipitated or aggravated by stress.

**Psychosomatic Medicine** is an interdisciplinary medical field exploring the relationships between social, psychological, and behavioral factors and the physiological function of the body.
Psychosomatic Medicine integrates diverse specialties, including psychiatry, psychology, neurology, internal medicine, surgery, allergy, dermatology, and psychoneuroimmunology.

## Psychoneuroimmunology

Psychoneuroimmunology (PNI) is a relatively new field that studies the interactions among psychological processes, the nervous system, and the immune system.

Dr. Kenneth Pelletier defines PNI as the study of the intricate interactions among consciousness (psych), the brain and central nervous system (neuro), and the body's defense against external infection and internal aberrant cell division (immunology).
PNI examines the relationship between mental processes and health by focusing on the interactions between the nervous and immune systems.
The influence of one system on the other is intricate and designed to sense danger and produce an appropriate adaptive response. Research conducted in recent years shows that brain-to-immune interactions are highly modulated by psychological factors that influence immunity and immune-mediated disease.
PNI is an interdisciplinary approach that incorporates psychology, neuroscience, immunology, physiology, genetics, pharmacology, molecular biology, psychiatry, behavioral medicine, infectious diseases, endocrinology, and rheumatology

## Coping with Stress

Hans Selye famously said, “insight, ‘It is not stress that kills us; it is our reaction to it.”

From Selye’s perspective, stressors are inevitable, but it is our internal, emotional, and physical responses to them that determine our health outcomes. He emphasized that changing our perspective or attitude and practicing stress-relief practices can help us shift negative, destructive stress (distress) into positive, manageable stress (eustress).

Selye argued that we can control the impact of stress through our responses.

# The Connection Between Stress and the 6 Trauma Responses

From a physiological perspective, the body’s response to stress is to activate the sympathetic nervous system, which results in one of the 6 trauma responses.

Since our brain does not know how to distinguish between “reality” and “imagination”, it cannot tell the difference between an external environmental stressor and an internal one. The body responds similarly to both types of stressors.

People react differently to acute and chronic stressors.

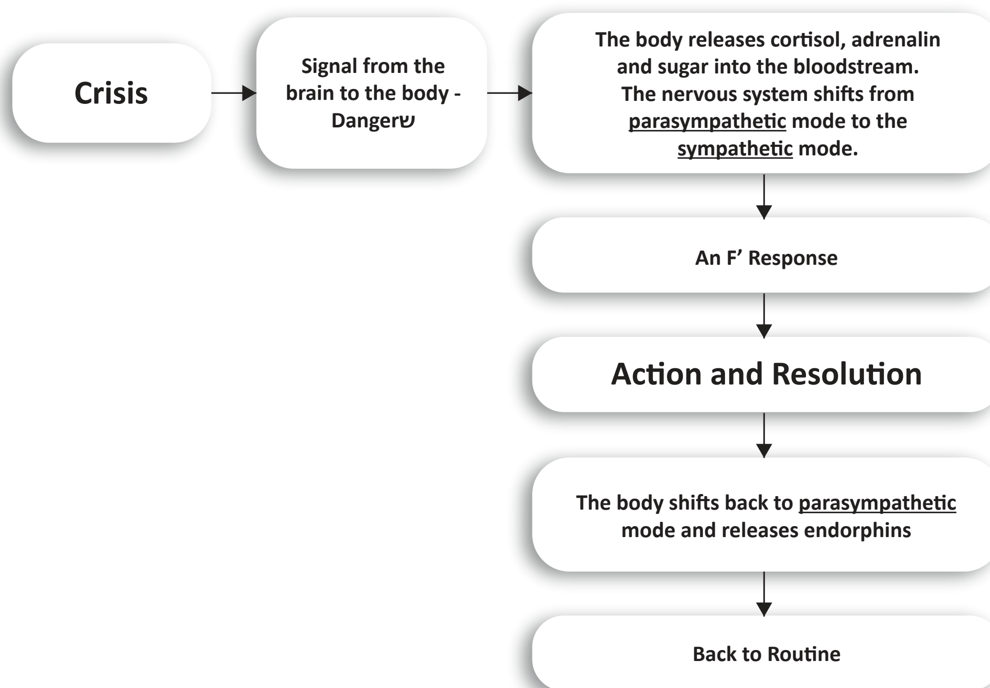
The response to a stressor stems from the emotions triggered by a person’s perception of it.

As Health and Medical Coaches, we focus on building resilience and effective coping skills, not on the story of the stressor.

## There are four types of reactions to stressors:

1. Physical reactions: blood pressure, heart rate, body temperature, breathing rate, etc.
2. Emotional reactions: fear, anxiety, anger, shame, sadness, etc.
3. Behavioral reactions: loss of interest, aggression, crying, nervousness, etc.
4. Mental reactions: confusion, distortions in perception, difficulty in judgment, etc.

An abstract flow chart of the stress reaction in the body




Chronic stress means that the person has not completed the 'action and resolution' phase.

In the Health and Medical Coaching process, we help the client complete the 'action and resolution' phase, enabling them to shift into the parasympathetic mode and return to a balanced state

*It's important to remember:*

1. The connection between stress and illness is 'a two-way street - Stress causes illness and illness causes stress.
2. Stressors are subjective and can be anything from an argument to an accident.
3. Positive events can be stressors.
4. Not all negative events are stressors.

## Coping with stress

There is no "right" way to cope with stress.

Medication alone does not provide a complete solution.
The downside of using medication alone is that it only addresses the symptoms and not the cause.
Paradoxically, that is also its benefit, as it allows a person to find relief while undergoing a deeper process of identifying and releasing the underlying stressors.
Alternative and complementary therapies offer a variety of efficient ways to cope with stress. Some provide symptomatic relief, and others help relieve stressors.

In Health and Medical Coaching, we work with our clients to clear stressors so that resources previously directed toward coping with stress can be redirected to the current stressor and onward toward healing.

# Burnout

Burnout is a term used to describe severe chronic stress related to a stressful working environment. The term was first coined in the mid-1970s by Herbert Freudenberger.

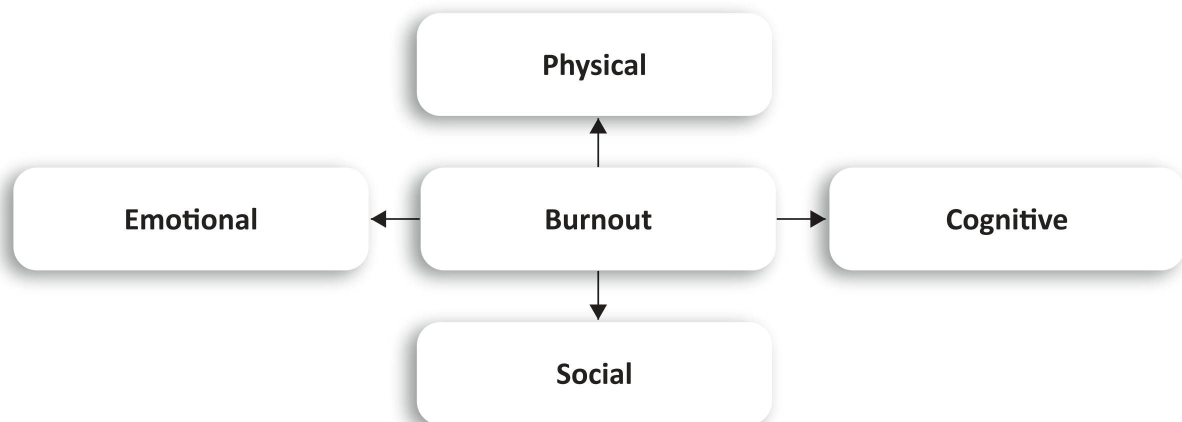
Burnout syndrome is characterized by three dimensions:
1) Emotional exhaustion (depletion of emotional resources)
2) Depersonalization (negative feelings and cynical attitudes toward the recipient of one's services or care)
3) Reduced personal accomplishment (a tendency to evaluate oneself negatively, particularly with regard to work)

*Maslach C, Schaufeli WB, Leiter MB. Job burnout. Annu Rev Psychol. 2001;52:397-422.

We can divide the causes of burnout into three main categories:

1. Personal – conflicts of values, conflicts of beliefs, negative self-talk, low self-esteem.
2. Interpersonal – conflicts within relationships at work and/or in life.
3. Organizational – conflicts of values and/or beliefs with the organization resulting in a breakdown of trust in the organization.

**Manifestations of burnout:**



***Physical:***

- Headaches
- Digestive problems: diarrhea, constipation, upset stomach
- Muscle tension
- Sleep disturbances: inability to sleep, insomnia, too much sleep
- Fatigue, chronic tiredness, or a sense of feeling drained
- Cardiac symptoms: chest pain/pressure, palpitations, tachycardia
- Frequent colds or other illnesses
- High blood pressure
- Anxiety/stress symptoms

***Emotional:***

- Mood swings
- Restlessness and Irritability
- Oversensitivity
- Stress and anxiety
- Sadness
- Reflective depression
- Anger and resentment
- Feeling hopeless or helpless
- Irritability or having a "short fuse"
- Feeling overwhelmed
- Decreased sense of purpose and meaning in life
- Feeling ineffective and cynical or negative about life in general

***Social:***

- Increased drinking or smoking marihuana
- Anger outbursts
- Changes in eating or shopping habits (including online shopping)
- Avoidance or dread of working with certain people
- Reduced ability to feel empathy towards others
- Frequent use of sick days and cancellation of sessions
- Lack of joyfulness
- Less desire to be with friends or family
- Impatience with others
- Increased anxiety in public places
- Greater need to be in control to feel safe
- Decrease in a sense of basic trust in others and in the world

***Cognitive:***

- Decreased concentration and focus
- Poor concentration, focus, and judgment
- Impaired memory
- "Seeing" scary images in your thoughts
- Decrease in creativity

## Compassion Fatigue

Compaction fatigue is a form of burnout connected with healthcare environments.

It is unique to professional and family caregivers.

Compassion fatigue is defined as a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress (Anewalt, 2009; Figley, 1995).

The term was first coined by nurse Clara Joinson in 1992 during her work with emergency room personnel. She identified Compassion Fatigue as a unique form of burnout that affects individuals in caregiving roles. That same year, Jeffrey Kottler (1992) emphasized the importance of compassion in treating extremely difficult and resistant patients in his book, Compassionate Therapy.
Most studies addressing the effectiveness of therapy point to the therapeutic alliance between clients and clinicians as the basis for empathizing, understanding, and helping clients (Figley & Nelson, 1989). When it is absent, it is highly unlikely that any change (therapeutic or otherwise) will occur.
In Health and Medical Coaching, we view the alliance between the Client and the Coach as the relationship that holds the coaching process together. The most important ingredient in building a Health and Medical Coaching relationship (or any other coaching or therapeutic relationship) is the client's trust in the coach and the process. This trust is directly related to the degree to which the coach utilizes and expresses empathy and compassion.
In the context of Health and Medical Coaching, we need to be aware of Compassion Fatigue when working with a client who is a caregiver and/or in contact with someone coping with a medical crisis.

In addition, we must recognize that, as Health and Medical Coaches, we are susceptible to Compassion Fatigue. There are several identifiable symptoms of Compassion Fatigue. These can be physical, emotional, behavioral, and cognitive.

It seems that in the past few years, the conversation around burnout and compassion fatigue has been reduced to a list of wellness tools, tips, and techniques.
This is both "victim shaming", as if a person failed in meditating and managing their stress enough, and a fundamental misunderstanding of what burnout and compassion fatigue really are. They are first and foremost manifestations of Chronic Stress.

Among the many internal stressors that cause Chronic Stress, two major ones are often overlooked.
One is a value conflict that is called **Moral Injury** – a transgression of deeply held moral beliefs and expectations.
And the other is a belief conflict that I call a **Trust Injury** - transgression of our belief system that creates a break in trust.
When addressing burnout and compassion fatigue, we must be brave enough to invite our clients to examine these conflicts, as well as their triggers and symptoms, and to resist the easy path of focusing on wellness tips and "quick fixes".

## The B.T.R.S. model

The B.T.R.S. model is the approach used in Health and Medical Coaching to help clients reduce and manage their stress.

B- Behavior
T- Trigger
R – Release
S – Self-care

**B- Behavior**

Stress shows itself through behaviors – internal and external.
Either there is a change in the ability to perform regular behaviors, or new (usually unwanted) behaviors are associated with stress.
The discussion about stress always starts by clarifying how it affects, shapes, and drives behaviors.

**T- Trigger**

Once we have identified the client's stress behaviors, we begin looking for the triggers that activate them.
Stress triggers are called stressors.
Stressors act like activation buttons, triggering a physical and physiological response (behavior) to stress.
Stressors can be external and internal. Most of all, they are subjective.
A stressor can activate one behavior or several.

**R – Release & Replace**

Once we have identified a stressor, we release it by clearing the actual stressor and replacing it with an anchored resource. We test and repeat this process as needed until the client experiences a significant change in the old behaviors.

**S – self-care**

We integrate the new resource into a self-care plan that we create with the client.

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*"It's not what happens to you, but how you react to it that matters."*

***- Epictetus***

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# Self-care

1. Self-care is an ongoing, action-oriented, intentional practice designed to:
2. Strengthen resilience
3. Increase wellness (wellbeing and quality of life)
4. Improve physical and mental health

Enhance satisfaction and fulfilment

Self-care is more than a set of techniques. It is an operational mode grounded in mindset, beliefs, emotions, and actions.
It is also an invitation to heal our relationship with concepts such as self-love, acceptance, dependence, needs, wants, and desires.
When coping with a health challenge or medical crisis, self-care is an essential part of a comprehensive health strategy and should be practiced regularly.

Caring for ourselves can be challenging because it requires addressing things we tend to avoid, such as our fears, insecurities, limiting beliefs, and difficult past experiences.
It is often easier to care for others than to care for oneself.

# Obstacles to self-care

Many people have obstacles that prevent them from following self-care practices.

- Sentences that indicate the presence of an obstacle:
- I don’t have the time right now
- I don’t have the money for it
- I have other obligations/commitments/responsibilities right now that are more important
- I am in the middle of a crisis
- There are more urgent things I need to do
- Once this is over, I will make time for it
- This doesn’t feel like a priority right now
- It can wait

**The 7 Main Obstacles to Self-care:**

1. **Identifying a need with a problem**.
   When having a need means something is wrong with me.
   Example: if I need ___________, it means I have a problem, because I am not able to ________ / I am __________ .
2. **Confusing a need with dependence.**
   Needing something can create a dependence on that thing, which can lead to feelings of shame and guilt.
   Example: If I need something from you & you give it to me, I will become dependent on you for that thing.
3. **Internalized messages about self.**
   Internalizing messages about the connection between asking/receiving help or support and self-worth.
   Examples: I am not worthy of ______, I don’t deserve _________, I can receive/ ask for what I need once everyone else has received theirs, I am not a baby/child that needs constant (self) care.

4. **Emotional Avoidance.**
   Addressing one need can reveal the pain of other unmet needs. This is often unconscious.
   Example: If I give myself _____, it will only bring up the pain of everything else that I was deprived of, and I prefer not to feel it.

5. **Beliefs and stories about receiving – what it says about me**.
   Connecting self-care with identity.
   Examples: only weak people need the help and support of others; I need ______ because I am not ______ enough; I must be self-sufficient and not rely on anyone else; I am loved/accepted when I am self-sufficient/strong.

6. **Beliefs and stories about receiving – what it says about others**.
   Placing the responsibility for my self-care and wellness on others.
   My ______ should know what I need and how to give it to me, and if they don't, it means they don't love/see/ care about me.

7. **Beliefs and stories about ability.**
   Addresses the ability to receive help, the implementation of self-care practices, and the efficacy of those practices on well-being.
   Example: I have tried everything, and nothing seems to help. There is nothing I can do to change this. I won't be able to cope with asking for help and not receiving it.

**The Pillars of Self-Care**

1. Identifying needs
2. Connecting to values
3. Realistic actions
4. Compassion
5. Self-nourishment

**When coaching on the topic of Self-Care, we want to address these five levels:**

1. Basic Needs – addressing the current crisis. If you are a Health, Wellness, or Medical Coach, this includes medical care and medication adherence.
2. Physical Needs – listening to the body's needs regarding nutrition, hydration, rest, movement, and touch.
3. Emotional needs –addressing issues of love, acceptance, authenticity, connection, and self-expression.
4. Spiritual needs –addressing vision, purpose, connection to a higher self, intuition, creativity.
5. Social & Relationship needs – addressing choice, connection, boundaries, open communication, support.

The roles of self-care and a healthy lifestyle are central in the prevention and/or recovery from burnout and compassion fatigue.

In Health and Medical Coaching, we use a Metrix template to help clients establish a structured and sustainable self-care practice.

## The Health and Medical Coaching Self-Care Matrix

| ***Level 3*** | Purpose | Spirituality | Personal Development | Mind-Body Connections (regulation) | Values |
|---|---|---|---|---|---|
| ***Level 2*** | Family Relationships | Work-Related Relationships | Relations with Medical Team/ Caregivers | Social Support | Communication Skills |
| ***Level 1*** | Nutrition | Movement & Exercise | Rest | Environment | Time & Resource Management |

## Working with the Health and Medical Coaching Self-Care Matrix

| | | | | | |
|---|---|---|---|---|---|
| ***Level 3*** | **Purpose**<br><br>Identify a sense of life's purpose ("for the sake of what is it important to address your stress and self-care?"). | **Spirituality**<br><br>Reframe spirituality as a self-care resource. | **Personal Development**<br><br>Identify areas the client would like to continue developing.<br><br>Explore options.<br><br>Create new strategies. | **Mind-Body Connections**<br><br>Create awareness regarding the "Body-Mind" connections.<br><br>Identify with the client what it means for him/her.<br><br>Create new strategies. | **Values**<br><br>Create awareness regarding the concept of values and core values.<br><br>Identify with the client the values around health and self-care.<br><br>Create new strategies. |
| ***Level 2*** | **Family Relationships**<br><br>Review stressors and challenges regarding relationships with family members.<br><br>Clear stressors.<br><br>Create new strategies. | **Work-related relationships**<br><br>Review stressors and challenges regarding workplace relationships.<br><br>Clear stressors.<br><br>Create new strategies. | **Relations with Medical Team/ Caregivers**<br><br>Review stressors and challenges regarding relationships with the medical team/ caregivers.<br><br>Clear stressors.<br><br>Create new strategies. | **Social Support**<br><br>Create awareness of the need and the added value of social support for self-care.<br><br>Identify specific needs.<br><br>Explore options.<br><br>Create new strategies. | **Communication skills**<br><br>Review stressors and challenges around specific communication skills.<br><br>Clear stressors.<br><br>Create new strategies |
| ***Level 1*** | **Nutrition**<br><br>Create awareness regarding healthy nutrition.<br><br>Invite the client to make a conscious choice.<br><br>Create new strategies. | **Movement & Exercise**<br><br>Create awareness regarding the importance and impact of movement and exercise.<br><br>Evaluate options.<br><br>Invite the client to make a conscious choice.<br><br>Create new strategies. | **Rest**<br><br>Create awareness regarding the quality and impact of rest.<br><br>Evaluate options.<br><br>Invite the client to make a conscious choice.<br><br>Create new strategies. | **Environment**<br><br>Create awareness regarding current stressors and challenges in the environment.<br><br>Evaluate options.<br><br>Invite the client to make a conscious choice.<br><br>Create new strategies. | **Time & Resource Management**<br><br>Review of current challenges regarding time & resource management.<br><br>Evaluate options.<br><br>Invite the client to make a conscious choice.<br><br>Create new strategies. |

**Self-care for Coaches**

Many coaches, us included, are not very good at self-care.  It's easy to neglect ourselves, especially if we love our work and it fulfills us.

Here are 3 reasons why YOUR self-care should be a priority:

1. Practicing self-care and attending to your stressors and needs will prevent you from experiencing burnout, exhaustion, and compassion fatigue, all of which affect the quality of your coaching.
2. Walk your talk because your clients learn from you. When your clients see you exhibiting self-compassion, they are more likely to follow your lead in caring for themselves. Modeling is a very important coaching tool.
3. As fulfilling and exciting as it is, Health and Medical Coaching is emotionally, mentally, spiritually, and even physically demanding. Often, after a session ends, we are left with a bundle of emotions about what the client said, felt, and experienced, and about what we said and did (or didn't). These do not resolve on their own; if we do not process and resolve them and practice self-care, they will evolve into depleting interactions and stressors.

# Pain

In the Health and Medical Coaching process, the client brings pain issues to the coaching space.
The pain comes in two forms:

- Emotional Pain
- Physical Pain

The main principle of working with pain is that once there is pain in the coaching space, it takes precedence over everything else.
This means that once the client introduces an active pain issue (emotional or physical) into the coaching space, we pause what we are working on and shift our focus to the pain.
Once the pain issue has been resolved or the pain intensity has reduced, we can return to the issue we were addressing with the client before.

# Emotional Pain

Emotional pain is an intense, non-physical form of distress, or anguish, arising from psychological, social, or emotional causes like grief, trauma, rejection, or loneliness. Emotional pain is often called the "ache of the psyche." It can feel as severe as physical pain—activating similar brain regions—and can manifest as physical symptoms, social withdrawal, and prolonged mental suffering.

We approach emotional pain in the same way we approach emotions.
(See the chapter about emotions)

# Conflicts

In Health and Medical Coaching, we view conflicts as emotional pain issues.

From a physiological perspective, conflict is a mental struggle between different and opposing representations of the world.

**External conflicts** occur between people when there is a lack of inner abilities/resources to cope with differences in perception of reality, which manifest as conflicting paradigms, beliefs, values, and behaviors.

**Internal conflicts** - occur between two different parts/representations of a person or an experience. Internal conflicts can be found in all Six Logical Levels of Change:

1. ***Environment***: Where do I need to change?
2. ***Behaviors:*** What do I need to change?
3. ***Capabilities and Skills:*** How do I make these changes?
4. ***Values and Beliefs:*** Why do I make these changes?
5. ***Identity:*** Who am I, and do I reflect that in the way I live?
6. ***Spirituality/Purpose:*** Whom do I serve and for what purpose?

## The experience of an internal conflict

One part of us wants A, another part of us wants B, and it feels as if A and B cannot co-exist.

*Example:*

- One part of me wants to be independent, and another part wants to be taken care of.
- One part of me wants to be spontaneous, and another part of me needs structure.
- One part of me wants to get ahead and succeed, and another part wants to be loved and accepted.

The conflict's content is very subjective. What might be a conflict for one person might not be a conflict for another.
An internal conflict creates an experience of an inner split.

When we feel split from within, it is difficult to experience and respond from a place of wholeness and resourcefulness.
A true and sustainable resolution can only be achieved when we approach the conflict from an integrative perspective that honors the positive intentions of all parties.

**From a Health and Medical Coaching perspective, an internal conflict is an experience of emotional pain.**

## When does an inner conflict take place?

1. When the hierarchy of values isn't clear
2. When the values and beliefs have not been updated after crossing a threshold in life
3. When there is a gap between the way I see/experience myself and the way others see/experience me
4. When there is a clash between two META-Programs

∗ **Remember.** When a client is interested in making a change, it is important to check the belief or belief system around that change and whether there is an inner incongruity. Inner incongruity leads to an internal conflict between beliefs.

## There are 2 types of incongruity:

### *1. "NEED / WANT" conflict*

This incongruity 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 / CAN'T" conflict*

This conflict occurs when a person expresses a desire for change but does not believe it is possible or that they deserve it.

The objective of resolving conflicts is to help the person become internally aligned across all Logical Levels. Common approaches to resolving conflicts include negotiation and mediation. In both cases, there is compromise and yielding.

From a Health and Medical Coaching perspective, a true and sustainable resolution can only be achieved when the positive intentions of all parts in the conflict are honored.

In Health and Medical Coaching, the approach to resolving conflicts is **Integration**.

## 4 Steps to Integrate a Conflict:

**1.** Identify the conflicting parts
**2.** Determine the positive intention of each part
**3.** Engage the parts in understanding and accepting the positive intention of each other
**4.** Create a representation that symbolizes the integration of the two positive intentions

## Parts Integration (Integration of Conflicting Parts)

**1.** Identify the conflicting parts

**2.** Elicit a state of relaxation

**3.** Begin with Part X - and ask the client:
- "Where is (name of the part) located in your body?"
- "Allow this part to travel to one of your shoulders (ask which shoulder), down the arm, and into the palm of your hand."
- "Create a representation that symbolizes this part."

**4.** Address Part Y - ask the client:
- "Where is (name of the part) located in your body?"
- "Allow this part to travel to your other shoulder, down the arm, and into the palm of your hand."
- "Create a representation that symbolizes this part."

**5.** Part X – elicit the positive intention of Part X by asking: "What is the gift/good thing you are bringing the client?"

**6.** Part Y – elicit the positive intention of Part Y by asking: "What is the gift/good thing you are bringing the client?"

**7.** Engage the parts in understanding and accepting the positive intention of the other by asking:
- Does X understand and accept the positive intentions of Y?
- Does Y understand and accept the positive intentions of X?

**8.** Instruct the client to turn their hands towards each other and slowly bring them closer together. As the client is doing this, reframe the process: "As your hands are coming closer together, your subconscious mind is creating a third resource that will be born out of the two positive intentions. This is not a process of mixing but of compounding (use the salad-and-cake metaphor). This is a process of alchemy, and your subconscious knows exactly how to do this." **Calibrate**

**9.** Ask the client:

- “There is a new image that has been created out of the two former parts. What is it? What is the resource that is being brought to you?”
- “Bring the new resource into four places in your body:
- **HEART -** allow it to sink in.
- **HEAD -** allow it to sink into your brain.
- **ABDOMEN -** allow it to sink into your guts.
- **ORGAN/PLACE IN THE BODY** (that the client intuitively feels needs this resource) - allow it to sink in.

**10.** Bring your client out of relaxation.

**11.** Ask your client to think about “that old issue” in light of the new learning, and be curious: “What becomes possible now that you can approach this issue in a different way?”

# Physical Pain

The International Association for the Study of Pain defines pain as: "an unpleasant sensory and emotional experience".
This means that we tend to call "physical pain", both physical and emotional pain. Always.
Medicine distinguishes between two types of physical pain: Acute and Chronic.

| | **Acute Pain** | **Chronic Pain** |
|---|---|---|
| ***Duration*** | Short Term<br>< 3 months | Long term<br>> 3 months |
| ***Onset*** | Sudden and sharp | ,Gradual or persistent<br>may come and go |
| ***Cause*** | Specific event (e.g., surgery, (injury | Related to an ongoing disease<br>often unknown |

# Coaching Clients Through Acute Pain

In the context of a Health and Medical coaching process, we will find ourselves needing to address an acute pain situation in the following events:

1. The client has experienced an injury
2. The client is recovering from a medical procedure

Coaching a client through acute pain will focus on the following:

1. **Behavioral Changes & Habits:** Helping clients modify daily habits to support healing. These include:
   - Sleep hygiene and rest to support tissue repair
   - Adhering to nutrition guidelines to manage inflammation.
   - Adhering to physical therapy and movement guidelines to support tissue repair and physical function
2. **Stress & Nervous System Regulation:** Helping clients regulate and calm the nervous system to reduce pain sensitivity and fear.
3. **Care Coordination:** Helping to communicate effectively with their healthcare team and supporting them in adhering to a prescribed therapy plan.
4. **Fear Management:** Supporting clients in understanding the nature of their acute pain and reducing the "fear-avoidance" cycle that can stall recovery.
5. **Pacing:** Helping clients
   - ❖ find a balance between rest and gentle movement
   - ❖ break tasks into smaller, manageable segments
   - ❖ include regular breaks, based on their healthcare team's recommendations.
6. **Listen to the Body**: Helping the client create a way to pay attention to their body's signals and adjust their activities accordingly.

## Coaching Clients Through Chronic Pain

Chronic pain is more than just a prolonged acute pain; it is an experience with unique characteristics and challenges.
In the context of a Health and Medical coaching process, we will find ourselves needing to address a chronic pain situation in the following events:

1. The chronic pain is a dominant symptom of their illness (a "Pain Illness").
2. The client is living with a chronic illness, but the pain is not considered a symptom of the illness by the health team, and its cause might be unknown or unrelated.

When working with a client in pain, it is important to understand the distinction between PAIN and SUFFERING.

From a Health and Medical Coaching perspective**, Pain** is an experience of hurt. Pain is a part of life. Pain changes because everything in this world changes; that is the nature of things.

**Suffering** is the experience of feeling powerless. Suffering happens when we feel powerless to create or stop change. In the context of pain, suffering results from feeling powerless to change or stop the pain. Living with chronic pain creates an additional experience of suffering.

**Important things we need to know about chronic pain:**

1. Living with chronic pain can be a debilitating and isolating experience.
2. Chronic pain has a profound impact on a person's quality of life.
3. In the quest for relief, our clients often find themselves having to explore a complex landscape of treatments, medications, and lifestyle adjustments.
4. Communicating the intensity, nature, and experience of pain can feel very difficult. Medical standard pain scales are often perceived as one-dimensional and insufficient.
5. Chronic pain is an invisible and subjective symptom.
6. The subjective perception affects pain through the context - the meaning it creates.
7. Chronic pain changes the brain – "neurons that fire together, wire together". The more the neurological "pain paths" are used, the stronger they become, increasing the sensitivity of the central nervous system (brain + spinal cord) and the peripheral nervous system (rest of the body).
8. Emotional states affect pain. Research shows that emotions like anger and sadness (often referred to as "negative emotions") amplify pain, while emotions like joy, happiness, and calm (often referred to as "positive emotions") reduce pain.
   Chronic pain is affected by unresolved emotions that have not been acknowledged or expressed on a conscious level.
9. Chronic pain generates anger. In every case of chronic pain, there is subconscious anger at the body for hurting.
10. Chronic pain can cause, over time, a disconnect from the body.
11. Stress affects pain. Stress elevates the sympathetic nervous system (SNS) by raising the levels of Cortisol and Adrenaline in the body. The sympathetic nervous system becomes sensitized over time, leading to increased pain. As the pain increases, it elevates stress, and a vicious cycle is formed.
12. Coping strategies affect pain. Coping strategies can be things we do, as well as things we avoid or stop doing.
13. Chronic pain is biopsychosocial. Meaning there are three interconnected factors that both produce and reduce the pain. These are:
   * Biological – includes tissue damage, mechanical and anatomical dysfunction, inflammation, genetics, age, immunological issues, and the pathology of the pain transmission system (the pain receptors that transmit signals to the brain that produce the perception of pain). These factors are treated through medical interventions (medication and surgery), which tend to be helpful for acute pain and less effective for chronic pain.
   * Psychological – includes emotions (anxiety, anger, sadness, helplessness, betrayal, loss), thoughts, beliefs, memories of previous experiences, expectations, values, previous trauma, and current existing strategies.
   * Social – includes cultural, societal, and socioeconomic factors such as relationships, cultural norms, race, religion, family dynamics, environmental context, income, access to health and health disparities, and social support.
   All three are intertwined:
   - Social factors affect psychological factors, which will have an emotional effect that will affect the biological factor through changes in
   - Psychological factors affect biological factors through their effects on hormone levels and brain chemistry, which will create changes in behavior that will affect the social factors.
   - Biological factors, through the change of health habits, affect psychological factors through emotional changes, which will create changes in behaviors and affect social factors.

## Coaching a client through chronic pain will focus on the following:

1. **Stress & Nervous System Regulation:** Helping clients identify stress triggers and regulate the nervous system.
2. **Understanding the Pain:** Supporting clients in understanding the nature of their pain, its triggers, and patterns.
3. **Pacing:** Helping clients find a balance between rest and activity, based on their experience.
4. **Listen to the Body**: Helping the client create a way to pay attention to their body's signals and adjust their activities accordingly.
5. **Self-Care**: Creating a self-care matrix that creates an effective and sustainable self-care plan and actions.
6. **Emotional Pain**: Helping the client clear existing emotional pain and loss issues.
7. **Lifestyle Adjustments**: Helping the client explore and embrace a holistic approach to wellness by addressing physical, mental, and emotional aspects of their life that promote overall well-being and can help alleviate pain**.**
8. **Attention to the Body**: Helping the client create a way to pay attention to their body's signals, and learn to adjust their energy levels, rest, and activities accordingly.
9. **Relationship with the Body**: Helping the client clear out pain issues related to the relationship with the body.
10. **Support Systems**: Helping the client build a strong support network with friends, family, or support groups.
11. **Relationship and communication with the Healthcare Team**: Helping the client create an empowering relationship with the healthcare team and develop open and effective communication to discuss symptoms, concerns, and the treatment options available with the team, and become an active participant in their healthcare decisions.
12. **Resilience**: Helping the client cultivate a positive mindset and resilience by focusing on what is within their control and adjusting their approach to better manage their chronic pain.
13. **Small Wins**: Helping the client acknowledge efforts and progress, and celebrate small wins, turning them into action models that can be used in the future.

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*You can't stop the waves, but you can learn to surf.*

***- Jon Kabat-Zin***

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# Additional Health and Medical Coaching Tools to Support Clients Through Chronic Pain

**Pain and Symptom Journal**: This is an important, effective, and empowering tool that helps clients keep a daily journal to track their pain levels, activities, and any factors that may influence their pain. This can provide valuable insights for both them and their healthcare team.
Look at the "Symptom Journal" document in the Resources of this lesson.

## EFT

We can use EFT in 3 different ways to work with a client's pain:
**Technique # 1** - assess the intensity of the pain as if it were a "regular" issue and tap on it using the reminder phrase: "this pain".

**Technique # 2** – elicit the sub-modalities of the pain and tap on them using advanced tapping.

**Technique # 3** – (By Nick Ortner)
We elicit sub-modalities of **Shape**, **Color**, **Texture,** and **Emotion**
We make sure the affirmation is sincere and authentic.

***The set-up:***

- Even though I have this **Shape**, I love and accept myself
- Even though I have this **Shape** and **Color,** I love and accept myself
- Even though I have this **Emotion,** I love, accept, and forgive myself

**Eyebrow**: This **Shape**
**Side of Eye**: This **Shape** and **Color**
**Under Eye**: This **Shape** and **Color** and **Texture**
**Under Nose**: This **Shape** and **Texture**
**Chin**: This **Shape** and **Color**
**Collarbone**: This overwhelm
**Thymus**: **Emotion**
**Under Arm**: This **Shape** and **Color** and **Texture**
**Wrist**: I am safe, calm and healing

***Deep breath and drink of water***

Reassess sub-modalities of: **Shape**, **Color**, **Emotion** and **Texture**

***Start a new round***

Get a new setup with the new sub-modalities and start tapping.

# Survivorship

Survivorship is defined as the state of being a survivor.
The term survivorship originated from cancer.

According to the National Cancer Institute Dictionary, survivorship in cancer focuses on the health and well-being of a person with cancer from the time of diagnosis until the end of life. This includes the physical, mental, emotional, social, and financial effects of cancer that begin at diagnosis and continue through treatment and beyond. The survivorship experience also includes issues related to follow-up care (including regular health and wellness checkups), late effects of treatment, cancer recurrence, second cancers, and quality of life. Family members, friends, and caregivers are also considered part of the survivorship experience.

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

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

Coaching in the survivorship stage addresses the shift back into a new wellness.
The coaching focuses on:

- Lifestyle changes
- Illness-related career and/or life adjustments
- Executive functions
- Resilience
- Self-care
- Support systems
- Addressing expectations to return to “normal”
- Fear of Reoccurrence or Fear of Recurrence.
- Survivor’s Guilt
- Shifting to an experience of an invisible illness
- Limiting beliefs about survivorship
- Loss
- Changes in close relationships.
- Life-changing decisions that were made during the active phase of the illness

It’s important to create a safe space for the client to process all of the above and to foster the understanding that ‘It’s okay not to be okay.’

There is a need to redefine what “normal” means, how it’s measured, and how to identify and cope with abnormalities.

# Health Literacy

In Module 1, we explored the concept of E-patients. Part of what the E stands for is Education, and one of the skills that allows patients to become educated is Personal Health Literacy.

Personal health literacy is the individual's ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Personal health literacy skills include reading and writing, calculating numbers, communicating with health care professionals, and using health technology.

It's important to remember that health literacy is a two-way street. While individuals have a responsibility to develop their health literacy, health care organizations also have a responsibility to improve their "organizational health literacy" and adopt strategies that make it easier for people to use their services.

Personal health literacy refers to the skills necessary for a person to participate in the health care system and maintain good health.
These include the ability to obtain, process, and understand basic health information and the services needed to make appropriate, informed health decisions.

Personal health literacy involves reading, listening, analysing, acting on medical information (such as medication instructions and consent forms) and navigating complex healthcare systems.

People make choices about their health every day, including what to eat, when to see a doctor, and how to take their medicine. All the tasks outlined below rely on health literacy skills:

1. Understanding the labels on medicine and food
2. Understanding medical instructions and translating them into actions
3. Locating the needed health services facilities
4. Reporting symptoms in an accurate and cohesive way
5. Completing medical paperwork
6. Locating reliable online health and medical information

Anyone can struggle with health literacy, even those who read and use numbers well.

From a social perspective, Health literacy is also a health equity issue. Factors such as race and ethnicity, age, primary spoken language, education level, and socioeconomic status all play a role in the prevalence of limited health literacy. People with limited health literacy skills experience poorer access to quality care and tend to have adverse health outcomes.

## The Health Literacy Pathway Model

This model views health literacy as a trajectory rather than a fixed skill. It guides coaches to move clients through four stages:

- **Access**: Helping the client find valid health information.
- **Understand**: Breaking down that information into actionable steps.
- **Appraise**: Helping the client learn how to judge the quality and relevance of health advice.
- **Apply**: Supporting the client as they use this knowledge to make informed decisions.

**Specific Areas Where a Health and Medical Coach Can Support a Client's Health Literacy**:

1. Reviewing health and medical instructions with the client to confirm comprehension and become aware of gaps that need to be addressed with the healthcare team.
2. Inviting the client to become more acquainted and knowledgeable with the medical jargon relevant to their condition and treatment.
3. Supporting the client in finding reliable online health information.
4. Helping the client prepare for meetings with the doctor and healthcare team (see attached resource)
5. Using Meta Programs to help the client address and process information with more ease.

# The Bio-Psychosocial–Spiritual (BPSS) model

The foundational Biopsychosocial (BPS) model was created by psychiatrist George L. Engel **in ١٩٧٧**. The extended "Biopsychosocial-Spiritual" (BPSS) model, which adds a spiritual dimension to Engel's biological, psychological, and social framework, has been developed and promoted by various authors (e.g., Sulmasy, 2002) as a holistic, patient-centered approach.

BPSS is a holistic framework that addresses the interconnected domains of people's lives:

- **Biological** (physical health) - Addresses physical well-being, including, but not limited to, nutrition, sleep, energy levels, and pain.
- **Psychological** (thoughts/emotions) - Addresses emotional health, cognitive processing, self-regulation, beliefs, and coping strategies.
- **Social** (environment/relationships) - Addresses environmental factors, family dynamics, relationships, social support, culture, and socioeconomic status.
- **Spiritual** (meaning/purpose) - Addresses meaning, purpose, values, and connection to something larger than oneself.

This framework enables coaches and clients to move beyond a narrow, symptom-focused approach to a comprehensive, sustainable one, fostering growth and resilience.

**Application in Coaching:**

- **Holistic Assessment:** Coaches use the model to identify strengths and needs across all four domains to create a more effective, personalized, and multidisciplinary approach.
- **Systemic View:** The model offers a systemic perspective by recognizing that client issues are rarely isolated to one area but are influenced by an interplay of factors.
- **Enhanced Resilience:** By addressing all domains, the model empowers clients to build greater, long-lasting resilience and, in some contexts, improve overall quality of life.
- **Contextual Understanding:** The model helps coaches understand that sometimes the issue has a psycho-physiological context and not just one core, simple reason, for example, in the case of chronic pain or profound behavioral changes.
- **Increasing Engagement:** Exploring an issue using these four domains helps clients feel fully seen and validated, as it addresses their complete experience rather than compartmentalizing it.
- **Creating Sustainable Change:** Strategies, solutions, and action plans are more comprehensive because they address a root cause that spans multiple domains.

# Health and Medical Coaching in Clinical Settings

In a clinical setting, the coach is an active member of the medical, health, and wellness team that provides physical and mental health care to people living with health and medical conditions.
This team can operate in a hospital, a public health clinic, a private health clinic, a rehabilitation center/hospital, or a patient support program (PSP) via a hospital, public health, or pharmaceutical company. The coaching can be done online or face to face.
Coaching in a clinical setting requires that the coach be able to do the following:

- Work in a multidisciplinary care team
- Understand the care team's scope of practice
- Know how to collaborate with other care team members to understand treatment planning, roles and responsibilities, and your role as a coach
- Be informed of ethical guidelines
- Articulate how coaching complements the roles of the other professionals
- Recognize other team members' responsibilities, training, and decision-making roles
- Navigate organizational structures and clinical hierarchies with respect
- Work within existing care plans and treatment priorities
- Partner with clients to co-create goals and strategies that support self-management, engagement, and psychological safety, while remaining aware of recommendations from the care team
- Avoid language that implies diagnosis, prescription, or therapeutic intervention
- Record the client's experience, goals, and progress in client-centered terms
- Practice interprofessional collaboration with clear, respectful, timely communication and accurate documentation
- Be familiar and aligned with the organizational standards and privacy regulations (e.g., HIPAA), distinguish what must remain private from what should be shared for safe, coordinated care
- Use accessible professional language, appropriate medical terminology, and structured tools
- Recognize red flags and urgent concerns that fall outside of the coaching scope and follow appropriate escalation and/or referral protocols
- Engage in ongoing case conferences, team training, and clinical and safety seminars
- Amplify the client's voice and support meaningful behavior change within the broader system of care
- Be familiar with the client's health context to support their empowerment in the healthcare setting
- Be knowledgeable of the common diagnoses, tests, symptoms, treatments, and side effects relevant to the client.
- Understand the clinical context and use it to support each client's relationship to their health and well-being.
- Require foundational medical literacy and strong information skills: familiarity with core medical vocabulary and acronyms, the ability to read peer-reviewed literature and guidelines, and the capacity to distinguish trustworthy, science-based information from unverified wellness claims.
- Stay current with relevant interventions in ways that support the client.

When coaching in clinical settings, it is the coach's responsibility to make sure to receive a structured process of onboarding that addresses all the above and helps them integrate into the organization, and familiarize them with procedures, culture, and their specific roles.