CHAPTER 12

Remembering Well-Being: The U-Assessment and Therapeutic Protocol

Dorothea Thomaßen

Dorothea Thomaßen is trained as a general surgeon. She has two additional areas of expertise: Traditional Chinese Medicine and Ericksonian hypnosis. She is a trainer and supervisor for the German Society for Dental Hypnosis and is the editor-in-chief of the German Journal of Dental Hypnosis. *She also teaches for the German Milton H. Erickson Society, facilitating seminars on pain management, changing habits, and hypno-oncology. At the present time, she has a private practice in Frankfurt am Main, Germany, where she works with patients of all ages, treating a variety of psychosomatic and somato-psychic disorders.*

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The consequences of a surgeon's decisions are often far reaching. Imagine a patient with severe abdominal pain. With this patient, you first have to make a diagnosis, selecting from a number of different possibilities. The treatment(s) that are appropriate for one cause of the pain could be completely inappropriate for a different cause. For some conditions, one should operate immediately. In other cases, such as with

severe infection, an operation would weaken the body. Then there are patients with so-called functional pain. For such patients, every organ is healthy, yet they still experience significant (and very real) pain. Finally, although rare, there are patients who pretend to have severe pain in order to avoid doing something they do not want to do, or to receive something that they think they cannot obtain in an easier way.

What these patients say during an evaluation may be very similar. But how their body responds during the examination, how their body smells, what their overall appearance is, the sound of their voice, what you hear when listening with the stethoscope; all of these factors differ from one patient to another and from one diagnosis to another.

With experience, a clinician learns to trust his or her own senses. Not only should the clinician listen carefully to the patient, but he or she should also be able to put the patient's words and the nonverbal and para-verbal signals into perspective. The more experience I have gained, the more I trust in nonverbal body signals as critical components of the assessment. As a result, my evaluations have become more accurate.

After having made the diagnosis and seeing how the patient responds to treatment, all the psychological changes that are occurring along with the physical healing can be observed. Based on my clinical experiences, my hypnotherapeutic thinking has become increasingly oriented towards state-dependent memory and state-dependent learning. This means that the patient's presenting problem and condition have a strong impact on his or her memory functions and shape what the patient is able to learn.

Up to this point, I have described the circumstances of an acute problem, in which the U-protocol (described later in this chapter) is not appropriate. In acute situations—new onset

illness or injury—the patient has not yet had the opportunity to develop learned associations to the symptoms of the illness or injury. The U-protocol is most useful to address the suffering associated with chronic conditions.

The U-Assessment and Therapeutic Protocol (UATP) was first developed for treating patients who have chronic functional pain conditions such as migraine and bruxism, as well as patients with pain associated with autoimmune diseases or cancer. Even if there is an identifiable somatic cause for the pain, and particularly in patients with autoimmune diseases or cancer, there may also be a pain memory problem. In this case it would be possible to ease the suffering by erasing the stored pain memories; this is done by inviting patients to recall, and be reminded of, memories of well-being.

These days, I find it useful to use the UATP in every case where state-dependent memory might have an influence on the patient's symptoms. As it turns out, this is the condition in almost every case where patients have established a problematic response pattern. I also use the UATP for identifying treatment goals. For example, to identify patients who have phobias such as a fear of flying. The therapeutic goal in this case would of course be for the patient to be able to fly in a state of comfort and well-being.

But what does well-being feel like? Our body contains nerves that send information to the brain, which the brain then uses to create our experience. We have nerves from the top of the head to the soles of the feet, from the surface of our body (skin) to deep inside (bones). Interestingly, when we are healthy, we tend to be unaware of our body. The body is a medium that essentially becomes unconscious when it is working well. Normal proprioception is like a background; a stage for the senses of sight, hearing, smell, and taste, which

are all concentrated at the head, combined with the kinesthetic structures in our ears that give us a sense of balance. Even more—these other senses are embedded in the sense of feeling. Eyelashes, a sensitive cornea, hairs in the nostrils, a tongue with a sense of touch—all serve to guard and protect the senses. As the body is a homeostatic self-adjusting intelligence, it does not usually need our conscious awareness to function well. We can observe our body processes, but we cannot usually control them directly. This is fine, of course, as it frees our consciousness to focus on our goals or otherwise enjoy our experiences.

One of my patients was a woman with a hemifacial spasm. The right side of her face quivered uncontrollably. She had a very difficult time seeing with both eyes. Reading was tiring, and she had a lot of headaches. When she tried to control her facial expression, her whole body became tense.

Because her primary symptom was so visible, she felt ashamed and led a life of seclusion. When I asked her what she wanted to achieve with treatment, she answered: "This [pointing to the right side of her face] should be gone!" I replied, "Do you really want half of your face to be gone?" "Of course not, I would only like the quivering to go away," she said. "And how would your face be then?" I asked. Taking a deep breath, she responded, "Then I would be happy." At that moment, her face distorted even more. Up to this point, she only described what should *not* be there, but not how she wanted her face to be. In order to identify a treatment goal to focus on, we needed a positive definition of healthy body sensations.

Very often patients say: "My body should do what I want. I don´t want to have to think about it. This is annoying." To become healthy and to be able to forget about the body is a healthy response to normal self-regulation, as already

mentioned. On the other hand, discomfort immediately attracts our attention and therefore limits what we are able to remember and learn. The steps required to move from illness and discomfort to wellness and well-being are often too many and too challenging for patients to take on their own.

However, when we are ill, we are motivated to move to wellness. Hypnosis makes it possible to achieve this goal through changing the focus of awareness. The UATP aims to provide a positive description of healthy proprioception. To achieve this goal, I follow the focus of the client, who usually begins treatment being absorbed by and focusing on the problem.

With the UATP, I first ask the patient to describe his or her experience associated with the illness. These qualities are written down on the left side of a flipchart in red (see Figure 12.1). In response, patients usually begin by describing or labelling the most bothersome symptoms. As they continue, and towards the end of their list of experiences, they will tend to describe the more discrete, almost normal sensations. After all symptoms are described, we then identify complementary positive or beneficial labels (i.e., what the patient would like to experience instead), which are written on the right side of the flipchart in green. To keep the steps simple, when identifying the positive responses I usually start in the reverse order of the red side, from the bottom to the top (see Figure 12.1). Because the symptoms at the end of the list are less troublesome, it is easier to find their antonyms.

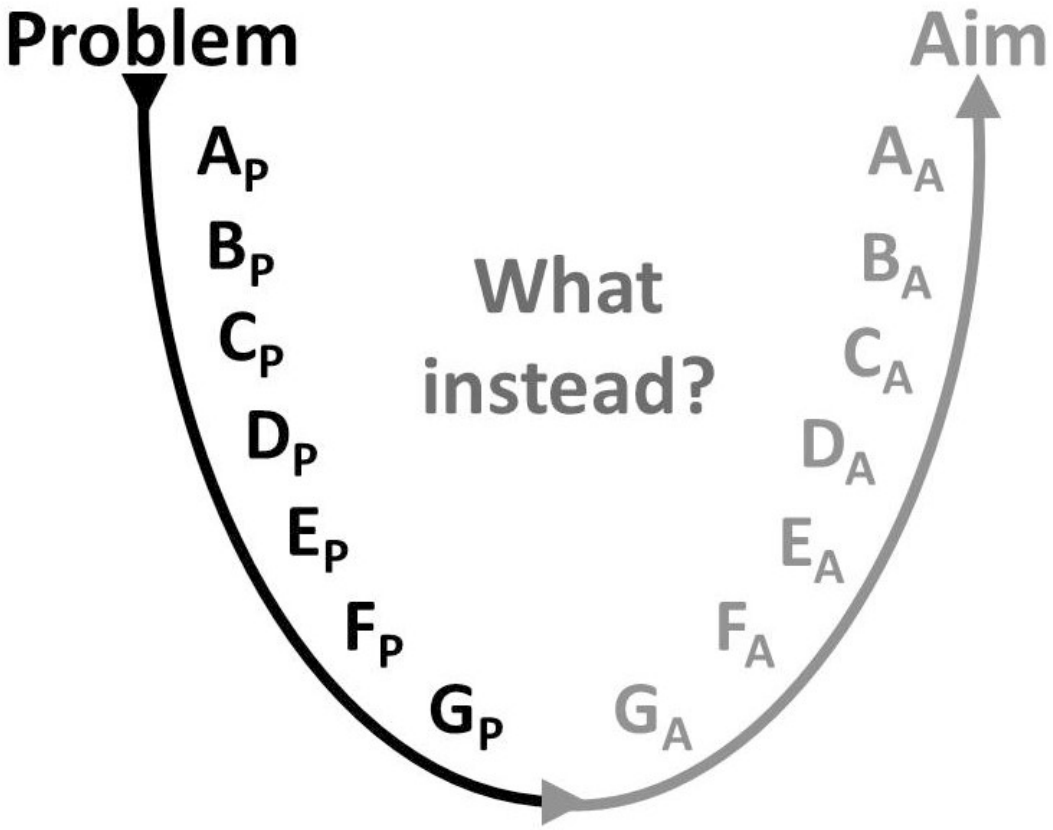

Figure 12.1. The U-Assessment and Therapeutic Protocol.

Because the patient has often been focusing on the negative symptoms for so long, he or she may have difficulty identifying the positive experience associated with each of the negative symptoms or experiences at first. However, as each positive quality is identified, it makes it easier to find the next. As with syphons, as soon as suction starts, water begins to easily flow upwards. The descending red list and ascending green list reciprocate with one another and form a U-shape.

Through visualization, patients learn to describe healthy feelings in their own words and to label them. Labelling also involves a process of remembering, given that patients have almost always, if not always, had the positive experiences in the past. Thus, the UATP is a 3-in-1 process: (1) a positive affect-bridge to comfort, (2) a process of activating favorable somatic

feelings in the present, and (3) a process of future goal setting. Moreover, the process of seeing the symptoms and experiences on a flipchart and of naming and remembering somatic states involves the three senses of seeing, hearing, and feeling. One can often see, quite quickly, the beneficial impact of the process reflected in the faces of patients. They look satisfied as they scan the list; they nod and take deep breaths. The use of the flipchart is a key component of the whole therapy.

I would like to emphasize a few more points. First, many patients with somatic discomfort try to avoid describing those somatic experiences. When I asked my patient to describe her somatic experiences, she did not start with body sensations but with emotional reactions: "I get nervous. It is enough to drive me up the wall and to go through the roof." Interestingly, the house is often used as a metaphor for the body by patients: "Up the wall and through the roof" symbolizes a wish to leave the body. Second, patients also often describe their strategies for coping with the symptoms. In the case of the patient presenting with hemifacial spasm, she said, "I feel ashamed, so I live by myself"; she avoided social activities. Another coping strategy often described by my patients presenting with somatic symptoms is, "Ignore it and go on"; a dissociation tactic that suppresses the awareness of proprioception.

The word *proprioception* is composed of two components: *proprio* (i.e., one's own) and *ception* (i.e., to take or grasp). So proprioception makes our body our property. Very often, I find it paradoxical that pain memory and dissociation coexist with the experience of proprioception. It usually requires effort to focus on, explore, and "make one's own" disturbing somatic sensations, because reactions and coping strategies are not proprioceptive qualities. Importantly, as long as sensations are avoided, one cannot create a therapeutic alliance with a kinesthetic goal.

Whenever you focus on pain, there is awareness of the body in the here and now. My patient experienced sensations of cramping, tension, and pressure. Observing only one quality, such as pressure, makes the other sensations take a back seat. At the same time, pressure is only a part of the entire experience, and its intensity therefore is less than the whole complex of pain. As a result, the exploration and focus on discrete components of the entire experience increases the sense of self; often discomfort eases during this process. This makes it easier for patients to open their awareness to other (perhaps more comforting) body regions.

I asked in this case, "What does your neck feel like? How is your abdomen?" The patient had not yet noticed that her body was rigid, her hands were restless, and her feet were cold; that there was heat around her eyes and there were many other symptoms. Finally, I asked her to concentrate on her whole body and to be aware of every sensation at the same time. At this point, after the exploration of the individual components of their experience, even patients with chronic pain may say, "Right now, everything is ok," despite the fact that we continuously focused on the problem. *Focusing on and being more aware of somatic sensations makes it possible to integrate these sensations; to make them (again) one's own*. The process addresses dissociation and can facilitate homeostatic regulation, a process very well known in mindfulness training, which has become a standard tool in chronic pain management.

Once "everything is ok," it is easier to begin to explore the healthy, normal states and label them more precisely. But even when this is not possible at this stage in therapy, the long list of red (less than helpful) words describing symptoms is useful. These words form the basis for identifying the (more helpful) antonyms, which represent a path forward towards

comfort and health. As a result, the more red words there are, the more green words we will identify.

The process of coming up with the green words requires the patient to comb through his or her experiences, looking for antonyms describing well-being. In this way, they start to activate these positive states. The body is able to identify wished-for states through remembering, and the positive somatic experiences identified become visible. One can observe how patients show small movements towards well-being as their awareness goes from one positive experience to another; their physiology changes. The terms "re-membering" and "re-minding" express it well. Words anchor states. What has been unconscious before becomes conscious and available. A memory of health is reinstalled, step-by-step.

Two points are crucial for the process to be effective. First, the word for the goal must be positive, without negation. Whenever there is a "not," clinicians are encouraged to ask, "What instead?" Still, many hidden denials can be missed; *painless, untroubled, unburdened, stress-free,* and *not tight* still contain the words *pain, trouble, burden, stress*, and *tight.* As long the patient works with a prefix or a suffix as *–less, un-, -free,* or *not,* I continue to ask, "… and what instead?"

This process increases access to a language of well-being. If the patient stops talking in terms of being *painless*, but instead in terms of having *comfort* and being at *ease*; if instead of being *untroubled* they identify a goal of feeling *safe* and *sound*; if they replace *unburdened* with *free* and *flexible*; *stress-free* is substituted by *relaxation* and *stability;* and *not tight* with *soft* and *easy going*; they will begin the process of feeling better. Especially, and importantly, if the replacement/goal labels are labels that they themselves identified.

The process can take time; the activation of the state comes first, naming it comes afterwards. If clinicians try to help with

their own words and labels, they interfere with this intermediate step. It is the clinician's job to ask the right questions, not to find the answers. Thus, they should elicit the new labels from the clients, and then repeat back to the patient any positive antonyms that the patient mentions. When I demonstrate the technique in a seminar and reiterate all the green words of the list before going to the next step, the participants sometimes get annoyed ("We've already heard the words, why are you repeating them? Let's get on with it!"). However, when I ask the patient about the utility of hearing their own labels repeated back to them, they always find it helpful.

The second point I would like to emphasize is that the word for the problem and the word for the solution must belong to the same sensory domain. Of course, it would be *great* to be without pain, but *great* is a judgement, not a sensation. When my patient with hemifacial spasm said that she would be happy without these symptoms, I understood her very well. However, she mentioned an emotion, not a sensation; and her face distorted and deformed even more. Why was the presenting symptom getting worse instead of better? She spoke about herself, not about her body. Also, with other patients I have observed that often the expression of a wish, such as to be handsome and fit, is followed by a somatic aggravation. I believe that if patients focus on a picture, an ideal, on how they *should* be, that this elicits the opposite experience. This then causes stress, because they are rejecting the way they are now. The process of formulating their goal through the UATP has a more useful outcome. Through the process of state-remembering, they gain access to the state that they wish to experience; they start to experience their wish as a real possibility. However, when there is focus on an ideal, global sense of well-being as a goal for addressing a specific negative somatic sensation, this can contribute to

ignoring the body's feedback, which may then lead to an increase in the symptoms. As a matter of fact, ignoring the body's feedback in an ongoing manner often leads to dis-ease.

When the patient has difficulty finding positive somatic words, it can help to focus on body parts that have healthy regulation. For example, after we had listed all symptoms, the patient with the hemispasm was not able to find proprioceptive antonyms for all of the symptoms. As the hemispasm afflicted only one side of her face, I asked her to be aware of and experience the other side, which was in good physical shape. She described it as "soft, peaceful, relaxed, with modulated temperature, elastic and flexible, familiar and at ease." As she did this, her whole face became calm and relaxed. It was obvious that the equivalent verbal properties gave rise to beneficial results. While she was scanning from one side to the other and back again, her eyes were moving as in Eye Movement Desensitization and Reprocessing (EMDR), she engaged in proprioceptive-induced reprocessing spontaneously.

The UATP can be used for a variety of presenting problems. Mental conflicts are usually accompanied by somatic configurations. For the protocol, the patients investigate their bodies while they imagine themselves having the problem. They become aware of how they dissociate as a way to cope with the symptoms. The felt sense of the dissociation is a link to the body. After patients have completed the whole process, they imagine themselves in the same situation feeling comfortable again; in this way they get access to resources which they have not been aware of previously. That is state-dependent memory and learning.

As I said in the beginning, the protocol is not appropriate for treating an acute injury or illness. Acute conditions have a strong impact on the mind; the UATP shows the power of words and language on somatic affects and effects. In acute

situations, the clinician's responsibility also includes use of language. As words anchor states, salutogenic language is an important component of a well-stocked first aid kit. Often, clinicians have the same problem as patients with chronic pain; a biomedical focus and language focused on pathology. The medical language is full of positive language associated with negative results; i.e., "The patient tested positive for HIV…." In what way is an HIV infection positive? Medical language is full of less-than-useful words that begin with *de-* or *un-*, or end with *-free* and *-less*. Professionals need to learn to describe the outcome of their work in a language which leads to an open and healthy perspective.

The UATP does not work against the pattern; instead, symptoms are used as a resource to identify more useful experiences and to bring back awareness to body sensations. The end goal of comfort and well-being evolves through an investigation of the problem. It has many beneficial effects. Patients associate again with their bodies and they remember the sensations as a resource. They regain access to healthy sensations, activate positive self-regulation, and find their own salutogenic language.

When the patient's words are written down on a flipchart/poster, the poster becomes a constant visual companion. Many patients take a photo of their flipchart, others write the words down to take them home. I keep the flipchart/poster. In some cases, the UATP works as a single-session intervention; if not, I present the poster in following sessions as a reminder of the patient's goals and path towards wellness. Only if the goal changes, or if the same patient comes for a different reason at another time, we would go through a new protocol.

The patient´s own words can be used by the patient and the therapist. These words not only provide a frame of

reference but also a tool for the treatment. I also use the helpful/healing words identified by the patient in other communications with the patient and independent from the UATP. For example, I may incorporate them as suggestions during formal hypnosis sessions or when I am providing acupuncture or medication treatment. These words anchor states and bring back recollections of well-being.

Example Transcript

I have described the principles of the UATP with chronic pain memory. Now I want to provide an example of how to work with state-dependent memory and learning using behavioral patterns which have been established in the past. In this example, a colleague comes for supervision with a patient's health record. It is the first supervision.

Supervisor: What is your goal for the supervision?

Client: I want to understand myself better. Sometimes something jumps up at me. *[She holds her right hand in front of her chest and moves it quickly upwards to her right side.]* **And then I take it with me. I want to learn to handle it.**

Supervisor: What jumps up at you?

Client: It surrounds me like a cloud. It runs like a thread through my everyday life. I really take it with me. *[With her hands she paints a cloud around herself, beginning at the top of her head.]*

Supervisor: Let us investigate your experience a little bit closer. Here I have a flipchart. Please describe precisely, what happens to you, when something jumps up at you and the cloud comes into being. I will list what you tell me about your experience here. *[Pointing to the flipchart.]* **From**

this list we will come up with ideas for helping you to handle the situation later on, okay?

Client: *[Nods.]*

Supervisor: You said something jumps at you, surrounds you like a cloud and then it runs like a thread through your everyday life…"

[The supervisor writes on the flipchart in red: "Something jumps at me" (P1), "Cloud" (P2), and "It runs like a thread through my everyday life" (P3).]

Client: Yes, and in my head I have a voice. It says continuously, "Be careful, do it right!" (P4)

Supervisor: What does it feel like to have this voice in your head?

Client: At the back of my head I have a disagreeable tingling (P5), and my forehead is tense (P6). … Yes, that really blocks me (P7). … Suddenly I feel obstructed (8P). *[She frowns.]*

Supervisor: When you are inside the cloud and this voice is talking in your head, the back of your head is tingling and the forehead is tense, what else is happening inside your body?

Client: I start trembling (P9), I get tense (P10) and agitated (P11). *[She wags her hands excitedly.]*

Supervisor: *[Pacing her movements.]* **And how are your hands then?**

Client: Sweaty and cold (P12), my whole body feels hot and cold (P13).

	PROBLEM	AIM
1	Something jumps up at me	I have a protective cover and feel secure
2	Cloud	The cloud is floating above the patient and is small
3	It runs like a thread through my everyday life	I can leave it with the patient
4	In my head: be careful, do it right	I have everything
5	Back of the head disagreeable tingling	Harmonious, relaxed
6	Tension in the forehead	Open agreeable good feeling
7	Blockade	Confident, I am capable
8	Obstruction	I can engage with what is coming up
9	Trembling	Open and calm
10	Tension	Stable, balanced
11	Agitation	Centered and concentrating on what is happening, appropriately activated
12	Sweaty, cold hands	Nicely warm and dry
13	Hot and cold feeling in body	Comfortably warm
14	Breathing flat and staccato	Steady, rhythmic, deep, soft
15	Faint belly	Round, comfortable, calm
16	Dry throat	Humid
17	Voice high, artificial	Soft, empathic, calm
18	Thick voice	Authentic, certain, sure
19	Beating heart	Peaceful and calm
20	Tight movements	At ease, connected, congruent
21	Stand at attention	Wait and see, guarded, reclined, observing
22	Ready to jump	Reclined, looking from inside
23	Thigh tense	Released, soft, down to earth, relaxed
24	Standing beside myself	Centered, being one
25	Observing myself from the right side	Seeing the other person
26	Toes rolled inside, cramping	Grounded, soft, firm
27	Feet icy-cold	Warm, distinct feeling
28	Back and neck stiff	Mobile, flexible, composed

Figure 12.2. Example of a completed U-Assessment and Therapeutic Protocol flipchart.

Supervisor: When you are agitated and you feel hot, cold, and tense, what else is happening?

Client: Oh, my breathing gets flat and staccato (P14). I have a faint feeling in my belly (P15). *[She moves one hand upon her abdomen and one at her throat.]*

Supervisor: *[Also moving one hand to her throat.]* **And how is it here?**

Client: My throat is dry (P16) and yes, my voice gets high and artificial (P17), it is even thick (P18).

Supervisor: Anything else?

Client: My heart is beating (P19) and my movements are tight (P20). I stand-at-attention (P21). *[She bends forward, leaning her arms on her thighs.]* **I am almost ready to jump (P22).**

Supervisor: *[Pacing again.]***… almost ready to jump, how do you feel in your thighs?**

Client: Totally tense (P23); somehow, I am standing beside myself (P24).

Supervisor: Where beside you, on your right or left side?

Client: It is funny, somehow on the right side (P25). And I observe myself from outside. … Yes, and I see how I roll my toes inside.

Supervisor: So, you see it, and how does it feel?

Client: Somehow, I am outside myself; I see it, but I don`t feel it.

Supervisor: Okay. There is one part standing beside another part of you and seeing the other part rolling the toes inside and this outsider is not able to feel the toes…

Client: *[Nods and suddenly says smiling,]* **That's why I stand beside myself.**

Supervisor: Exactly, and still you are both parts: one observer, who is standing on the right side; and a subject of observation, who is sitting there, is rolling the toes inside. In the situation with your patient, you were the observing outsider. While you are remembering the situation today, it might be possible to associate a little bit with the insider, who is sitting there, rolling the toes inside. What does it feel like?

Client: *[Sitting with tense thighs, leaning forward and rolling her toes.]* **The toes are rolled inside and cramped (P26) and the feet are icy-cold (P27). My whole back and my neck are stiff (P28).** *[For a short moment, she is sitting there, in a stand-of-attention pose—almost ready to jump. Then she is shaking.]* **Brrr.**

Supervisor: Brrr…? *[Shaking also.]*

Client: I shake it off; I want to get rid of it.

Supervisor: How is it now?

Client: *[Moving her back and neck,]* **Elastic and mobile, composed.** *[Smiling,]* **I am composed again.**

[Having reached the turning point of the UATP, she starts the green list with: mobile, flexible, composed (A28). These words are written on the flipchart by the supervisor.

To stand beside oneself is dissociation from feeling oneself. When the client started to feel herself again, she started an association process and fulfilled it with those little shakings and shiverings, which are well-known reactions from animals as they come out of thanatosis. The supervisor and the client could start now to move upwards on the green side. But the supervisor takes a break.]

Supervisor: *[Repeats all the labels on the red list and asks,]* **Is there anything on the red side we haven't mentioned yet?**

Client: No, isn't that enough? Most of them I even didn't notice when it happened.

Supervisor: How does it feel, what you were only able to observe standing beside yourself?

Client: It's strange. As I was standing beside me, I was judging myself. When I associate I have compassion. I become friendlier to myself. *[She looks thoughtfully and the supervisor waits until she catches the client's gaze again.]*

Supervisor: Now that you have become your friendly companion… compassion is composing. … *[Both are smiling.]* **Let's go forward and explore how it is to be composed again.**

> *[From now on the supervisor will use the salutogenic idiolect of the client in a repetitive manner. Pacing to match the breath of the client, the rate of speech will slow.]*

Imagine yourself in the same situation with your patient… but now being composed again… with a flexible neck and a mobile back. … If your feet were mobile, what would there be instead of the freezing icy-coldness?

Client: I would feel them distinctively and warm (A27). *[She changes the position of her feet. The foot tips point outwards; and while she was talking, she pressed the soles of the feet.]*

Supervisor: And if your feet were distinctively warm and flexible… what would there be instead of cramps and rolled toes?

Client: They are grounded, a contact firm and soft at the same time (A26). *[Again, she moves her feet a little bit and smiles.]*

Supervisor: Soft and firm contact, the back and the neck warm and flexible, being composed again. … What would there be, instead of standing beside yourself and observing yourself?

Client: Being one and grounded; I am centered (A25) and see the other person (A24).

Supervisor: If you are mobile… softly and firmly centered and grounded, what will happen to your thighs?

Client: They release, they become soft and relaxed. They are down to earth again (A23).

> *[This is happening now as she describes it. A change in the shape of her thighs, from oval and high to broad and flat, can be observed beneath the fabric of her trousers. Spontaneously, she has also changed her posture and is leaning backwards.]*

Supervisor: What a relief to come down to earth. You are not jumping anymore. Have you noticed how your *stand-at-attention* has changed?

Client: Yes, I am reclined now; I am looking from inside out (A22). I wait and see, guarded, simply observing. I can patiently wait to see what is coming next (A21).

Supervisor: Grounded and reclined… simply waiting, what's coming next… warm … soft and firm, what is there instead of tight movements?

Client: Moving is easy and connected. I am congruent (A20).

Supervisor: What is a congruent heartbeat?

Client: *[Puts her hand over her the heart.]* **Peaceful, smooth, and calm (A19).**

Supervisor: *[Also puts her own hand on the heart and then moves it to the throat.]* **Reclined and at ease with a calm heart…**

grounded soft and firm… what will happen instead of a thick voice?

Client: Then the voice is authentic and certain. I am sure of what I am saying (A18). *[Her voice has already become more grounded, but now she emphasizes the words with resonance.]*

Supervisor: Wow, did you hear the difference in the resonance? How your body tonus and your vocal tone reflect each other?

Client: Yes, I feel and hear it.

Supervisor: When you are authentic and certainly sure of what you are saying… firmly composed and softly released… how does this transform the high and artificial voice?

Client: Although my voice is firm, it is also calm and soft. And as I have compassion with myself, I have empathy with my patient (A17).

Supervisor: Soft and firm as your contact to the ground?

Client: Yes, whole and composed.

Supervisor: Flexible composed and firmly mobile… tonus and tone being one, whole… how does your throat feel?

Client: Humid (A16). *[She swallows.]*

Supervisor: If you only swallow when you are sure… at ease with what is coming up… reclined and centered, seeing the other person… waiting until you are certain to speak with an authentic voice, how will be your belly?

Client: There is a round feeling, comfortably calm and smooth (A15).

Supervisor: Comfort in the belly… mobility in the whole body… an authentic certain voice… when breathing gets easy, what is the difference to staccato and flatness?

Client: It has a deep and soft and steady rhythm, down to my smooth belly (A14). *[Her breathing is already like this.]*

Supervisor: Like now?

Client: *[She takes a deep breath and smiles.]* **Yes, like now.**

Supervisor: Breathing like this, soft and deep… a calm belly… round… being one in movement and heart… in tonus and tone… comfortably tuned… easy… what is the temperature of your body?

Client: Well, it is comfortably warm (A13). *[She spontaneously takes the next step.]* **As well as my hands, which are comfortably warm and dry (A12).**

Supervisor: Imagine yourself being grounded in this warm reclined comfort… able to handle the situation flexible and firm, what is there instead of agitation?

Client: I am centered and concentrated on what is happening. My activation is appropriate (A 11).

Supervisor: And what is there instead of tension?

Client: Some tension is fine. It is a balance between stability and flexibility… appropriate (A10). *[She holds her hands like scale pans and moves her body softly from one side to the other.]*

Supervisor: *[Pacing the movement.]* **And this soft appropriate balancing… what is there instead of trembling?**

Client: *[She brings the hands together and opens them like a funnel in front of her heart.]* **If I don't tremble anymore, I am open and calm (A9).**

Supervisor: Open and calm… balanced… open view and open heart… standing flexible and firm… even reclined and at ease… composed, what is there instead of obstruction?

Client: I am engaged in what is coming (A8).

Supervisor: Engaged in what is coming up… seeing the other person… waiting and seeing guarded… authentic with an open view… being in a soft rhythm of heartbeat and breath… distinctive feeling of the own body… what is there instead of blockade?

Client: I am confident and capable (A7).

Supervisor: Confidently engaged… capable to balance breath and voice, belly and heart, softness and firmness… centered and being one… waiting and seeing guarded… appropriate activated… composed… how is your forehead?

Client: It is open and upright *[Smiling.]* **and I am upright too, because I give me the right to be up the way I am. That is a very good agreeable feeling (A6).**

Supervisor: This very good feeling in your forehead, when you agree the way you are… giving you the right to be… up… and balanced, how does it affect the back of the head?

Client: It is harmonious and relaxed. Reclining not only relaxes my back and my neck, but also my head (A5). My head is a harmonious part of my body now.

Supervisor: Having a balanced harmony in your body and your head… a firm and empathic voice to speak to another person… what happens to this inner warning voice, when you agree with the way, you are?

Client: There is silence and fullness at the same time. I know I have it all (A4).

Supervisor: When you know in your head, your heart and in your belly: You are composed in the right way… capable to engage in what is coming… grounded soft and firm… centered… being one… waiting and seeing guarded… distinctively feeling… once there was a thread running through your everyday life. What will be with this thread?

Client: I can leave it with the patient (A3).

[Although the client hasn´t said anything about the conflict with her patient, the supervisor decides to deepen the trance and transfer the beneficial state into the specific problematic situation. For the resource transfer she does not need a formal induction, a simple "…please allow yourself to close your eyes… and imagine yourself in your office…" will be enough. Why is it so easy? The UATP is a conversation, which constantly uses hypnotic elements like pacing, reiteration, slowing down, and leading by a question, suggesting a change. The three parameters, which constitute a trance (state, focus, and suggestion) are built into the protocol. It is a conversational trance and it induces a natural flow, which is open to all kinds of hypnotic strategies; in this case, resource transfer.]

Supervisor: When you know you have everything… to leave it with the patient… being empathic and calm… certain and sure… please allow yourself to close your eyes… just to feel how your body is right now… your muscles… your breath… your heart… your throat… just feel it as it is right now… ease… as it is… it is good enough… to agree… and imagine yourself in your office… sitting reclined and released… waiting and seeing guarded… being there with this special patient… whose health record is in front of you… on the table right now. Observe him… centered and concentrated

on what is happening… staying comfortably warm. … What happened to the cloud?

Client: *[She starts laughing.]* **Now the cloud is floating above the patient… and actually it is pretty small (A2).**

Supervisor: When you see this small cloud… what do you know about your work as a therapist?

Client: I know, it is his cloud, he has to solve it. He is not the cloud… I can see him… and the cloud. I am capable of helping him, when I am upright and authentic.

Supervisor: In the past, when you met this patient, you had the feeling that something jumped at you. What happened with this?

Client: That is very interesting, now I have a protective cover and I feel secure. My own feelings secure me (A1).

Supervisor: That is very interesting… now you have a protective cover… you are secure. … What is the color of the protective cover?

Client: It is grey, grey as the cloud was. *[She re-orientates herself and opens her eyes.]* **That is weird. What I thought to be a cloud were my own feelings. My feelings clouded my view, because I didn't want to feel what I was feeling. I dissociated from feeling.**

Supervisor: You dissociated from feeling, starting to look at yourself from the right side. And now those clouded feelings have become your protective cover. In the very beginning of our meeting, you said that you wanted to understand. What do you understand?

Client: To look after me first is even right, if I do it in a friendly compassionate way. It is a ranking: First to be in

harmony with myself, secondly with the patient. *[She looks thoughtful, pauses, then smiles.]* **It is not that I haven`t heard it before.**

Supervisor: Yes, you have heard it before; what is the difference having gone through this process?

Client: Now it is such a deep experience, it is real understanding. When I heard it, it was logical. But I was not aware what was happening to me. Only through this process of awareness do I understand how I dissociated. *[She laughs.]* **It is insight from inside. In experiencing the problem, I found the solution. The key is to stay associated even with disagreeable feelings, compassion. Not to demand strength, but to be soft… empathy starting with myself. What a release.**