Instead of Psychotherapy

Dr Richard Bolstad

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A Series of Articles on NLP in Personal Change

Dr Richard Bolstad

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Preface

Welcome to this collection of articles on NLP. All these articles were originally published in NLP journals in the United States, Britain and New Zealand. The original versions of some of them were co-written with my late partner Margot Hamblett. Together they provide a coherent presentation of the use of NLP in personal change.

Psychotherapists have always been committed to the task of helping human beings to change as quickly and fully as is possible. The models you will study and the techniques you will read of in this book provide new and exciting ways to achieve these goals. The Neuro Linguistic Programming model which is presented here is different enough from most psychotherapy to merit the title however. This truly is a new way of thinking about how people change.

Richard Bolstad
March, 2004

A. The Neurology of Change

The Use Of Neurology

Increasingly, those of us working with human beings have come to terms with the fact that we are communicating with and through the human nervous system. Of course, what happens between human beings is not able to be *reduced* to neurology, any more than the beauty of a Rembrandt painting can be *reduced* to the chemistry of oil paints. However, if we want to paint like Rembrandt, a knowledge of that chemistry can be crucial. If we want to understand human communication, a knowledge of how the brain functions (neurology) will be similarly crucial. This is the starting point of the discipline called Neuro Linguistic Programming.

It was also the starting point for most of western psychotherapy. Sigmund Freud's declared aim was "to furnish a psychology that shall be a natural science: that is to represent psychical processes as quantitatively determined states of specifiable material particles, thus making these processes perspicuous and free from contradiction." (Freud, 1966).

Everything we experience of the world comes to us through the neurological channels of our sensory systems. The greatest spiritual transcendence and the most tender interpersonal moments are "experienced" (transformed into internal experiences) as images (visual), sounds (auditory), body sensations (kinesthetic), tastes (gustatory), smells (olfactory) and learned symbols such as these words (digital). Those experiences, furthermore, can be re-membered (put together again) by use of the same sensory information. Let's take a simple example.

Think of a fresh lemon. Imagine one in front of you now, and feel what it feels like as you pick it up. Take a knife and cut a slice off the lemon, and hear the slight sound as the juice squirts out. Smell the lemon as you lift the slice to your mouth and take a bite of the slice. Taste the sharp taste of the fruit.

If you actually imagined doing that, you mouth is now salivating. Why? Because your brain followed your instructions and thought about, saw, heard, felt, smelled and tasted the lemon. By recalling sensory information, you recreated the entire experience of the lemon, so that your body responded to the lemon you created. Your brain treated the imaginary lemon as if it was real, and prepared saliva to digest it. Seeing, hearing, feeling, smelling and tasting are the natural “languages” of your brain. Each of them has a specialised area of the brain which processes that sense. Another NLP term for these senses is "Modalities". When you use these modalities, you access the same neurological circuits that you use to experience a real lemon. As a result, your brain treats what you’re thinking about as “real”.

Understanding this process immediately illuminates the way in which a number of psychotherapeutic problems occur. The person with Post Traumatic Stress Disorder uses the same process to recreate vivid and terrifying flashbacks to a traumatic event. And knowing how these brain circuits allow them to do that also shows us a number of ways to solve the problem.

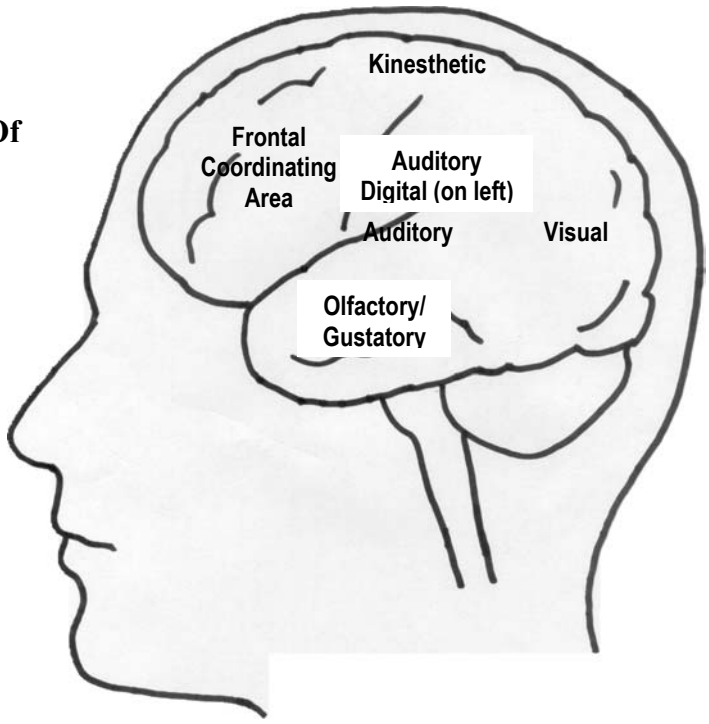
Perception Is Not A Direct Process

Perception is a complex process by which we interact with the information delivered from our senses. Biochemist Graham Cairns Smith points out that there are areas of the neural

cortex (outer brain) which specialise in information from each of the senses (he lists the modalities as olfactory, gustatory, somatosensory, auditory and visual). However there is no direct connection between the sense organ (the retina of the eyes, for example) and the specialised brain area which handles that sense. The cortex is the outer area of the brain, and each sense has an area of cortex specialised for it. The visual cortex, for example, is at the back of the brain. A great deal of redesigning has to happen at other places, before the raw sensory data gets to areas of the cortex where we can “perceive” it.

Consider the case of vision, for example. Impulses from the retina of the eye go first to the lateral geniculate body (see second diagram below), where they interact with data from a number of other brain systems. The results are then sent on to the visual cortex, where “seeing” is organised. Only 20% of the flow of information into the lateral geniculate body comes from the eyes. Most of the data that will be organised as seeing comes from areas such as the hypothalamus, a mid-brain centre which has a key role in the creation of emotion (Maturana and Varela, 1992, p 162). What we “see” is as much a result of the emotional state we are in as of what is in front of our eyes. In NLP terminology, this understanding is encapsulated in the statement "The map is not the territory". The map your brain makes of the world is never the same as the real world.

Specialised Areas Of The Cortex



Because the brain is a system with feedback loops, this process goes both ways. What we see is affected by our emotions, and it also shapes those emotions. Depression, anxiety, confusion, and anger are all related to certain “maps” of the world; certain types of perceptual distortion. So are joy, excitement, understanding and love. For example, the person who is depressed often actually takes their visual memories of the day's experiences and darkens them, creating a gloomy world. Notice what that does. Take a memory of a recent experience you enjoyed, and imagine seeing it dull and grey. Usually, this doesn't feel as good, so make sure you change it back to colour afterwards.

Colouring The World

To get a sense of how “creative” the perception of sensory information is, consider the example of colour vision. Tiny cells in the retina of the eye, called rods and cones, actually receive the first visual information from the outside world. There are three types of “cones”, each sensitive to light at particular places on the spectrum (the rainbow of colours we can see, ranging from violet through blue, green, yellow and orange to red). When a cone receives light from a part of the spectrum it is sensitive to, it sends a message to the brain. The cone does not know exactly which “colour” it just saw; it only knows whether the light was within its range. The first type of cone picks up light at wavelengths from violet to blue green, and is most sensitive to light that is violet. The second type picks up light from violet to yellow, and is most sensitive at green. The third type picks up light from violet to red, and is most sensitive to yellow. The most overlap in the sensitivity of these three types of cone happens in the middle colours (green-and yellow) and as a result these colours appear “brighter” than red and blue, when independent tests verify that they are not (Gordon, 1978, p 228).

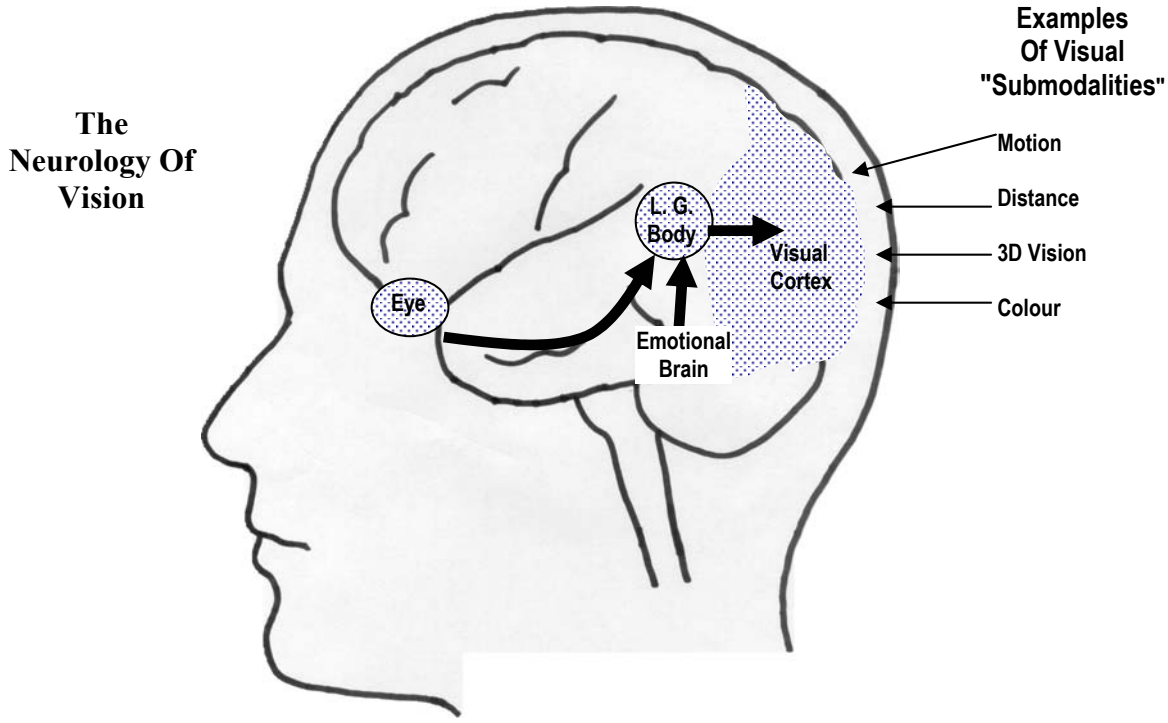
If the brain only gets information from three overlapping types of cone, how does the brain tell which colour was “actually there”? The answer is that it makes an estimate. In a specific "colour" area of the visual cortex, the brain compares the results from several cones next to each other, taking a sample of the three different kinds, in order to guess which colour was actually present (Cairns-Smith, 1998, p 163-164). The colour scheme that we “see” is a very complex guess. In fact, you’ve probably noticed that colours seem to change when placed next to other colours. A blue that looks quite “pleasant” next to a green may look “too strong” when seen next to a red, or vice versa. Placing a dark border around a colour makes it seem less “saturated” or pure (Gordon, 1978, p 228). Furthermore, what colours we see will also be affected by our emotional state. In everyday speech, we talk about “having a blue day” and about “seeing the world through rose tinted glasses”. Emotional information altering the perception of colour is actually fed into the visual system at the lateral geniculate body, as mentioned above.

The area of the visual cortex which makes final colour decisions is very precisely located. If this area of the brain is damaged in a stroke, then the person will suddenly see everything in black and white (acquired cerebral achromatopsia). At times a person will find that damage results in one side of their vision being coloured and one side being “black and white” (Sacks, 1995, p 152). This phenomenon was first reported in 1888, but between 1899 and 1974 there was no discussion of it in the medical literature. Medical researcher Oliver Sacks suggests that this resulted from a cultural discomfort with facts that showed how “manufactured” our vision is.

In 1957, Edwin Land, inventor of the Polaroid instant camera, produced a startling demonstration of the way our brain “makes up” colour schemes. He took a photo of a still life, using a yellow light filter. He then made a black and white transparency of this image. When he shone a yellow light through this transparency, viewers saw an image of the still life, showing only those areas that had emitted yellow light. Next he took a photo of the same still life, using an orange filter. Again he made a black and white transparency, and shone orange light through it. This time, viewers saw all the areas that had emitted orange light. Finally, Land turned on both transparencies at once, shining both yellow and orange light onto the screen. Viewers expected to see a picture in orange and yellow. But what they actually saw was full colour; reds, blues, greens, purples –every colour that was there in the original! The difference between the yellow and orange images had been enough to enable the viewers’ brains to calculate what colours might have been there in the “original scene”. The full colour experience was an illusion; but it is the same illusion that our brain performs

at every moment (Sacks, 1995, p 156). That is to say, the colours you are seeing right now are not the colours out here in the world; they are the colours your brain makes up.

While we are on the subject of colour, it's worth noting how fully our social and psychological experience shapes our colour vision. Dr T.F. Pettigrew and colleagues in South Africa were studying "dichoptic vision". Their subjects had a mask on so they could be shown one picture to their right eye and one to their left eye. A picture of a white face was sent to one eye, and that of a black face to the other eye, at the same time. Both English speaking South Africans and "coloured" South Africans reported seeing a face. But Afrikaners tested could not see the face. They saw nothing! At a level deeper than the conscious mind, they could not fuse a black face and a white face (Pettigrew et alia, 1976).



Modalities And Submodalities

Inside the visual cortex, there are several areas which process "qualities" such as colour. In NLP these qualities are known as visual "submodalities" (because they are produced in small sub-sections of the visual modality). Colour is one of the first fourteen visual submodalities listed by Richard Bandler (1985, p 24). The others are distance, depth, duration, clarity, contrast, scope, movement, speed, hue, transparency, aspect ratio, orientation, and foreground/background. Colour is also one of a list described by Psychology pioneer William James as early as 1890:

"The first group of the rather long series of queries related to the illumination, definition and colouring of the mental image, and were framed thus: Before addressing yourself to any of the questions on the opposite page, think of some definite object -suppose it is your breakfast table as you sat down to it this morning- and consider carefully the picture that rises before your mind's eye.

1. *Illumination*.- Is the image dim or fairly clear? Is its brightness comparable to that of the actual scene?
2. *Definition*.- Are all the objects pretty well defined at the same time, or is the place of sharpest definition at any one moment more contracted than it is in a real scene?
3. *Colouring*.- Are the colours of the china, of the toast, bread-crust, mustard, meat, parsley, or whatever may have been on the table, quite distinct and natural?" (James, 1950, Volume 2, p51)

Since 1950, another such list has been constructed by research on the physiology of vision. Within the visual cortex, certain areas of cells are specialised to respond to specific visual structures. The function of such cells can be found in two ways. Firstly, in a rather inhumane way, their function can be identified by connecting an electrode to the cells in a monkey's brain and finding out which visual objects result in those cells being activated. Secondly, the cells' function can be identified by studying people who have accidentally suffered damage to them. When a group of such cells are damaged, a very specific visual problem results.

For example, there are cells which respond only to the submodality of motion. These cells were found in the prestriate visual cortex of monkeys' brains in the early 1970s. When the monkey watched a moving object, the motion cells were activated as soon as movement began. In 1983, the first clinical cases were found of people with these specific cells damaged, resulting in central motion blindness (akinetopsia). A person with akinetopsia can see a car while it is still, but once the car moves, they see it disappear and reappear somewhere else. They see life as a series of still photos (Sacks, 1995, p 181).

Neurologically speaking, size, motion and colour are specialised functions, deserving of the name "submodalities". Many other such functions have been neurologically identified, including brightness, orientation (the tilt of the picture), and binocular disparity (depth and distance).

The first research on the neurological basis of visual submodalities was done by David Hubel and Torsten Wiesel in the 1950s and 1960s (Kalat, 1988, p 191-194). They showed that even these core submodality distinctions are a learned result of interaction with the environment. We are not born able to discriminate colour, for example. If we lived in a world with no blues, it is possible that the ability to "see" blue would not develop. If this seems unbelievable, consider the following experiment on the submodality of orientation, done by Colin Blakemore and Grant Cooper (1970).

Newborn cats were brought up in an environment where they could only see horizontal lines. The area of the cortex which discriminates vertical lines simply did not develop in these cats, as demonstrated by checking with electrodes, and by the cats' tendency to walk straight into chair legs. Similarly, cats raised where they could only see vertical lines were unable to see horizontal objects, and would walk straight into a horizontal bar. These inabilities were still present months later, suggesting that a critical phase for the development of those particular areas of the brain may have passed.

Higher Levels Of Analysis

The story of seeing is not yet complete with submodalities, however. From the visual cortex, messages go on to areas where even more complex meta-analysis occurs, in the temporal cortex and parietal cortex.

In the temporal cortex there are clusters of cells which respond only to images of a face, and other cells which respond only to images of a hand. In fact, there seem to be cells here which store 3-D images of these and other common shapes, so that those shapes can be "recognised" from any angle. Damage to these areas does not cause "blindness", but it does cause an inability to recognise the objects presented (Kalat, 1988, p 196-197). There is a specific area which puts names to faces, and damage here means that, while a photo of the person's partner may look familiar, the person is unable to name them. There is also an area of the temporal cortex which creates a sense of "familiarity" or "strangeness". When a person is looking at a picture, and has the "familiarity" area stimulated, they will report that they have suddenly "understood" or reinterpreted the experience. When they have the "strangeness" area stimulated, they report that something puzzling has occurred to them about the image. If you then explain to them "rationally" that the object is no more or less familiar than it was, they will argue for their new way of experiencing it. They will tell you that it *really* has changed! It feels changed! It looks different.

The analysis done in the parietal cortex is even more curious. This area seems to decide whether what is seen is worth paying conscious attention to. For example, there are cells here which assess whether an apparent movement in the visual image is a result of the eyes themselves moving, or a result of the object moving. If it decides that the "movement" was just a result of your eyes moving, it ignores the movement (like the electronic image stabiliser on a video camera). Occasionally, this malfunctions; most people have had the experience of scanning their eyes quickly across a still scene and then wondering if something moved or if it was just their own eye scanning.

Interestingly, if one of these meta-analysis areas is stimulated electronically, the person will report that there have been changes in their basic submodalities. Researchers have found that if they stimulate the "familiarity" area, not only do people report that they get the feeling of familiarity, but they also see objects coming nearer or receding and other changes in the basic level submodalities (Cairns-Smith, p 168).

This relationship between submodalities and the "feeling" of an experience is the basis of some important NLP processes, called submodality shifts. If we ask someone to deliberately alter the submodalities of something they are thinking about, for example by moving the imagined picture away from them and brightening it up, they may suddenly get the "feeling" that their response to that thing has changed. And in fact, it will have changed. Remember the lemon I had you imagine at the start of this chapter. As you smell the juiciness of it, imagine it bigger and brighter and the smell getting stronger. Changing these submodalities changes your response right down to the body level.

Remembered and Constructed Images Use The Same Pathways As Current Images

So far, we have talked about research on how people "see" what is actually in front of their eyes. We have shown that raw data from the eyes is relayed through the lateral geniculate body (where it is combined with information from other brain centers including emotional centers), and through the occipital visual cortex (where the submodalities are created in specific areas). From here, messages go on to the temporal and parietal lobes where more complex analysis is done. One more key point explains how this comes to be so significant for personal change and psychotherapy.

Edoardo Bisiach (1978) is an Italian researcher who studied people with specific localised damage to a specific area of the posterior parietal cortex associated with "paying attention visually". When this area of the cortex is damaged on one side, a very interesting result occurs. The person will fail to pay attention to objects seen on the affected side of their visual field. This becomes obvious if you ask them to describe all the objects in the room they are sitting in. If the affected side is the left, for example, when they look across the room, they will describe to you all objects on the right of the room, but ignore everything on the left. They will be able to confirm that those objects are there on the left, if asked about them, but will otherwise not report them (Kalat, 1988, p 197; Miller, 1995, p 33-34). Bisiach quickly discovered that this damage affected more than the person's current perception. For example, he asked one patient to imagine the view of the Piazza del Duomo in Milan, a sight this man had seen every day for some years before his illness. Bisiach had him imagine standing on the Cathedral steps and got him to describe everything that could be seen looking down from there. The man described only one half of what could be seen, while insisting that his recollection was complete. Bisiach then had him imagine the view from the opposite side of the piazza. He then fluently reported the other half of the details.

The man's image of this remembered scene clearly used the same neural pathways as were used when he looked out at Dr Bisiach sitting across the room. Because those pathways were damaged, his remembered images were altered in the same way as any current image. In the same way, the depressed person can be asked to remember an enjoyable event from a time before she or he was depressed. However, the visual memory of the events is run through the current state of the person's brain, and is distorted just as their current experience is distorted.

The successful artist Jonathon I suffered damage to his colour processing areas at age 65. After this a field of flowers appeared to him as "an unappealing assortment of greys". Worse, however, was his discovery that when he imagined or remembered flowers, these images were also only grey (Hoffman, 1998, p 108). If we change the functioning of the system for processing visual information, both current and remembered images will change.

Cross-referencing of Modalities

Submodalities occur neurologically in every sense. For example, different kinesthetic receptors and different brain processing occur for pain, temperature, pressure, balance, vibration, movement of the skin, and movement of the skin hairs (Kalat, 1988, p 154-157).

Even in what NLP has called the auditory digital sense modality (language), there are structures similar to submodalities. For example, the class of linguistic structures called presuppositions, conjunctions, helper verbs, quantifiers and tense and number endings (words such as "and", "but", "if", "not", "being") are stored separately from nouns, which are stored separately from verbs. Broca's aphasia (Kalat, 1988, p 134) is a condition where specific brain damage results in an ability to talk, but without the ability to use the first class of words (presuppositions etc). The person with this damage will be able to read "Two bee oar knot two bee" but unable to read the identical sounding "To be or not to be". If the person speaks sign language, their ability to make hand signs for these words will be similarly impaired.

I have talked as if each modality could be considered on its own, separate from the other senses. The opposite is true. Changes in the visual submodalities are inseparable from changes in other modalities, and vice versa.

When we change a person's experience in a visual submodality, submodalities in all the other senses are also changed. Office workers in a room repainted blue will complain of the cold, even though the thermostat has not been touched. When the room is repainted yellow, they will believe it has warmed up, and will not complain even when the thermostat is actually set lower! (Podolsky, 1938). A very thorough review of such interrelationships was made by NLP developer David Gordon (1978, p 213-261). These cross-modality responses are neurologically based, and not simply a result of conscious belief patterns. Sounds of about 80 decibels produce a 37% decrease in stomach contractions, without any belief that this will happen – a response similar to the result of "fear", and likely to be perceived as such, as the writers of scores for thriller movies know (Smith and Laird, 1930). These cross-modality changes generally occur out of conscious awareness and control, just as submodality shifts within a modality do.

Sensory Accessing and Representational Cues

As a person goes through their daily activities, information is processed in all the sensory modalities, continuously. However, the person's conscious attention tends to be on one modality at a time. It is clear that some people have a strong preference for "thinking" (to use the term generically) in one sensory modality or another.

As early as 1890, the founder of Psychology, William James defined four key types of "imagination" based on this fact. He says "In some individuals the habitual "thought stuff", if one may so call it, is visual; in others it is auditory, articulatory [to use an NLP term, auditory digital], or motor [kinesthetic, in NLP terms]; in most, perhaps, it is evenly mixed. The auditory type... appears to be rarer than the visual. Person's of this type imagine what they think of in the language of sound. In order to remember a lesson they impress upon their mind, not the look of the page, but the sound of the words.... The motor type remains - perhaps the most interesting of all, and certainly the one of which least is known. Persons who belong to this type make use, in memory, reasoning, and all their intellectual operations, of images derived from movement.... There are persons who remember a drawing better when they have followed its outlines with their finger." (James, 1950, Volume 2, p58-61)

Research identifying the neurological bases for these different types of "thought" began to emerge in the mid twentieth century. Much of it was based on the discovery that damage to specific areas of the brain caused specific sensory problems. A. Luria identified the separate areas associated with vision, hearing, sensory-motor activity, and speech (the latter isolated on the dominant hemisphere of the brain) as early as 1966.

By the time NLP emerged in the 1960s, then, researchers already understood that each sensory system had a specialised brain area, and that people had preferences for using particular sensory systems. In their original 1980 presentation of NLP, Dilts, Grinder, Bandler and DeLozier (1980, p 17) point out that all human experience can be coded as a combination of internal and external vision, audition, kinesthesis and olfaction/gustation. The combination of these senses at any time (VAKO/G) is called by them a 4-tuple. Kinesthetic external is referred to as tactile (somatosensory touch sensations) and kinesthetic internal as visceral (emotional and prioceptive).

The developers of NLP noticed that we also process information in words and that words too have a specific brain system specialised to process them, as if they were a sensory system. They described this verbal type of information as "auditory digital", distinguishing it from the auditory input we get, for example, in listening to music or to the sound of the wind. In

thinking in words (talking to ourselves) we pay attention specifically to the “meaning” coded into each specific word, rather than to the music of our voice. “The digital portions of our communications belong to a class of experience that we refer to as “secondary experience”. Secondary experience is composed of the representations that we use to *code* our primary experience –*secondary* experience (such as words and symbols) are only meaningful in terms of the *primary* sensory representations that they anchor for us.” (Dilts et alia, 1980, p 75). When we talk to you in words about “music” for example, what we say only has meaning depending on your ability to be triggered by the word *music* into seeing, hearing or feeling actual sensory representations of an experience of music.

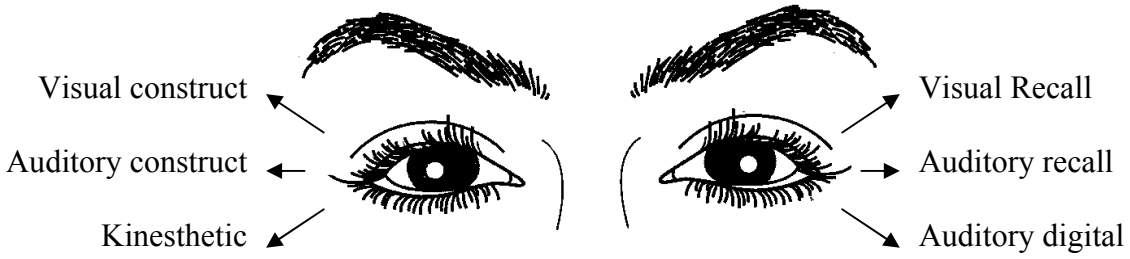
Words (auditory digital) are therefore a meta-sensory system. Apart from words, there are other digital meta-representation systems. One is the visual "digital system" used by many scientists, by composers such as Mozart, and computer programmers. This system too has a specific area of the brain which manages it. (Bolstad and Hamblett, "Visual Digital", 1999). In visual digital thinking, visual images or symbols take the place of words. Hence, Einstein says (quoted in Dilts, 1994-5, Volume II, p 48-49) “The words or the language, as they are written or spoken, do not seem to play any role in my mechanism of thought. The psychical entities which seem to serve as elements in thought are certain signs and more or less clear images which can be “voluntarily” reproduced and combined.” Digital senses do not just meta-comment on “stable” primary representations of course. They actually alter those representations. By learning the word “foot” and the word “leg”, you actually perceive those areas of your body as visually and kinesthetically distinct units, for example. This distinction does not occur in the New Zealand Maori language, where the leg from the thigh down plus the foot is called the *wae-wae*, and is considered one unit.

Robert Dilts (1983, section 3, p 1-29) showed that different brain wave (EEG) patterns were associated with visual, auditory, tactile and visceral thought. The developers of NLP claimed to have identified a number of more easily observed cues which let us know which sensory system a person is using (or "accessing") at any given time. Amongst these cues are a series of largely unconscious eye movements which people exhibit while thinking (1980, p 81). These "eye movement accessing cues" have become the most widely discussed of all the NLP discoveries. Outside of NLP, evidence that eye movements were correlated with the use of different areas of the brain emerged in the 1960s (amongst the earliest being the study by M. Day, 1964). William James referred to the fact that peoples eyes move up and back as they visualise. At one stage he quotes (Volume 2, p50) Fechner’s “Psychophysique”, 1860, Chapter XLIV. “In imagining, the attention feels as if drawn backwards towards the brain”.

The standard NLP diagram of accessing cues (below) shows that visual thinking draws the eyes up, auditory to the sides and kinesthetic down. Note that auditory digital is placed down on the left side (suggesting that all the accessing cues on that side may correspond to the dominant hemisphere, where verbal abilities are known to be processed). In left handed subjects, this eye pattern is reversed about 50% of the time.

Eye movements are clues as to the area in their brain from which a person is getting (accessing) information. A second aspect of thinking is which sensory modality they then "process" or re-present" that information in. Accessing and representing are not always done in the same sensory system. A person may look at a beautiful painting (Visual accessing) and think about how it feels to them (kinesthetic representation). The person’s representing of their experience in a particular language can be identified by the words (predicates) they use to describe their subject. For example, someone might say “I see what you mean.” visually,

"I've tuned in to you." auditorally, or "Now I grasp that." kinesthetically. The person who looks at the beautiful painting and represents it to themselves kinesthetically might well say "That painting feels so warm. The colours just flow across it." They experience the painting, in this case, as temperature and movement.



The NLP Eye Accessing Cues
For A "Normally Organised" Right Handed Person

Research On The Eye Movement Phenomenon

Everything in the brain and nervous system works both ways. If place "A" affects place "B", then place "B" affects place "A". We saw previously that if changing submodalities affects whether you feel familiar looking at a picture, then changing the feeling of familiarity will also change the submodalities of your image.

In the same way, if thinking visually causes your eyes to be drawn up more, then placing the eyes up more will help you to visualise. Specifically, looking up to the left (for most people) will help them recall images they have seen before. Dr F. Loiselle at the University of Moncton in New Brunswick, Canada (1985) tested this. He selected 44 average spellers, as determined by their pretest on memorising nonsense words. Instructions in the experiment, where the 44 were required to memorise another set of nonsense words, were given on a computer screen. The 44 were divided into four subgroups for the experiment.

Group One were told to visualise each word in the test, while looking up to the left.
Group Two were told to visualise each word while looking down to the right.
Group Three were told to visualise each word (no reference to eye position).
Group Four were simply told to study the word in order to learn it.

The results on testing immediately after were that Group One (who did actually look up left more than the others, but took the same amount of time) increased their success in spelling by 25%, Group Two worsened their spelling by 15%, Group Three increased their success by 10%, and Group Four scored the same as previously. This strongly suggests that looking up left (Visual Recall in NLP terms) enhances the recall of words for spelling, and is twice as effective as simply teaching students to picture the words. Furthermore, looking down right (Kinesthetic in NLP terms) damages the ability to visualise the words. Interestingly, in a final test some time later (testing retention), the scores of Group One remained constant, while the scores of the control group, Group Four, plummeted a further 15%, a drop which was consistent with standard learning studies. The resultant difference in memory of the words for these two groups was 61% .

Thomas Malloy at the University of Utah Department of Psychology completed a study with three groups of spellers, again pretested to find average spellers. One group were taught the

NLP "spelling strategy" of looking up and to the left into Visual Recall, one group were taught a strategy of sounding out by phonetics and auditory rules, and one were given no new information. In this study the tests involved actual words. Again, the visual recall spellers improved 25%, and had near 100% retention one week later. The group taught the auditory strategies improved 15% but this score dropped 5% in the following week. The control group showed no improvement.

These studies support the NLP Spelling Strategy specifically, and the NLP notion of Eye Accessing Cues, in general (reported more fully in Dilts and Epstein, 1995). There are many other uses to which we can put this knowledge. Counsellors are frequently aiming to have their clients access a particular area of the brain. For example, a counsellor may ask "How does it *feel* when you imagine doing that?". Such an instruction will clearly be more effective if the person is asked to look down right before answering. The English phrase "it's *down right* obvious" may have its origins in this kinesthetic feeling of certainty.

The claim that which sensory system you talk in makes a difference to your results with specific clients was tested by Michael Yapko. He worked with 30 graduate students in counselling, and had them listen to three separate taped trance inductions. Each induction used language from one of the main three sensory systems (visual, auditory and kinesthetic). Subjects were assessed before to identify their preference for words from these sensory systems. After each induction, their depth of trance was measured by electromyograph and by asking them how relaxed they felt. On both measures, subjects achieved greater relaxation when their preferred sensory system was used. (Yapko, 1981)

Strategies

To achieve any result, such as relaxation, each of us has a preferred sequence of sensory "representations" which we go through. For some people, imagining a beautiful scene is part of their most effective relaxation strategy. For others, the strategy that works best is to listen to soothing music, and for others simply to pay attention to their breathing slowing down as the feeling of comfort increases.

The concept of Strategies was defined in the book Neuro-Linguistic Programming Volume 1 (Dilts et alia, 1980, p 17). Here the developers of NLP say “The basic elements from which the patterns of human behaviour are formed are the perceptual systems through which the members of the species operate on their environment: *vision* (sight), *audition* (hearing), *kinesthesis* (body sensations) and *olfaction/gustation* (smell/taste)…. We postulate that all of our ongoing experience can usefully be coded as consisting of some combination of these sensory classes.” Thus, human experience is described in NLP as an ongoing sequence of internal representations in the sensory systems.

These senses were written in NLP notation as V (visual), A (auditory), K (kinesthetic), O (olfactory) and G (gustatory). To be more precise, the visual sense included visual recall, where I remember an image as I have seen it before through my eyes (V^r); visual construct, where I make up an image I’ve never seen before (V^c); and visual external, where I look out at something in the real world (V^e). So if I look up and see a blue sky, and then remember being at the beach, and then feel good, the notation would go: $V^e \rightarrow V^r \rightarrow K$. Notice that, at each step, I did have all my senses functioning (I could still feel my body while I looked up), but my *attention* shifted from sense to sense in a sequence. The digital senses (thinking in symbols such as words) have also been incorporated into this NLP strategy notation, so that

we can describe one of the common strategies people use to create a state of depression as $K^i \rightarrow A_d \rightarrow K^i \rightarrow A_d$ …. (Feel some uncomfortable body sensations; tell themselves they should feel better; check how they feel now, having told themselves off; tell themselves off for feeling that way, and repeat ad nauseum!)

The TOTE Model

The developers of NLP used the T.O.T.E. model to further explain how we sequence sensory representations. The "TOTE" was developed by neurology researchers George Miller, Eugene Galanter and Karl Pribram (1960), as a model to explain how complex behaviour occurred. Ivan Pavlov's original studies had shown that simple behaviours can be produced by the stimulus-response cycle. When Pavlov's dogs heard the tuning fork ring (a stimulus; or in NLP terms an "anchor"), they salivated (response). But there is more to dog behaviour than stimulus-response.

For example, if a dog sees an intruder at the gate of its section (stimulus/anchor), it may bark (response). However, it doesn't go on barking forever. It actually checks to see if the intruder has run away. If the intruder has run away, the dog stops performing the barking operation and goes back to it's kennel. If the intruder is still there, the dog may continue with that strategy, or move on to another response, such as biting the intruder. Miller, Gallanter and Pribram felt that this type of sequencing was inadequately explained in Pavlovs simple stimulus-response model. In Miller and Pribram's model, the first stimulus, (seeing the intruder) is the Trigger (the first T in the "TOTE"; Pavlov called this the "stimulus", and in NLP we also call this an "anchor") for the dog's "scaring-intruders-away" strategy. The barking itself is the Operation (O). Checking to see if the intruder is gone yet is the Test (second T). Going back to the kennel is the Exit from the strategy (E). This might be written as $V^e \rightarrow K^e \rightarrow V^e/V^c \rightarrow K^e$. Notice that the checking stage (Test) is done by comparing the result of the operation (what the dog can see after barking) with the result that was desired (what the dog imagines seeing –a person running away). In the notation, comparison is written using the slash key "/".

Lets take another example. When I hear some music on the radio that I really like (trigger or anchor), I reach over and turn up the radio (operation). Once it sounds as loud as I enjoy it sounding (test), I sit back and listen. The strategy, including the end piece where I listen (another whole strategy really) is $A^e \rightarrow K^e \rightarrow A^e/A^r \rightarrow K^e \rightarrow A^e$.

To revisit the strategy for depression mentioned above, we can now diagram it as $K^i \rightarrow A_d \rightarrow K^i /K^c \rightarrow A_d$. The first K^I is the *trigger, stimulus* or *anchor* which starts the strategy. The person feels a slightly uncomfortable feeling in their body. The next step, the A_d, is where they talk to themselves and tell themselves off for feeling that way. Next, they compare the feeling they get internally now (after telling themselves off) with the feeling they got before. (K^i /K^c). Noticing that it feels worse, they tell themselves off some more (the final exit A_d). The feeling of depression can be thought of as the result of repeatedly running this strategy, called "ruminating" by researchers into the problem (Seligman, 1997, p 82-83).

Once we understand that every result a person achieves is a result of a strategy which begins with some trigger and leads them to act and test that action, then we have a number of new choices for changing the way they run their strategy and the results they get. We will discuss these later in the book.

Meta-levels in Strategies

Miller, Gallanter and Pribram (1960) had recognised that the simple stimulus-response model of Pavlov could not account for the complexity of brain activity. Of course, neither can their more complex TOTE model. Any map is an inadequate description of the real territory. The TOTE model suggests that each action we take is a result of an orderly sequence A-B-C-D. In fact, as we go to run such a "strategy", we also respond to that strategy with other strategies; to use another NLP term, we go "meta" (above or beyond) our original strategy.

The developers of NLP noted that "A meta response is defined as a response about the step before it, rather than a continuation or reversal of the representation. These responses are more abstracted and disassociated from the representations preceding them. Getting feelings about the image (feeling that something may have been left out of the picture, for instance)… would constitute a meta response in our example." (Dilts et alia, 1980, p 90). Michael Hall has pointed out that such responses could be more usefully diagrammed using a second dimension (Hall, 1995, p 57) for example:

$$K^i$$
$$\downarrow$$
$$V^e \rightarrow V^c \rightarrow V^c$$

This emphasises that the TOTE model is only a model. Real neurological processes are more network-like (O'Connor and Van der Horst, 1994). Connections are being continuously made across levels, adding "meaning" to experiences. The advantage of the TOTE model is merely that it enables us to discuss the thought process in such a way as to make sense of it and enable someone to change it.

States and Strategies

The NLP term "state", is defined by O'Connor and Seymour (1990, p 232) as "How you feel, your mood. The sum total of all neurological and physical processes within an individual at any moment in time. The state we are in affects our capabilities and interpretation of experience". Many new NLP Practitioners assume that an emotional state is a purely kinesthetic experience. A simple experiment demonstrates why this is not true. We can inject people with noradrenalin and their kinesthetic sensations will become aroused (their heart will beat faster etc). However, the emotional state they enter will vary depending on a number of other factors in their environment. They may, for example, become "angry", "frightened" or "euphoric". It depends on their other primary representations and on their meta-representations -what they tell themselves is happening, for example (Schachter and Singer, 1962). The same kinesthetics do not always result in the same state!

Robert Dilts suggests that a person's state is a result of the *interplay* between the primary accessing, secondary representational systems, and other brain systems (1983, Section 1, p 60-69, Section 2, p 39-52, Section 3, p 12 and 49-51). Older theories assumed that this interplay must occur in a particular place in the brain; a sort of control centre for "states". It was clear by the time of Dilts' writing that this was not true. A state (such as a certain quality of happiness, curiosity or anxiety) is generated throughout the entire brain, and even removal of large areas of the brain will not stop the state being able to be regenerated. The state does involve a chemical basis (neuro-chemicals such as noradrenalin, mentioned above) and this

specific chemical mix exists throughout the brain (and body) as we experience a particular state.

Ian Marshall (1989) provides an update of this idea based on the Quantum physics of what are called “Bose-Einstein condensates. The simplest way to understand this idea is to think of an ordinary electric light, which can light up your room, and a laser, which with the same amount of electricity can beam to the moon or burn through solid objects. The difference is that the individual light waves coming off a normal light are organised, in a laser, into a coherent beam. They all move at the same wavelength in the same direction. It seems that states in the brain are a result of a similar process: protein molecules all across the brain vibrate at the same speed and in the same way. This forms what is called a Bose-Einstein condensate (a whole area of tissue which behaves according to quantum principles; see Bolstad, 1996). This vibration results in a coherent state emerging out of the thousands of different impulses processed by the brain at any given time. Instead of being simultaneously aware that your knee needs scratching, the sun is a little bright, the word your friend just said is the same one your mother used to say, the air smells of cinnamon etc (like the electric light scattering everywhere), you become aware of a “state”. This “state” sort of summarises everything ready for one basic decision, instead of thousands.

States, as Dilts originally hypothesised, are still best considered as "meta" to the representational systems. They are vast, brain-wide commentaries on the entire set of representations and physiological responses present. Our states meta-comment on *and* alter the representations (from the primary senses as well as from the digital senses) “below them”. For example, when a person is angry, they may actually be physically unable to hear their partner or spouse telling them how much they love them. The interference from the state reduces the volume of the auditory external input. This often results in a completely different strategy being run! Put another way, the "state" determines which strategies we find easy to run and which we are unable to run well.

States That Regulate States

Psychotherapist Virginia Satir noted that times when a person feels sadness, frustration, fear and loneliness are fairly predictable consequences of being human. In most cases, what creates serious problems is not so much the fact that people enter such states. What creates disturbance is how people feel *about* feeling these states. Satir says "In other words, low self-worth has to do with what the individual communicates to himself about such feelings and the need to conceal rather than acknowledge them." (Satir and Baldwin, 1983, p 195). The person with high self esteem may feel sad when someone dies, but they also feel acceptance and even esteem for their sadness. The person with low self esteem may feel afraid or ashamed of their sadness.

Such "states about states" are generated by accessing one neural network (eg the network generating the state of acceptance) and "applying it" to the functioning of another neural network (eg the network generating the state of sadness). The result is a neural network which involves the interaction of two previous networks. Dr Michael Hall calls the resulting combinations "meta-states" (Hall, 1995). Our ability to generate meta-states gives richness to our emotional life. Feeling hurt when someone doesn't want to be with me is a primary level state that most people will experience at some time. If I feel angry about feeling hurt, then I create a meta-state (which we might call "aggrieved"). If I feel sad about feeling hurt, a completely different meta-state occurs (perhaps what we might call "self-pity"). If I feel

compassionate about my hurt, the meta-state of "self-nurturing" may occur. Although in each case my initial emotional response is the same, the meta-state dramatically alters and determines the results for my life.

How Emotional States Affect The Brain

To understand the effect of emotional states in the brain, it will be useful for us to clarify exactly what happens when a strategy is run in the brain. Strategies are learned behaviours, triggered by some specific sensory representation (a stimulus). What does "learned" mean? The human brain itself is made up of about one hundred billion nerve cells or neurons. These cells organise themselves into networks to manage specific tasks. When any experience occurs in our life, new neural networks are laid down to record that event and its meaning. To create these networks, the neurons grow an array of new dendrites (connections to other neurons). Each neuron has up to 20,000 dendrites, connecting it simultaneously into perhaps hundreds of different neural networks.

Steven Rose (1992) gives an example from his research with new-hatched chicks. After eating silver beads with a bitter coating, the chicks learn to avoid such beads. One peck is enough to cause the learning. Rose demonstrated that the chicks' brain cells change instantly, growing 60% more dendrites in the next 15 minutes. These new connections occur in very specific areas –what we might call the "bitter bead neural networks". These neural networks now store an important new strategy. The strategy is triggered each time the chick sees an object the right shape and size to peck at. This is a visual strategy of course. The trigger (seeing a small round object) is Visual external (V^e) and the operation (checking the colour) is also Visual external (V^e). The chick then compares the colour of the object it has found with the colour of the horrible bitter beads from its visual recall (V^e/V^r) and based on that test either pecks the object or moves away from it (K^e). We would diagram this strategy: $V^e \rightarrow V^e \rightarrow V^e/V^r \rightarrow K^e$.

Obviously, the more strategies we learn, the more neural networks will be set up in the brain. California researcher Dr Marion Diamond (1988) and her Illinois colleague Dr William Greenough (1992) have demonstrated that rats in "enriched" environments grow 25% more dendrite connections than usual, as they lay down hundreds of new strategies. Autopsy studies on humans confirm the process. Graduate students have 40% more dendrite connections than high school dropouts, and those students who challenged themselves more had even higher scores (Jacobs et alia, 1993).

How do messages get from one neuron to another in the brain? The transmission of impulses between neurons and dendrites occurs via hundreds of precise chemicals called "information substances"; substances such as dopamine, noradrenaline (norepinephrine), and acetylcholine. These chemical float from one cell to another, transmitting messages across the "synapse" or gap between them. Without these chemicals, the strategy stored in the neural network cannot run. These chemicals are also the basis for what we are calling an emotional *state*, and they infuse not just the nervous system but the entire body, altering every body system. A considerable amount of research suggests that strong emotional states are useful to learning new strategies. J. O'Keefe and L. Nadel found (Jensen, 1995, p 38) that emotions enhance the brain's ability to make cognitive maps of (understand and organise) new information. Dr James McGaugh, psychobiologist at UC Irvine notes that even injecting rats with a blend of emotion related hormones such as enkephalin and adrenaline means that the rats remember longer and better (Jensen, 1995, p 33-34). He says "We think these chemicals

are memory fixatives…. They signal the brain, "This is important, keep this!"… emotions can and do enhance retention."

Neural Networks Are State Dependent

However there is another important effect of the emotional state on the strategies we run. The particular mixture of chemicals present when a neural network is laid down must be recreated for the neural network to be fully re-activated and for the strategy it holds to run as it originally did. If someone is angry, for example, when a particular new event happens, they have higher noradrenaline levels. Future events which result in higher noradrenaline levels will re-activate this neural network and the strategy they used then. As a result, the new event will be connected by dendrites to the previous one, and there will even be a tendency to confuse the new event with the previous one. If my childhood caregiver yelled at me and told me that I was stupid, I may have entered a state of fear, and stored that memory in a very important neural network. When someone else yells at me as an adult, if I access the same state of fear, I may feel as if I am re-experiencing the original event, and may even hear a voice telling me I'm stupid.

This is called "state dependent memory and learning" or SDML. Our memories and learnings, our strategies, are *dependent* on the state they are created in. "Neuronal networks may be defined in terms of the activation of specifically localised areas of neurons by information substances that reach them via diffusion through the extracellular fluid…. In the simplest case, a 15-square mm neuronal network could be turned on or off by the presence or absence of a specific information substance. That is, *the activity of this neuronal network would be "state-dependent" on the presence or absence of that information substance*." (Rossi and Cheek, 1988, p 57). Actually, all learning is state dependent, and examples of this phenomenon have been understood for a long time. When someone is drunk, their body is flooded with alcohol and its by-products. All experiences encoded at that time are encoded in a very different state to normal. If the difference is severe enough, they may not be able to access those memories at all… until they get drunk again!

At times, the neural networks laid down in one experience or set of experiences can be quite "cut off" (due to their different neuro-chemical basis) from the rest of the person's brain. New brain scanning techniques begin to give us more realistic images of how this actually looks. Psychiatrist Don Condie and neurobiologist Guochuan Tsai used a fMRI scanner to study the brain patterns of a woman with "multiple personality disorder". In this disorder, the woman switched regularly between her normal personality and an alter ego called "Guardian". The two personalities had separate memory systems and quite different strategies. The fMRI brain scan showed that each of these two personalities used different neural networks (different areas of the brain lit up when each personality emerged). If the woman only pretended to be a separate person, her brain continued to use her usual neural networks, but as soon as the "Guardian" actually took over her consciousness, it activated precise, different areas of the hippocampus and surrounding temporal cortex (brain areas associated with memory and emotion).(Adler, 1999, p 29-30)

Freud based much of his approach to therapy on the idea of "repression" and an internal struggle for control of memory and thinking strategies. This explanation of the existence of "unconscious" memories and motivations ("complexes") can now be expanded by the state dependent memory hypothesis. No internal struggle is needed to account for any of the previously described phenomena. The "complex" (in Freudian terms) can be considered as

simply a series of strategies being run from a neural network which is not activated by the person's usual chemical states. Rossi and Cheek note "This leads to the provocative insight that *the entire history of depth psychology and psychoanalysis now can be understood as a prolonged clinical investigation of how dissociated or state-dependent memories remain active at unconscious levels, giving rise to the "complexes"... that are the source of psychological and psychosomatic problems*." (Rossi and Cheek, 1988, p 57).

Dr Lewis Baxter (1994) showed that clients with obsessive compulsive disorder have raised activity in certain specific neural networks in the caudate nucleus of the brain. He could identify these networks on PET scan, and show how, once the OCD was treated, these networks ceased to be active. Research on Post Traumatic Stress Disorder has also shown the state-dependent nature of its symptoms (van der Kolk et alia, 1996, p291-292). Sudden re-experiencing of a traumatic event (called a flashback) is one of the key problems in PTSD. Medications which stimulate body arousal (such as lactate, a by-product of physiological stress) will produce flashbacks in people with PTSD, but not in people without the problem (Rainey et alia, 1987; Southwick et alia, 1993). Other laboratory studies show that sensory stimuli which recreate some aspect of the original trauma (such as a sudden noise) will also cause full flashbacks in people with PTSD (van der Kolk, 1994). This phenomenon is Pavlov's "classical conditioning", also known in NLP as "anchoring". State dependent learning is the biological process behind classical conditioning. The results of such classical conditioning can be bizarre. Mice who have been given electric shocks while in a small box will actually voluntarily return to that box when they experience a subsequent physical stress (Mitchell et alia, 1985). This is not a very nice experiment, but it does shed light on some of the more puzzling behaviours that humans with PTSD engage in.

People come to psychotherapists and counsellors to solve a variety of problems. Most of these are due to strategies which are run by state-dependent neural networks that are quite dramatically separated from the rest of the person's brain. This means that the person has all the skills they need to solve their own problem, but those skills are kept in neural networks which are not able to connect with the networks from which their problems are run. The task of NLP change agents is often to transfer skills from functional networks (networks that do things the person is pleased with) to less functional networks (networks that do things they are not happy about).

Rapport: The Work of The Mirror Neurons

In 1995 a remarkable area of neurons was discovered by researchers working at the University of Palma in Italy (Rizzolatti et alia, 1996; Rizzolatti and Arbib, 1998). The cells, now called "mirror neurons", are found in the pre-motor cortex of monkeys and apes as well as humans. In humans they form part of the specific area called Broca's area, which is also involved in the creation of speech. Although the cells are related to motor activity (ie they are part of the system by which we make kinaesthetic responses such as moving an arm), they seem to be activated by visual input. When a monkey observes another monkey (or even a human) making a body movement, the mirror neurons light up. As they do, the monkey appears to involuntarily copy the same movement it has observed visually. Often this involuntary movement is inhibited by the brain (otherwise the poor monkey would be constantly copying every other monkey), but the resulting mimickery is clearly the source of the saying "monkey see, monkey do".

In human subjects, when the brain is exposed to the magnetic field of transcranial magnetic stimulation (TMS), thus reducing conscious control, then merely showing a movie of a person

picking up an object will cause the subject to involuntarily copy the exact action with their hand (Fadiga et alia, 1995). This ability to copy a fellow creatures actions as they do them has obviously been very important in the development of primate social intelligence. It enables us to identify with the person we are observing. When this area of the brain is damaged in a stroke, copying another's actions becomes almost impossible. The development of speech has clearly been a result of this copying skill. Furthermore, there is increasing evidence that autism and Aspergers syndrome are related to unusual activity of the mirror neurons. This unusual activity results in a difficulty the autistic person has understanding the inner world of others, as well as a tendency to echo speech parrot-fashion and to randomly copy others' movements (Williams et alia, 2001).

Mirror neurons respond to facial expressions as well, so that they enable the person to directly experience the emotions of those they observe. This results in what researchers call "emotional contagion" – what NLP calls rapport (Hatfield et alia, 1994).

A Range Of NLP Intervention Choices

The cases of Post Traumatic Stress Disorder I worked with in Bosnia-Herzegovina provide a good example of the problems created by state-dependent strategies. In persons with PTSD, memories of a traumatic event such as a motor vehicle accident are reactivated by any future events that involve motor vehicles or any events that generate high levels of adrenaline in the body. The person has of course had many other mildly disturbing experiences that they have coped with effectively in their life before (by "reframing" the meaning of the event, and by distancing themselves as they review the event, for example). But in the case of their memory of the motor vehicle accident, they find themselves unable to use these healthy resources. This is because as soon as they begin to re-experience the traumatic event, they are operating from a neural network which has inadequate connection to their "healthy" state. When reliving the accident, they are unable to remember their usual skills. They can only run the strategies that are associated with the neural networks laid down at the time of the crash.

Using NLP-based techniques, we have several choices for getting the resources from where they reside in the person's other neural networks, and shifting them into the neural network where the accident has been coded. The following categorisation of these methods is not intended to be comprehensive. NLP is a vast and constantly evolving field, and these are merely some of the models in use within that field. Furthermore, the techniques listed are not simply tools which can be taken out and "used on" human beings. These techniques work when offered within the context of the RESOLVE model, to be explored in the next chapter.

I group the NLP interventions in ten categories:

1) Anchoring (in the PTSD example, having the person remember a time they felt relaxed, get back that feeling, and associate that relaxation with the situation they want to heal)

2) Installing a new strategy (teaching the person a new sequence of responses to go through each time they experience discomfort related to the PTSD)

3) Changing submodalities (having the person alter the qualities of the memory they have trouble with, for example by distancing themselves from it visually)

4) Trancework (relaxing the person and asking their unconscious mind to deal with the PTSD issue more resourcefully)

5) Parts Integration (connecting the part of them that is trying to protect them from further danger by flashbacks with the part of them that wants to relax)

6) Time Line changes (going back to the time in their memory storage where they first experienced the problem and changing the way they recall that memory)

7) Linguistic reframing (changing their understanding of the meaning of the events they went through, so those events no longer trigger panic)

8) Changing interpersonal dynamics (teaching them interpersonal skills to get support and meet their needs in other ways in their daily life)

9) Changing physiological contexts (changing the body posture they use to recall the events, for example having them recall the events while doing rapid side to side eye movements or while doing some enjoyable and challenging physical activity)

10) Tasking (Giving the client a task to complete in their own time, in order to produce one of the above results)

The Brain And NLP: A Summary

A number of the factors I have discussed in this article create choices for an NLP Practitioner wanting to help a client transfer functional skills to the neural networks where they are needed. To summarise what we have said about the brain with this in mind:

- The brain responds to visual, auditory, kinesthetic, olfactory-gustatory and auditory digital (verbal) cues. Remember the lemon!
- Each of these modalities is run by a particular area of the cortex (outer brain).
- The sensory organs are only indirectly connected to the areas of the cortex that analyse their data. On the way, the deeper areas of the brain where emotion and memories are stored influence the results of perception.
- Within each modality (sensory system) in the cortex, there are specific smaller areas which adjust the qualities of that sensory experience (the 'submodalities'). These include such qualities as colour and distance, visually. When these submodalities change, the person's "feeling state" about the experience will change.
- Memories and imagined experiences are run through the same sensory areas of the brain as new experiences. The submodalities of our memories and our imaginings are altered by our emotional state as we think of those memories or imagine those possibilities.
- All the outcomes people generate in their brain are the result of a series of internal sensory "representations". In NLP such a series is called a strategy.
- As people run through a strategy, and access information from the different modalities, there are a number of ways we can observe their thinking in these modalities. By watching their eye movements, we can see which area of the brain they are drawing information from. By listening to their words, we can hear which sensory system they are using to re-present the information to themselves.
- Strategies can be thought of as having a trigger that starts them (also called an "anchor" in NLP), an operation where the person acts and collects information in some sense, a test where the person checks whether the results they got are the results they wanted, and an exit where they act based on this test. This sequence is known by the acronym TOTE.
- In real life, strategies are not simple sequential operations. The brain is able to meta-respond to a strategy.
- Each strategy is run by a neural network (a set of neurons connected by dendrites and supported by a chemical mix of neuro-transmitters).
- This chemical mix which supports a specific neural network is a key ingredient of what we call an "emotional state", which is a brain-wide experience.

- When a neural network is dependent on a state which is very different to those usually occurring, then the person's usual coping skills may not be available while that state is active.
- Social skills including language use and empathy are dependent on the use of mirror neurons in the language area in the brain. Mirror neurons result in a tendency to involuntarily copy the gestures and facial expressions of others and to thus build an internal representation of their experience. This process is known in NLP as rapport.
- Helping someone change involves helping them access or trigger useful neural networks (running useful strategies) at the times they need them (often times when, in the past, they were triggered into using unresourceful strategies).
- Amongst the ways of doing this are Anchoring, Installing a strategy by rehearsal, Changing submodalities, Trancework, Parts Integration, Time Line Changes, Linguistic reframing, Changing interpersonal dynamics, Changing physiological contexts, and setting a Task.

B. RESOLVE: The Structure Of An NLP Session

A Model of NLP Changework

RESOLVE is an acronym for a series of steps used in NLP based change work. Steve Andreas says (1999) “I think that someone who uses the NLP methods exceptionally well has several ways of gathering all the different skills and techniques under a single overarching framework of understanding.” In meeting this aim, the RESOLVE model has a similar function to Carkhuff and Egan’s “Developmental Models of Helping” (Carkhuff, 1973; Egan, 1975). Most models of psychotherapy propose some structuring of the session, or of the process of psychotherapy. In NLP terms, there are several key elements of this process which enable NLP “tools”, such as the Trauma process, to work effectively.

The co-developers of NLP (especially Richard Bandler and Dr John Grinder) did not initially teach a framework for understanding the vast array of new patterns they revealed and developed. Dr Tad James was one of the first NLP trainers to do so. His General Model of Therapy (James, 1995) evolved out of his own modelling of Richard Bandler’s client work. My colleague Bryan Royds grouped all the NLP interventions we had studied, based on this model. Margot Hamblett and I expanded this grouping and formalised it into the RESOLVE model, which is now taught in a number of NLP training programs round the world. The book RESOLVE (Bolstad, 2002) expands on this model and the research behind it. Videotapes are also available from the course in which I teach the use of the model and from client sessions which demonstrate its use.

What Helping Is Not

From an NLP perspective, there are risks with the traditional role of a "counsellor" or "psychotherapist". In their search for a term not tainted by the expectations of “counsellor” and “psychotherapist”, Carkhuff and Berenson (1977) used the term “helper”.

Their concern was based on some important research. For example, in 1951, E. Powers and H. Witmer published one of the most extensive and well designed studies of the results of counselling and therapy, “An Experiment in the Prevention of Delinquency”. In this study 650 high risk boys aged 6-10 were chosen and grouped into pairs based on various demographic variables. One of each pair was then assigned to counselling (either client-centred or psychoanalytic), and linked up to support services such as the YMCA. After an average five years of counselling, the boys were followed up. Counsellors rated 2/3 of the boys in their care as having “benefited substantially” from the counselling, and the boys agreed, saying it gave them more insight and kept them out of trouble.

Such is success, isn’t it? Well, except for one detail. The treated boys were more likely to have committed more than one serious crime, had higher rates of alcoholism, mental illness, stress related illness, and lower job satisfaction than those left untreated. This remained true at 30 year followup, and the researchers lamely suggest that there “must be” some positive benefits, but they were unable to find them. Just because counsellors believe that counselling “feels good” doesn’t mean it helps. This 1951 study demonstrates the risks of dependency-producing models of treatment in general. The boys and their therapists valued “their relationship”, but it did not empower the boys to change; it disabled them (Zilbergeld 1983, p132-134)

Consulting: A Resourceful State For The Helper

The depressed, confused or anxious person is hiring me as a consultant (like a consultant in the business setting) to give them advice and support to put into action a plan that will change their life. If it is to work, this will be a collaborative relationship, in which they will need not only to "help", but also to experimentally follow the advice the consultant gives. I have no magic way of solving their problems for them. But if they do the things I suggest, I believe that they will experience change. I often say "NLP doesn't work. *You* work…. NLP just explains how you work, perfectly.". The other side of this is that if I am not hired as a consultant, I accept that. I do not carry on trying to "sell my services".

A consultant in a business context is hired to suggest strategies to enable their client to meet the client's goals. There are several implications to this arrangement, which I consider appropriate to the NLP setting:

- The consultant has some expertise in the area where they recommend changes, as well as some expertise in co-operating with clients. In the 1960s and 1970s, counselling developers Robert Carkhuff and Bernard Berenson published a number of research studies showing that helping interactions tend to influence clients either for better *or* for worse. They identified several measures of successful human functioning, and showed that helpers who function well on these dimensions are able to assist others to function well on these dimensions too. Helpers who function poorly on these dimensions actually influence clients to deteriorate in their functioning! (Carkhuff and Berenson, 1977, p 5, p 35). Carkhuff and Berenson likened most psychotherapists to professional lifeguards with extensive training in rowing a boat, throwing a ring buoy, and giving artificial respiration, but without the ability to swim. "They cannot save another because, given the same circumstances, they could not save themselves." What this emphasizes is that effective change agents are models of the skills they want to convey to their clients. What you do matters far more than what you tell your clients to do.
- The consultant elicits, clarifies and works towards the *client's* goals, not towards the consultant's own goals. The client is in charge of their own business. The consultant needs to be "hired" either formally or informally. That is, they offer their expertise in response to a request. They are not just a person who enjoys interfering in others lives. The client can choose to action the consultants suggestions, or not. Without this action, the consultant's work is recognised to be of little significance. The consultant is in charge of the process of consulting; the client is in charge of the content of their business.
- Consultants operate with certain explicit professional guidelines, such as confidentiality, and avoidance of double relationships (eg combining a consulting relationship with a sexual relationship) with clients. In return they expect their clients to operate with some guidelines such as turning up to arranged meetings on time.

Adopting this consultant role is itself a therapeutic step. As I spell out for my clients what kind of relationship I want, I am modelling healthy relating for them. I am also treating them as if they are "at cause" in their life, rather than a helpless victim. The NLP attitude and the consulting role are conveyed very simply at the beginning of any encounter. In doing this, I convey my own sense of resourcefulness; the ability to swim without being caught up in the currents of dependency and despair which many clients are dealing with. Creating this consulting contract is the first step of the RESOLVE model.

Establishing Rapport

Once I am clear on my role as a consultant, there are several steps still remaining before we can "change" the client's life. The first is known in NLP as building rapport. The developers of NLP noted that the chances of a helper being able to lead someone to change their strategy were increased by the helper elegantly joining the person's reality first. "When you join someone else's reality by pacing them, that gives you rapport and trust, and puts you in a position to utilise their reality in ways that change it." (Bandler and Grinder, 1979, p 81). For example, one of the set of strategies that often help create anxiety is to make scary internal visual images. If I talk with the visually anxious person about what they can *see* as they sit beside me, there is an increased chance that when I gradually shift my comments to talk more about kinesthetic relaxation, the person will follow this lead into the new strategy of relaxation (Yapko, 1981). Examination of films and videotapes of therapy sessions and other conversations by communication researchers (Ivey et alia, 1996, p 60; Condon 1982, p 53-76; Hatfield et alia 1994) now confirms the significance of what researchers call "interactional synchrony" or "movement complementarity". This same process is variously referred to in the NLP literature (eg Bolstad and Hamblett, 1998, p 68-72) as "non-verbal matching", "pacing" or "rapport skills".

What are these non-verbal rapport skills? NLP developers propose that when conversation flows smoothly, people breathe in time with each other, and co-ordinate their body movements as well as their voice tonality and speed. The more this matching of behaviour happens, the more the other person gets a sense of shared understanding and at-one-ness or "rapport". Also, the more this matching happens, the more the other person will be open to useful suggestions, and adopt the emotional responses of the helper or therapist. All learning and change depends on this willingness of the client to be open to new responses.

William Condon has meticulously studied videotapes of conversations, confirming these patterns. He found that in a successful conversation, movements such as a smile or a head nod are matched by the other person within 1/15 of a second. Within minutes of beginning the conversation, the volume, pitch and speech rate (number of sounds per minute) of the peoples voices match each other. This is correlated with a synchronising of the type and rate of breathing. Even general body posture is adjusted over the conversation so that the people appear to match or mirror each other. Elaine Hatfield, John Cacioppo and Richard Rapson, in their book *Emotional Contagion*, show that matching another person's behaviour in these detailed ways results in the transfer of emotional states from one person to another. If I feel happy, and you match my breathing, voice, gestures and smiles, you will begin to feel the same emotional state. This is the source of empathy, and also of much therapeutic change.

By revealing the nonverbal basis of rapport, NLP has been able to add considerably to the skills which a helper uses to convey empathy. Research identifying the effectiveness of *verbal* pacing (reflective listening; restating what the person said) first emerged in 1950, and a summary of the 50 years of continuing evidence for this core helping skill is presented by Allen Bergin and Sol Garfield (1994) in their Handbook of Psychotherapy. Building rapport in NLP terms also includes pacing the person's core metaprograms and values as these are revealed. Clients have been shown, for example, to prefer a counsellor whose word use matches their own representational system (visual, auditory, kinesthetic or auditory digital) by a ratio of three to one! (Brockman, 1980).

Specifying Outcomes

Once rapport is established, chunking down to detailed plans becomes very significant. While using vague language helps to build a feeling of rapport, the ongoing use of vague language is part of the system by which many clients maintain their problem. For example, Thomas Macroy (1998) found that when family communication was analysed in terms of the NLP metamodel, those families who were most dissatisfied were also using the most deletions, distortions and generalisations in their language (especially deletions). Research on the Solution Focused Therapy model (a model closely allied with NLP) confirms that clients improve after questions from their helper which focus on what outcome the client has. Also, the amount of discussion of solutions and outcomes in the first session is strongly correlated to the chances that the client will continue with the change process (Miller et alia, 1996, p 259). William Miller has done an overview of the research into successful psychotherapy, in which he identifies that enabling the client to set their own goal for therapy significantly increases their commitment to therapy and enhances the results (Miller, 1985). Solution focused therapists focus their entire intervention on eliciting the client's own outcomes and solutions. As de Shazer reports, this results in 75% success over four to six sessions (Chevalier, 1995). That is to say, setting an outcome is itself a change process.

Opening Up The Client's Model Of The World

Once we have a wellformed outcome, are we ready to make the changes? The answer is maybe. More of the "art" of NLP happens at the next stage in consulting than at any other. Here I need to open up the client's model of the world, so that they allow for the possibility of change. The one core factor in the client's "personality" that reliably predicts how well they will respond to the change process itself is whether they experience themselves as having an internal locus of control. Clients who believe that they are in charge of their own responses ("At cause", to use the NLP jargon) do far better in numerous research studies with a variety of different models of therapy (Miller et alia, 1996, p 319, 325). Furthermore, research shows that this sense of being in control is not a stable "quality" that some clients have and others do not; it varies over the course of their interaction with the helper. Successful therapy has been shown to result first in a shift in the "locus of control", and then in the desired success (Miller et alia, 1996, p 326). In their study of NLP Psychotherapy, Martina Genser-Medlitsch and Peter Schütz in Vienna (1997) found that NLP clients scored higher than controls in their perception of themselves as in control of their lives (with a difference at 10% significance level).

Dealing first with this meta-level change, dramatically increases your chances of enabling someone to change. There are three steps to putting someone "at cause" with their situation. These are 1) demonstrating the general possibility of change, 2) demonstrating the specific possibility of changing the client's current problem, and 3) demonstrating the possibility of using a selected, specific change technique to change that problem. Completing these tasks means that reframing is *always* part of my work as an NLP Practitioner.

Verifying The Change

Once I have a client who is "at cause" and knows their outcome, I am indeed ready to run standard NLP change processes. I do not merely run the process and send the person home of course. Solution focused therapists have studied the difference in the way they ask about the results of change processes afterwards (for example when the client returns to the next session). In studies replicated several times, they have found that if they ask questions which imply the possibility of failure (eg "Did the change process work?") they get a different result

than if they ask questions which presuppose success (eg "How did that change things?"). When asked a question that presupposes change, 60% of clients will report success. If the question presupposes failure, 67% will report that their situation is the same as it was before (Miller et alia, 1996, p 255-256).

Many times I have seen a client tell me that "nothing has changed" one minute, and then report that they have actually achieved every goal they set for our time together. What causes the shift? My willingness not to assume that their memory of events *is* reality, but instead to ask persistently, firstly..."So what has changed in your life (or in your experience of the situation that was a problem)? No matter how small the changes seem at first, what is different?", and then secondly, to genuinely congratulate them - "Wow, that's great. How did you do that?" and then thirdly, to keep asking "And what *else* has changed?" These three questions come from the Ericksonian school of Solution Focused Therapy (Chevalier, 1995). In asking them, I'm coaching the client to sort for solutions.

Milton Erickson explained that change is an unconscious process, and that the conscious mind needs re-assuring that change has occurred. He says (Erickson and Rossi, 1979, p 10) "Many patients readily recognise and admit changes they have experienced. Others with less introspective ability need the therapist's help in evaluating the changes that have taken place. A recognition and appreciation of the trance work is necessary, lest the patient's old negative attitudes disrupt and destroy the new therapeutic responses that are still in a fragile state of development". Here Erickson refers to pacing a client's strategy for being convinced.

Ecological Exit

Verifying the changes for the client leaves us one key task still to do. A number of studies have led helpers to recognise the importance of futurepacing the changes their clients initiate (having the client imagine themselves back in their actual life using their new skills). This process functions both to check out the appropriateness of their plans, the "ecology" in NLP terms, and also to install the expectation of success in the person's future (Mann et alia, 1989; Marlatt and Gordon, 1985). Allen Ivey and others have their clients write a "future diary" of their success a year into the future. Alan Marlatt has clients step into the future and fully consider what might make them change their mind about their changes, and then has them plan to prevent that. Both approaches have been shown to deliver far more robust change than parallel programs which skip this futurepacing stage. Of course, if any undesirable consequences of the change are detected at this stage, the process shifts back to clarifying outcomes.

The Stages Set Out

In summary, there are seven stages that successful consulting takes the NLP Practitioner and client through:

Resourceful consultant approach
Establish rapport
Specify person's outcome
Open up person's model of the world
Lead the person to their outcome
Verify change
Exit process

1. Resourceful State: To explore the RESOLVE model, I want to give an example from the work of NLP co-developer Richard Bandler. In this example session, Bandler works with Susan, who suffers panic attacks where she imagines that people in her family may have died in a car accident (Bandler, 1984, p 1-31). Bandler begins the session by asking Susan to tell him what she wants him to do, and explaining that he is not a magician (p 5).

> Richard: Okay Susan. Now why don't you tell me what it is that you would like?
> I don't know. We just got brought here and wired up, so you have to give me a hint.

As Susan replies, she is accepting the roles Bandler has defined. She has begun contributing her share to the process of change. This simple statement by Bandler communicates much of the attitude of the NLP consultant, as described above.

2. Establish Rapport: Next, Bandler uses pacing statements to build rapport. For example (Bandler, 1984, p 7).

> Susan: It's a fear of losing friendships or close relationships. Even when I anticipate a loss that isn't even real I get a panic attack.
> Richard: The situation that you are worried about being in is the one of anticipating and thinking about the loss?

These simple checks assure Susan that Bandler understands her concern. This makes it safer for him to playfully challenge her later inn the process of change.

3. Specify Client's Outcome: In his work with Susan's anticipatory anxiety, Richard Bandler checks carefully that she has a sensory specific and ecological outcome. When she first tells him that fear is her problem, he asks her, "Is the fear appropriate?" checking the ecology of making this change (Bandler, 1984, p 7). She tells him its not, and says she wants some distance from her problem. He checks her outcome more fully to elicit a clear description of what it would be like for her to be changed (p 16):

> Richard: If you were to have distance how would you know you had it?
> Susan: Well I believe I wouldn't feel those feelings. I'd have confidence, some self confidence and I think I could say to myself, well, just because they're not here now doesn't mean that you've lost them and it really doesn't matter. Maybe something happened. And also you can go on. So what if they don't show up. You can go on.

4. Open Up The Person's Model Of The World: Bandler does a number of things to open up Susan's model of the world and "pre-frame" the possibility of change. He asks her to explain to him the strategy she uses to get anxious (1984, p.9)

> Richard: But how do you do it? How do you know, how do you get the panic?
> Susan: Do you mean what feelings do I get?
> Richard: Let's say I had to fill in for you for a day. So one of the parts of my job would be if somebody was late I'd have to have the panic for you. What do I do inside my head in order to have the panic?
> Susan: You start telling yourself sentences like ..."
> Richard: I've got to talk to myself.
> Susan: So and so is late, look they're not here. That means that they may never come.
> Richard: Do I say this in a casual tone of voice?
> Susan: No

He continues asking her in similar detail about the visual aspects of her strategy for producing panic. He checks that, by bringing the pictures up close, she can bring on a feeling of panic, and then he compliments her on her success (p 16-17).

> Richard: You've obviously mastered this. By the way, do you know that this is an accomplishment?
> Susan: You mean to master the panic?
> Richard: I bet you a lot of people here couldn't panic.
> Susan: Probably not. Not like I do I'm sure.

Far from being the "dysfunctional" person in the interaction, Susan is now described as very skilled. From this point on, Bandler is operating as a consultant to help her reach her own goal. In a sense, she is no longer "owning the problem". She is now actively involved in changing herself. She happily accepts Bandler's direct instructions to change her way of thinking; instructions which would have come across as insulting and intrusive if given at the very start.

Leading: Bandler guides Susan through the NLP Swish technique (Bandler, 1984, p 21). This process begins with her using her ability to scare herself by seeing the picture of a car accident as if she were involved in it. The "swish" gets her to alter this picture rapidly, shifting to what NLP calls a dissociated viewpoint (giving her the distance she has been asking for). Repeating this several times "installs" the new perspective in her brain.

> Richard: Go ahead and make the picture bright and focus on it. Close your eyes again, move right in and as you approach very closely to it you begin to feel the panic. What I want you to do is to see in the small, lower left hand corner a little tiny dark square that has a picture of you the way you would be if you had made this change. It's real darkened in the corner but suddenly the big picture begins to get darker and the other one begins to expand and become brighter until it fills the whole screen. But you can do it faster than that. There you go. Hurry up. Until you can see yourself the way you would be. Now I want you to do the exact same thing. I want you to do it five times real fast.

Verify Change: Richard ensures that Susan is fully convinced that she has changed. He tells her (Bandler, 1984, p 24-25):

> Richard: You go ahead this time and go back and look at that panic. See if you can hold it. I want you to try as much as you can in vain.
> Susan: It's hard. I just keep getting white.
> Richard: What do you mean?
> Susan: I'm having trouble doing it.
> Richard: I thought you'd mastered that.
> Susan: I am a master at panic. Right now all I'm getting is white.…
> Richard: Try it once more. Just to be sure.
> Susan: I really just can't do it.

Ecological Exit: Once he has this clear, unequivocal statement verifying the change, Bandler moves on to "futurepacing" (planning for the future effects of the change). He reminds Susan that she believed this would change her future. He says (Bandler, 1984, p 25-26):

Richard: You've got to keep your promise. You said it would change your whole life.
Susan: Yeah.
Richard: Now you have to keep your end of the bargain.
Susan: Well I think if I don't have this problem that it is going to change. Because it's going to affect everything.
Richard: You're not going to be able to do it.
Susan: That would be wonderful.
Richard: Try it
Susan: I've tried it.
Richard: Try it now.
Susan: I just can't get it. I just can't get it.
Richard: Well if it was so easy before and its so hard now, that's an indication. You can go try it in the real world. I tell you what. Why don't you go outside by the coffee machine and I'll meet you there in ten minutes?

Eight months later, Susan was interviewed by Michael Saggese about her experience. She told him (p28-30):

Susan: When I left the studio that day I knew I felt really good but I was still a little skeptical of what had happened because my panics are so bad and so painful to me. I went home that evening and the same situation occurred. Someone was supposed to come and they didn't show up for several hours. And I didn't get upset at all. I was able to lie down and take a nap. It didn't upset me at all. I was just truly amazed….

Summary: The RESOLVE Model of Consulting

Resourceful state for the consultant
Establish rapport
Specify person's outcome
Open up person's model of the world
Lead the person to their outcome
Verify change
Exit process

The RESOLVE model begins with understanding that all change requires the guide themselves to begin in a resourceful state. During the first three steps, the consultant alternately uses two key verbal skills. The first is verbal pacing, which is the linguistic expression of the rapport skills by which they align with the person and create a sense of shared understanding or empathy. The second is open questioning, by which the consultant guides the person to identify and specify their outcome. A key shift then occurs at the stage of Opening up the Client's Model of the World. At this stage it becomes clear to the client that they have the resources to change, and are in charge of creating the outcomes they have chosen. The purpose of helping is thus for the consultant to be a support person who assists the client to identify their own goals and design their own solutions. The consultant is clear that they do have some specialised knowledge which will assist the client to do that. Having run whatever NLP change processes they select, the consultant then helps their client verify that change has happened, and then install the expectation of that change into their future.

C. The Personal Strengths Model

Why do particular NLP techniques work well with some clients and not with others? Imagine being able to identify which techniques will work as soon as the client describes their dilemma. That's the aim of this article, as I show you how every client who enters your office is revealing their *strengths* by the very way they claim to have a "problem".

Milton Erickson, the extraordinary hypnotherapist who was modelled by the developers of NLP, continuously urged the identification and utilisation of clients "problem" strategies in therapy. He says "The author has repeatedly stressed the importance of utilising patients' symptoms and general patterns of behaviour in psychotherapy. Such utilisation renders unnecessary any effort to alter or transform symptomatology as a preliminary measure to the re-education of patients in relation to the crucial problems confronting them in their illness." In the following article I provide a simple, easy to use, format for NLP Practitioners to quickly identify a client's "pattern of behaviour" and utilise it by providing NLP processes which pace it. My model is based on an earlier model developed by Carl Jung.

Jung's Model of Personality

Before NLP, most models of personality were explanations of the various ways in which human beings were considered to be "broken". Freud's model lists various personality types, for example; each of them being variations on what he called the "Psychopathology of everyday life" (Masson, 1992, p 85).

In developing the metaprograms model of personality, NLP began with one of the few exceptions to this psychopathology approach: Jungian analytic psychology. It was Jung who first coined the terms Thinker, Feeler, Sensor and Intuitor to refer to personality types. In Jung's model, these terms referred not merely to types, but also to skills for living, which people developed to various extents. He explains (1964, p49) "These four functional types correspond to the obvious means by which consciousness obtains its orientation to experience. *Sensation* (ie sense perception tells you that something exists; *thinking* tells you what it is; *feeling* tells you whether it is agreeable or not; and *intuition* tells you whence it comes and where it is going."

Tad James and Wyatt Woodsmall (1988, p95-106) describe the Thinker-Feeler and Intuitor-Sensor continua as measures of what percentage of time/energy a person invests in each of the four functions. Their questions ask "Does the person use thinking or feeling more?" and "Does the person use intuiting or sensing more?" Jung's original model allowed for a second type of question. Just because someone develops their thinking skills doesn't mean they have reduced their feeling skills. The second type of question is "For each skill, how fully has this person developed the skill?" As Jung suggests, every human being benefits by being able to fully use all four faculties. People vary in the extent to which they are skilled in each area.

Using NLP Terminology Instead of Jungian

We find the Jungian categories, as described by James and Woodsmall, immensely useful. We also think they are rather non-specific (chunked up in NLP terms, intuitive in Jungian terms). The ability of NLP to get down to the actual sensory data is something we really value (even in creating this overview). In NLP terms, we think four important analogues of Jung's skills are the ability to

1) Dissociate (distance oneself from experiences, seeing them from outside; corresponding to Thinker)
2) Associate (step into experiences, feeling them from inside; corresponding to Feeler) ,
3) Chunk up (Be aware of the global “big picture”; corresponding to Intuitor)
4) Chunk down (Be aware of the specific details; corresponding to Sensor)

These four skills (amongst others!) are essential for living an enjoyable life. They are also necessary prerequisites for all other internal processing, including the processing we call NLP techniques. To experience anchoring, for instance, you need to be able to associate into experiences. To run the phobia cure you need to be able to dissociate. To set a well formed outcome you need to be able to chunk down, and to do the parts integration process you need to be able to chunk up.

When a client comes seeking change, they bring their own personal skills; ones they've developed over a lifetime. Certain upbringings support the development of skills for dissociating; encouraging the person to step out of their experience. Certain upbringings support the development of skills for associating into and fully "living" experiences. Some upbringings nurture both abilities. It's the same for chunking skills.

Designing Interventions to Pace and Lead a Client's Strengths

If you study the original Jungian model more fully, you’ll read Jung’s claim that each function (each strength) had an active expression and a passive expression (Whitmont, 1991, p 140-147). The active expression refers to healthy use of the skill in a conscious, directed way. The passive expression refers to an unconscious, compulsive use of the skill (the way most clients will have been using the skills in their problem area). Rather than pacing the person’s “passive” use of a function, Jung aimed to directly access and use the opposite “active” skills in his analysis. The NLP notion of pacing and leading suggests a more elegant method.

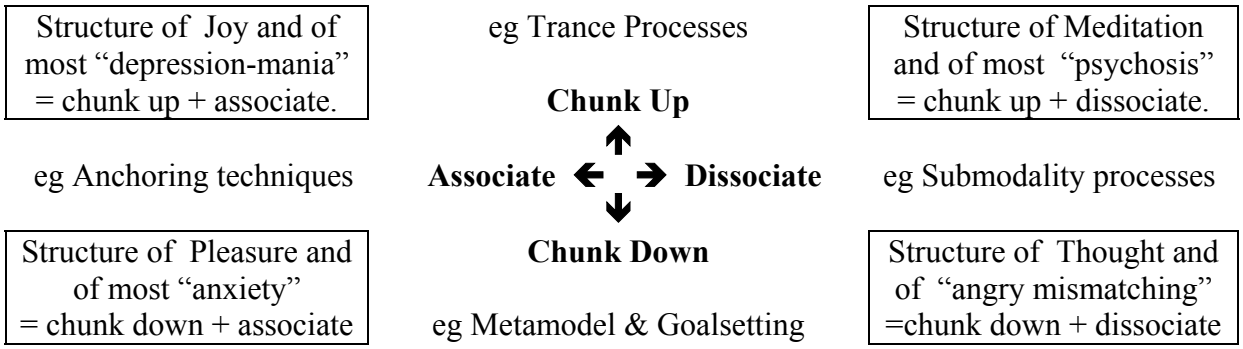
Anchoring processes require associating into a specific situation. A client who is excellent at associating will generally be good at anchoring. They've been doing it already (possibly using it to create phobias, but the skill is intact). They may or may not have acquired the skill to dissociate that is presupposed in the phobia cure. If we use collapsing anchors before the phobia cure, or stack a resource anchor first, we are utilising their strength (pacing) before leading them to new skills.

Submodality change processes require being able to dissociate somewhat from the experience you are eliciting submodalities for. Some submodality processes (such as the phobia/trauma cure) specifically require making dissociated, constructed images. Time Line Therapy™ (in which the person imagines floating up above the Time Line of their life) requires dissociating from the experiences on the Time Line. A client who is excellent at dissociating will generally be good at Time Line Therapy™ (see James and Woodsmall, 1988). They may find checking an experience in the time line less convincing, but will experience the change from being way up above and before the problem event. Someone who "feels" cut off from their experience may appreciate healing their limiting decision (to be cut off) from above the time line before coming back and anchoring themselves to a powerful resource state.

It's the same with chunking. Using the detailed NLP questioning style called the Metamodel to clarify your thoughts and set specific goals requires chunking down. The person skilled at

chunking down to the thousand details of their day and getting anxious may appreciate setting a sensory specific goal before you do trancework and chunk up to some generalised "change". On the other hand, using the “artfully vague” language patterns developed by Milton Erickson to induce trance presupposes the ability to chunk up, as do techniques which ask for the purpose or “higher intention” of your behaviour. A client who gets depressed because "everything" is hopeless may find it easier to use parts integration before setting specific goals.

If you are an NLP Practitioner, you've already discovered that some techniques work better with certain clients. It's not random. Clients have strengths. This four-skill model is one method for "diagnosing" those strengths. Some clients can do everything you suggest easily; that's great -they have all four skills.



NLP Techniques As Training; A) The Four Skills Combinations

In a sense, every time you use an NLP technique with a client, you help them to develop the skills presupposed by it. In that way, it's not only the specific issue that changes. Your client develops the skills required by the technique; which are simultaneously the skills to live an enjoyable life. NLP techniques are training skills for life.

As Jung noted in his model, people generally utilise a pair of the basic skills. In our model, for example, a person may use skills to associate into a chunked up experience ("*Everything feels* like this.") which could be used to create euphoria or "depression". This person may benefit from developing their ability to chunk down and dissociate, using submodality processes and dissociated goal setting.

Someone who uses skills to dissociate in a chunked up way ("*Everything I'm conscious of* is like this") could have used these skills to create a state of meditation or "psychosis". They could benefit from taking aboard techniques to chunk down and associate, such as strategy installation and associated goalsetting.

If your client uses skills to associate into chunked down experiences (*"These specific details feel* like this"), which can be used to generate pleasure or "anxiety disorders", they might benefit from learning how to chunk up and dissociate, with such trance techniques as Time Line Therapy™.

Lastly, the person who uses skills to dissociate in a chunked down way ("*These specific details I'm conscious of* in this way") which support planning successful action or extreme mismatching (what in psychiatry might be called a borderline personality disorder) could benefit from developing the skills of chunking up and associating into life with parts integration, anchoring and trance work.

NLP Techniques As Training: B) The Polarity Swings

Two types of polarity swing can be understood with this model. Firstly, some swings, such as "manic-depressive disorders" can be understood as simple uses of the same skills with different content. Both the "manic" person and the "depressed" person will agree that "*everything feels..."* something. What neither of them does well may be to chunk down and dissociate.

Secondly, some people develop strengths which focus on two categories "opposed" to each other, rather than two next to each other. This is called incongruity, or "addiction". An addict may appear to oscillate between associating into one experience/part/set of values/behaviour at one time, and dissociating from it totally at another. Neither skill is fully available, so they are unable to successfully dissociate from undesired experiences and associate into chosen experiences. They are, in Isobel Briggs Myers terms "perceivers" rather than "judgers" (Briggs Myers, 1962). That is, their strengths are on the “perceiving” intuitor-sensor axis (chunk up/chunk down) rather than the “decisionmaking” feeler-thinker axis (associate/dissociate). How can the addict’s skills be used in change work then? Chunking down to "one step at a time" and chunking up with parts integration are two examples.

Two Examples

What all this means is that when a client steps into your office and tells you they have a “problem”, they are describing a skill they have. As you listen to how they describe their difficulty, they will either say it affects everything, or it affects specific things. They will say either that they feel intensely or that they have difficulty identifying their feelings. In any case, they are telling you which strengths they are using, and thus telling you which NLP processes they are already running inside. Within five minutes, you can identify which NLP processes are most likely to work for them as you help them change.

As my partner, the late Margot Hamblett, and I were developing this model, a client came to see me asking for NLP processes to help her create a sense of spiritual awakening. This, she said, was something she had never really had access to. I initially assumed that she wanted to experience processes such as Core Transformation (A process involving chunking up to a profound “core state”; see Andreas, 1992), but as I attempted to lead her through this and other similar techniques, she continuously interrupted and disagreed with the instructions. In describing her goal, she had actually described in intricate detail what needed to change for her to achieve “spiritual awakening”, but complained that while she could “think about it” the description had no feeling with it. As soon as I recognised her style as chunking down and dissociating, I offered to change to another technique. She was delighted to be introduced to the far more detailed and dissociated submodality belief change, which she reported gave her the real experience of spiritual opening.

A client came to Margot Hamblett complaining that he had a phobia of meeting people. This problem had been diagnosed by a psychiatrist, and he had heard that NLP had a phobia cure

which could perhaps solve it in one session. However, as Margot listened to his description of the problem, it became clear that his “anxiety” was not the kinesthetic result of associating into traumatic memory that NLP describes as a phobia. In fact, he had never experienced the events he claimed to be phobic about (meeting women romantically) and was rather confused about what would happen if he did. He felt disoriented by being with women, and tended to avoid these experiences. He complained that he didn’t know how he felt about the situation. His chunking up and dissociating meant that he benefited initially from the use of Time Line Therapy™, and then from being invited to more fully associate into his body at earlier times when he had been with women, and rediscover his actual feelings.

These examples emphasise that the diagnostic terms such as “depression”, “phobia” and “psychosis” only roughly correspond to the metaprograms that we are sorting for here. I am interested in which strengths people actually demonstrate in relation to this particular challenge at this particular time, rather than which label someone has given them.

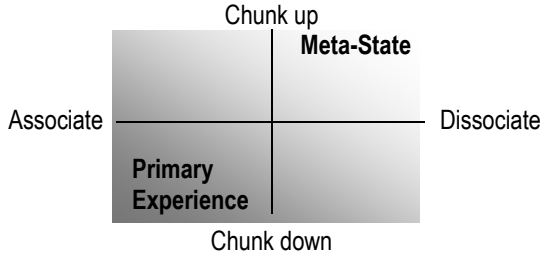
Expanding Personal Strengths

Not only can you pace and lead using this model for selecting NLP processes, but also you can design an exercise to facilitate your clients' ability to achieve change and to expand their repertoire of personal strengths. Such exercises can be given as between sessions activities and include:
1) Stopping at specific predecided times in the day to ask themselves "What is this specific situation an example of?... and what is that an example of?" (practise chunking up).
2) Identifying general trends in their life and asking themselves "What is a specific example of this trend?... and what specifically do I see/hear/feel as I recall that example?"
3) Taking a current situation or a remembered situation (an enjoyable one thanks) and experiencing it from first position (associated), seeing it exactly through their eyes, hearing through their ears, having any internal voice in their throat, and feeling the feelings in their body fully (using overlapping of sensory systems to do so).
4) Using the same experience , see, hear and otherwise experience it from a "third position" (dissociated), experiencing the "self" as simply another individual in the situation. Remember to have them associate back in after, and enjoy it again!

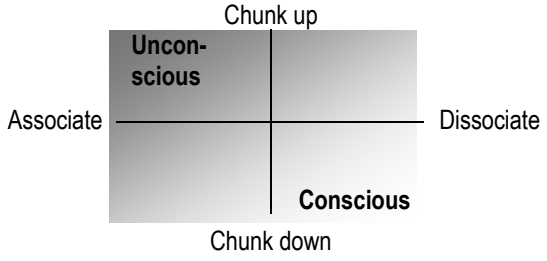
Other Implications

There's a lot more to understanding the four key skills of chunking up/down and associating/dissociating. You may already have noticed that Chunking up and Associating form the basis of NLP processes which access the "unconscious mind", while Chunking down and Dissociating are the basis of "conscious mind" processes. Combining the two types is the key to multilevel communication in consulting.

A. Personal Strengths and Meta-States



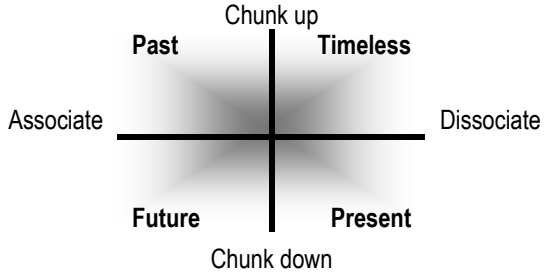
B. Personal Strengths and The Unconscious



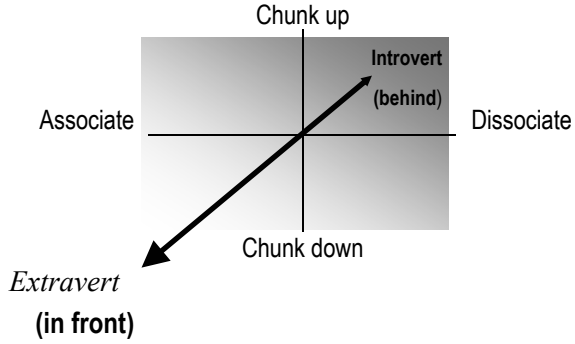
You may also have noticed that chunking up and dissociating are two ways of being "meta" to the experience, while chunking down and associating access more original sensory representations.

The personal strengths quadrants also correspond to time orientation differences. Ericksonian therapist Michael Yapko points out that human distress is a consequence of "temporal rigidity". When a person is unable to live flexibly from all three temporal perspectives (past, present and future), they suffer. The person with anxiety is stuck looking towards the future. The person with depression is stuck looking towards the past (even when they think they are considering life "now"). The person with impulse disorders such as addictions is stuck in now. Yapko explains (1992, p 118-120): "A temporal component is a part of virtually every experience…. For example, a structural component of anxiety disorders is a future temporal orientation: the anxious individual anticipates (orients to) the future in such a way as to create images (or internal dialogue or feelings) about events that have not yet occurred…. In contrast to anxiety disorders, in impulse disorders, the overwhelming emphasis is on the immediacy of experience –a present temporal orientation. The person is not particularly attached to either past tradition or future consequences. Rather it is the emphasis on here-and-now experience that governs the impulsive need for immediate gratification. In the case of depression, the emphasis is overwhelmingly on a past temporal orientation. The depressive is continually hashing and rehashing old traumas, including rejections, humiliations, disappointments, and perceived injustices -and in essence all the hurtful things from the past."

C. Personal Strengths and Time Orientation



D. With Introvert/Extravert Axis



Finally, Jung's original model also contained another distinction which could be added to the Personal Strengths model. This is extraversion-Introversion (Whitmont, 1991, p 139-140). Some clients will describe their problem in an introverted way ("This is what happens inside me") and some will describe their problem in an extraverted way ("This is what happens between others and me."). This is like a third axis on the model, making it a three dimensional chart. This distinction has been less significant in NLP consulting because most NLP processes are done internally, and most NLP trainings attract a disproportionate amount of introverts. None-the-less, some variation along this continuum does occur. Time Line Therapy™ is clearly a more introverted way of using Time Line than Robert Dilt's Re-imprinting on the Time Line, where the person actually walks along the floor.

In general, the type of action methods and psychodrama developed by Jacob Moreno are more extraverted (as a Myers Briggs assessment of the people at an action methods/psychodrama workshop will easily demonstrate). For a description of how to use these methods in the one to one consulting situation, see David Kipper's book *Psychotherapy Through Clinical Role Playing* (1986). In the NLP field, there is one other important place to find extraverted techniques, and that is in the setting of tasks. Milton Erickson frequently set tasks which involved considerable interaction with other human beings and considerable movement. Describing how he routinely sent his clients in Phoenix to specific shops, and to the Botanical gardens, and to climb Squaw Peak, Erickson explains "Because I believe that patients and students should do things. They learn better, remember better." (Zeig, 1980, p72).

A Map Of Squaw Peak Is Not The Territory

Most of all, I hope you've noticed that the Personal Strengths model is only a model. The map is not the territory. The aim is to use your ability to identify these strengths in yourself and in your clients, so you can let go of puzzling over their weaknesses, and instead build on their strengths. This attitude is crucial to NLP, in my opinion, and the model is only another tool to support it. Put simply, when your next client enters the room, you can ask yourself "As this person tells me their "problem", do they describe chunking up or down; do they describe associating or dissociating?" As soon as you know the answer to these questions, you know which NLP skills will be useful and successful for this client.

D. Parts Integration:
An Example of an NLP Change Process

What is Parts Integration?

In this article I want to examine one of the hundreds of NLP change techniques, and show how it has evolved out of the general field of Psychotherapy. The technique is “Parts Integration”. Let me begin by sharing one simple example of it’s use:

Pam came to see me wanting to improve her relationship with her two primary school age kids. She found herself yelling at these children most of the time she was with them, and she knew it was an ineffective method of getting their co-operation. Also, she felt bad about the lack of closeness between them. We used the NLP collapse anchors process (a development of Pavlov’s classical conditioning) to take Pam's own resources (a time of relaxation and a time when she helped successfully resolve a problem with people at her job) to the situation of being with her kids.

When Pam came back the next month she said that the anchoring process had worked for a couple of weeks but now things were as bad as ever. She suggested perhaps we could do it again.

That is one choice, but I was also aware that something inside Pam must have had a powerful enough reason to restart her yelling. After all, none of Pavlov's dogs came back a month later and complained that they couldn't salivate any more. What was different about Pam's experience? Pam said it felt as if her yelling wasn't under her control, "Almost as if there's a part of me that enjoys hurting them by yelling."

Parts: The Peaceful Country

When someone wants to change their behaviour, sometimes a part of them (a neural network, to use the technical term) has a powerful reason to keep the behaviour the same. There's a story I often tell to illustrate this:

Once there was a very peaceful country. Its citizens were co-operative and believed in working together in harmony. Unfortunately, it was still a very young nation when one of its neighbours launched an attack. The peaceful community didn't know what to do. They knew they had to defend themselves, but they were afraid that waging a war would destroy their co-operative society. So they set up within them a group of people whose job was to deal with the invader, and the community as a whole tried to carry on as before. They really didn't want to know too much about what the special group did.

After some years though, ugly rumours began to leak back to the centre of the main society. The special group was accused of horrific excesses on the border. They were attacking innocent people, both in the neighbouring country and in their own country. It seemed they were a law unto themselves. Under their slogan "Keep the border secure at all costs" they had taken over an ever increasing area of the peaceful country. Life inside the main community became more and more difficult as a result.

Finally, the community decided to investigate. They met with the leaders of the special group and *thanked them* for protecting the border. They pointed out that the higher intention of protecting the border was to enable peaceful co-operative life to continue. They combined their resources to find ways to achieve this even better than what the special group could do on its own, even better than what the community centre could do on its own. Most amazing of all, once they became one community again, they discovered that the attack had been over for many years now.

Parts Integration : Part One

To return to the story of Pam, who was yelling at her kids: I explained to Pam that there was a "part" of her, like that special group, which had a "reason" to keep yelling at her kids. I asked her if she'd like to find out that reason. She was curious.

I asked her "Which hand would the part of you that causes the yelling stand on, if it was to stand on the palm of your hand?"

"The right hand". She held out her right hand, palm up, and I held out my left hand mirroring hers.

"If that part was standing on that hand right now, what would it look like?" Pam laughed, looking intently at her hand.

"It's me with a ferocious look on my face."

"And what would it feel like? Does that hand feel heavy or light, warm or cool?"

"Its heavy and quite hot."

"Great. And if you were to ask it what it's purpose in yelling is, what would it say and what sort of voice does it have? Pam looked to the side, a little tearfully.

"To make them feel sorry for what they're done to me; to make them realise," she said in a shaky voice.

"I'd like to thank that part for talking to us," I said, more to the hand than to Pam, "and ask it; if it makes them sorry and makes them realise, if it totally achieved that, what would that do for you that's even more important?" Seeing her puzzlement, I repeated the question for Pam's conscious mind. She listened inside.

"Then I'd feel respected and valued."

"Excellent. And if you felt respected and valued; what's even more important than that? What would that do for you?"

"I guess I'd know that I was doing well as a parent."

"And what's the part's intention for doing that. What would knowing that do for you that's even more important?"

"A sense of inner confidence."

She smiled, feeling some of that confidence. "So this part wants inner confidence" I summarised.

"Yes," she agreed, "It seems so, but its got a weird way of doing it!"

Parts Integration : Part Two

Next I asked Pam "Now there's a part of you that has been most opposed to this part that causes the yelling, and if it was to stand on your left hand, where would it stand? The part that wants to stop yelling."

She held her other hand up and I mirrored, holding up my right hand. Her hands were now both palm up, about fifty centimetres away from each other.

"The part that wants to stop the yelling is in the centre of my left hand," Pam explained, and in answer to my questions she added, "It's me sitting down looking peaceful ... My hand feels cool and light, and it says it wants for me to be loving and accepting of the kids."

"So if this part gets to be loving and accepting, what even more important thing does that do for you?"

"I'd be close to my family."

"And what that would do for you is ....?"

"Wow". Pam was staring at a space between her hands. "If I was close to my family I'd have that feeling of inner confidence."

I nodded. "So do these two parts notice that they have the same highest intention?"

"Mmmm-hmm"

"And does this part (gesturing to her right hand) notice that this part (left hand) has resources that can help it achieve its intention?" She nodded. "Well, does this part (left hand) realise that this part (right hand) has resources that could help it achieve its intention?". She moved back a little.

"Sort of..... It does now."

There were tears in her eyes again. "So", I checked, "These parts have the same highest intention, and do they understand now that they were once part of a greater whole ... and it's okay for them to become one now?"

As she looked up and agreed "Yes" her hands began to float slowly, gently, towards each other. I followed by moving my hands together.

"Richard, I'm not moving my hands. How are they doing that?" Pam commented, watching in astonishment.

"Your unconscious," I explained, "is moving. The hands know where to go."

Oneness

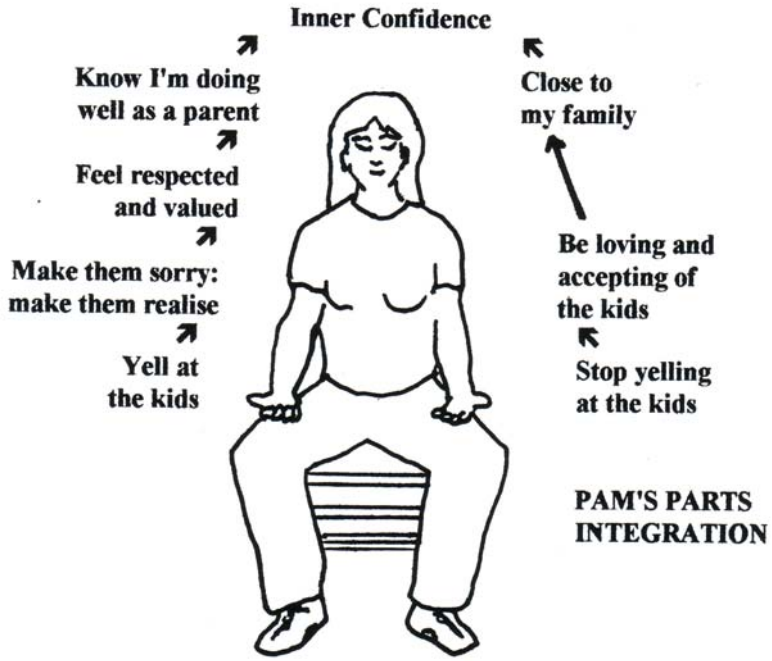
Once Pam's hands had floated together I had her feel that they now had the same weight and temperature. She could see the new integrated her, with all the resources each of the old parts had had, speaking with one voice. I invited her to feel where in her body her hands felt drawn to, and move her hands together to that place to "Bring that new wholeness back inside your body and let it spread through your entire neurology."

As I watched, continuing to mirror Pam's actions, I could see a dramatic change in her appearance. Her skin glowed, her face was very flushed and her breathing was full and deep. Her posture was more upright. When she spoke, her voice had a resonance to it.

"That is amazing", she concluded.

"It was powerful", I agreed. "You'd been waiting a long time to heal that."

When I spoke to Pam a few weeks later, the yelling was a thing of the past. She was discovering new ways to give a voice to her new confidence, not just with her children but in all areas of her life.



How Parts Integration Succeeds

Parts Integration works! Instead of trying to suppress the part of you that was causing the problem, it recognises and values that part. Sometimes people get into telling off the part that they disapprove of. I simply remind them that that's the *other* part speaking. Once *both* parts are valued, we can always find their shared highest intention.

In my experience there is *always* a shared highest intention. Sometimes I need to come back from one part to the other and keep asking the question "And what even more important thing will having that get for me?" But always the highest intention is shared. It's no surprise to me: after all, the part was developed by the person, inside their neurology, so it must have initially been developed by them to meet their goals ... even if it was to cope with an invasion that was over long ago.

Because the Parts Integration process works with deep inner areas of the neurology, not previously available to the conscious mind, it's very important that the guide in this process has the ability to:

- be fully *accepting* of and *valuing* of the person's inner parts.
- keep close rapport with the person
- Slow down with the person into a deeply relaxed state where their unconscious parts are more able to use their neurology fully.

The Brain

Now, let's go a little deeper into this technique. Since the brain is so closely linked to our psyche, it seems a good enough place to begin in attempting to explain what happens when we heal that psyche in a case such as Pam's. The human brain itself is made up of about one hundred billion nerve cells or neurons. These cells organise themselves into networks to manage specific tasks. When any experience occurs in our life, new neural networks are laid down to record that event and its meaning. To create these networks, the neurons grow an array of new dendrites (connections to other neurons). Each neuron has up to 20,000 dendrites, connecting it simultaneously into perhaps hundreds of different neural networks.

Steven Rose (1992) gives an example from his research with new-hatched chicks. After eating silver beads with a bitter coating, the chicks learn to avoid such beads. One peck is enough to cause the learning. Rose demonstrated that the chicks' brain cells change instantly, growing 60% more dendrites in the next 15 minutes. These new connections occur in very specific areas –what we might call the "bitter bead neural networks". These neural networks now store an important new strategy. The strategy is triggered each time the chick sees an object the right shape and size to peck at. This is a visual strategy of course. The trigger (seeing a small round object) is Visual external (V^e) and the operation (checking the colour) is also Visual external (V^e). The chick then compares the colour of the object it has found with the colour of the horrible bitter beads from its visual recall (V^e/V^r) and based on that test either pecks the object or moves away from it (K^e). We would diagram this strategy, for NLP purposes: $V^e \rightarrow V^e \rightarrow V^e/V^r \rightarrow K^e$.

Obviously, the more strategies we learn, the more neural networks will be set up in the brain. California researcher Dr Marion Diamond (1988) and her Illinois colleague Dr William Greenough (1992) have demonstrated that rats in "enriched" environments grow 25% more dendrite connections than usual, as they lay down hundreds of new strategies. Autopsy studies on humans confirm the process. Graduate students have 40% more dendrite connections than high school dropouts, and those students who challenged themselves more had even higher scores (Jacobs et alia, 1993).

How do messages get from one neuron to another in the brain? The transmission of impulses between neurons and dendrites occurs via hundreds of precise chemicals called "information

substances"; substances such as dopamine, noradrenaline (norepinephrine), and acetylcholine. These chemical float from one cell to another, transmitting messages across the "synapse" or gap between them. Without these chemicals, the strategy stored in the neural network cannot run. These chemicals are also the basis for what we call an emotional *state*, and they infuse not just the nervous system but the entire body, altering every body system. A considerable amount of research suggests that strong emotional states are useful to learning new strategies. J. O'Keefe and L. Nadel found (Jensen, 1995, p 38) that emotions enhance the brain's ability to make cognitive maps of (understand and organise) new information. Dr James McGaugh, psychobiologist at UC Irvine notes that even injecting rats with a blend of emotion related hormones such as enkephalin and adrenaline means that the rats remember longer and better (Jensen, 1995, p 33-34). He says "We think these chemicals are memory fixatives…. They signal the brain, "This is important, keep this!"… emotions can and do enhance retention."

Neural Networks Are State Dependent

However there is another important effect of the emotional state on the strategies we run. The particular mixture of chemicals present when a neural network is laid down must be recreated for the neural network to be fully re-activated and for the strategy it holds to run as it originally did. If someone is angry, for example, when a particular new event happens, they have higher noradrenaline levels. Future events which result in higher noradrenaline levels will re-activate this neural network and the strategy they used then. As a result, the new event will be connected by dendrites to the previous one, and there will even be a tendency to confuse the new event with the previous one. If my childhood caregiver yelled at me and told me that I was stupid, I may have entered a state of fear, and stored that memory in a very important neural network. When someone else yells at me as an adult, if I access the same state of fear, I may feel as if I am re-experiencing the original event, and may even hear a voice telling me I'm stupid.

This is called "state dependent memory and learning" or SDML. Our memories and learnings, our strategies, are *dependent* on the state they are created in. "Neuronal networks may be defined in terms of the activation of specifically localised areas of neurons by information substances that reach them via diffusion through the extracellular fluid…. In the simplest case, a 15-square mm neuronal network could be turned on or off by the presence or absence of a specific information substance. That is, *the activity of this neuronal network would be "state-dependent" on the presence or absence of that information substance*." (Rossi and Cheek, 1988, p 57). Actually, all learning is state dependent, and examples of this phenomenon have been understood for a long time. When someone is drunk, their body is flooded with alcohol and its by-products. All experiences encoded at that time are encoded in a very different state to normal. If the difference is severe enough, they may not be able to access those memories at all… until they get drunk again!

At times, the neural networks laid down in one experience or set of experiences can be quite "cut off" (due to their different neuro-chemical basis) from the rest of the person's brain. New brain scanning techniques begin to give us more realistic images of how this actually looks. Psychiatrist Don Condie and neurobiologist Guochuan Tsai used a fMRI scanner to study the brain patterns of a woman with "multiple personality disorder". In this disorder, the woman switched regularly between her normal personality and an alter ego called "Guardian". The two personalities had separate memory systems and quite different strategies. The fMRI brain scan showed that each of these two personalities used different neural networks (different areas of

the brain lit up when each personality emerged). If the woman only pretended to be a separate person, her brain continued to use her usual neural networks, but as soon as the “Guardian” actually took over her consciousness, it activated precise, different areas of the hippocampus and surrounding temporal cortex (brain areas associated with memory and emotion).(Adler, 1999, p 29-30)

To give an example from another psychiatric condition, research on Post Traumatic Stress Disorder shows the state-dependent nature of its symptoms (van der Kolk et alia, 1996, p291-292). Sudden re-experiencing of a traumatic event (called a flashback) is one of the key problems in PTSD. Medications which stimulate body arousal (such as lactate, a by-product of physiological stress) will produce flashbacks in people with PTSD, but not in people without the problem (Rainey et alia, 1987; Southwick et alia, 1993). Other laboratory studies show that sensory stimuli which recreate some aspect of the original trauma (such as a sudden noise) will also cause full flashbacks in people with PTSD (van der Kolk, 1994). This phenomenon is Pavlov's "classical conditioning", also known in NLP as "anchoring". State dependent learning is the biological process behind classical conditioning. The results of such classical conditioning can be bizarre. Mice who have been given electric shocks while in a small box will actually voluntarily return to that box when they experience a subsequent physical stress (Mitchell et alia, 1985). This is not a very nice experiment, and it also sheds light on some bizarre behaviours that some humans engage in.

Freud based much of his approach to therapy on the idea of “repression” and an internal struggle for control of memory and thinking strategies. This explanation of the existence of “unconscious” memories and motivations (“complexes”) can now be expanded by the state dependent learning hypothesis. No internal struggle is needed to account for any of the previously described phenomena. The “complex” (in Freudian terms) can be considered as simply a series of strategies being run from a neural network which is not activated by the person’s usual chemical states. Rossi and Cheek note “This leads to the provocative insight that *the entire history of depth psychology and psychoanalysis now can be understood as a prolonged clinical investigation of how dissociated or state-dependent memories remain active at unconscious levels, giving rise to the “complexes”… that are the source of psychological and psychosomatic problems*.” (Rossi and Cheek, 1988, p 57).

People come to psychotherapists to solve a variety of problems. Most of these are due to strategies which are run by state-dependent neural networks that are quite dramatically separated from the rest of the person's brain. This means that the person has all the skills they need to solve their own problem, but those skills are kept in neural networks which are not able to connect with the networks from which their problems are run. The task of NLP change agents is often to transfer skills from functional networks (networks that do things the person is pleased with) to less functional networks (networks that do things they are not happy about). One easy way to do this is to ensure that the neural networks are connected into one unit.

Parts Integration In NLP

In describing trance, Milton Erickson makes the distinction between the "conscious mind" and the "unconscious mind" (Erickson, 1980, Vol III, p 611). This recognition of two separate "subpersonalities" within the brain is one specific example of a wider model, describing what are called in NLP "parts". For our purposes, the word "part" refers to any state dependent neural network with enough functional autonomy to run its strategies without control by the rest of the brain. The "conscious mind" is, in this sense, as much a part as the unconscious.

As early as 1976 Richard Bandler and John Grinder presented a variety of different ways to work with conflicting parts, including Satir's Parts Party and the Gestalt Empty Chair process. Their methods involved conceptually separating or "sorting" the "polarities" (another Gestalt term for opposing parts) and having the client assume a meta-position from which they can enable the parts to "reorganise themselves into a new, single representation which will include all of the paramessages of both, and will be itself greater than the sum of the two." (Grinder and Bandler, 1976, p 82).

One early model of parts work used in NLP was called six step reframing. Bandler and Grinder explain its rationale in an early demonstration by saying "This only makes sense if you have a belief system that says "Look. If he had conscious control over this behaviour it would have changed already." So some part of him which is *not* conscious is running this pattern of behaviour…. I also make the assumption that the part of you that makes you X -even though you don't like that consciously- is doing something on your behalf, something that benefits you in some way." (Bandler and Grinder, 1979, p 139-140).

Six step reframing involves communicating with the part and asking the person's unconscious mind to think up some equally effective and more acceptable ways to meet the positive outcome of that part. This method has been shown to be as effective as relaxation training at curing psychosomatic physical symptoms (such as headaches; see Bacon, 1983). Six step reframing, unlike relaxation, does not need to be consciously applied in an ongoing way to keep the problem solved. The method has also been successfully used with addictive and compulsive behaviour patterns such as bulimia (Glöser, 1991) and alcoholism (Sterman, 1990).

The parts integration model itself is a development of an earlier process called the Visual Squash. Its advantage is that it connects two opposing parts together, where the six step reframe left the part that was of concern to generate new behaviours while still separate. Parts Integration is discussed by Robert Dilts in the book *Beliefs* (Dilts, Hallbom and Smith, 1990, p 101-126, p 165) where Dilts gives a transcript of its successful use to treat an allergy to cats, tested in the training room immediately after.

Since the development of Parts Integration, other NLP processes to deal with parts issues have continued to evolve, including Core Transformation (Andreas 1992) and Time Line Therapy™ (James and Woodsmall, 1988). Generally, these utilise the outcome chain process, where the person is asked for the part's "outcome" and then asked "If you get that fully and completely, what do you get, through having that, that's even more important?".

Parts Integration In Psychodynamic Therapies

Each model of psychotherapy has had to account for the activity of state dependent neural networks, and evolve some model of such "parts" of the mind. In each case, the structures are defined differently, and the precision of these definitions is often of importance to the development of techniques within that therapy. Respecting this importance, I will attempt to acknowledge carefully some of these distinctions here, while drawing attention to the universality of parts work in the field.

The notion of parts has its psychotherapeutic origins in the dynamic model of psychoanalysis. There, the core parts of the psyche spoken of are the id (which Freud says is based on "untamed passions"), the ego (the area based on "reason and circumspection") and the

superego (which upholds socially required, moral "norms of behaviour"). Freud suggested that the psychoanalyst is allied with the ego to defend it from anxiety and extend its "territory". He says his aim is "to strengthen the ego, to make it more independent of the super- ego, to widen its field of vision, and so to extend its organisation that it can take over new portions of the id. Where id was, there shall ego be." (Freud, 1933).

Modern object-relations based psychoanalysis has paid more attention to certain splits within the ego itself; particularly splits which occur pathologically if too severe a challenge confronts the ego early in life. A healthy mature ego, says Otto Kernberg, can repress undesired material out of conscious awareness, without needing to split it off completely. He says "Splitting consists in dissociating or actively maintaining apart identification systems with opposite valences (conflicting identification systems) without regard to access to consciousness or to perceptual or motor control." (Kernberg, 1976, p 44). The result is severe personality disorders and what NLP calls "sequential incongruity" -doing and desiring one thing at one time, and the opposite at another time. Healing is a process of "learning of "managerial skills" in order to understand one's self, one's boundaries, one's internal needs, one's environment and one's life tasks." (Kernberg, 1976, p 265). This managerial or co-ordinating function of the healthy ego is what NLP refers to as parts work.

By contrast, the focus of Transactional Analysis has been on healthy functional divisions within the ego. It defines three core ego states called the Parent (using strategies copied from parents/caregivers), Adult (using strategies developed in adult life and as here-and-now responses) and Child (using strategies learned as a child), and some subdivisions of these. Each ego state is "a consistent pattern of feeling and experience directly related to a corresponding persistent pattern of behaviour" (Stewart and Joines, 1987, p 15). In other words, each ego state is a state-dependent set of strategies. The aim of TA work with these ego states is often to prevent one state "contaminating" another or "excluding" another from expression. Again, the aim is the development of a situation where each state has access to expression in ways that are useful to the entire person, and this is what we are doing in parts work in NLP.

Parts Integration In Transpersonal and Interpersonal Therapies

In these formulations we have been discussing, the assumption is made that the main "parts" to be found in a human being are largely similar from one person to another. With the theory of archetypes common to the collective unconscious of humanity, Carl Jung takes this a step further. He describes an archetype as "an inherited mode of psychic functioning…. In other words it is a 'pattern of behaviour'." (quoted in Whitmont, 1991, p 104). He describes in this way such elements as the anima (inner feminine principle in a male) and animus (inner masculine principle in a woman), the persona (our adaptation to social expectations) and the Self (a suprapersonal summation of ones life and its meaning). Archetypes are the central elements of complexes. Jung explains that each complex "appears as an autonomous formation intruding on consciousness…. While complexes owe their relative autonomy to their emotional nature, their expression is always dependent on a network of associations, grouped round a centre charged with affect." (in Whitmont, 1991, p 63-64). In other words, again, we have here a definition of state dependent strategies. Unlike Freud, however, Jung did not see it as the ego's task to replace such other complexes. He says "Conscious and unconscious do not make a whole when one of them is suppressed and injured by the other…. Both are aspects of life…. It is the old game of hammer and anvil; between them the patient iron is forged into an indestructible whole, an "individual"." (in Whitmont, 1991, p 18).

The work of Roberto Assagioli describes parts work in a very similar frame to that used by NLP. The aim, in both cases, is the integration of separate parts into one unitary whole (a process called by Assagioli Psychosynthesis). Assagioli describes his aim as "Co-ordination and subordination of the various psychological energies and functions, the creation of a firm organisation of the personality." (Assagioli, 1976, p 29). In Psychosynthesis, as in NLP, this process is recognised as ultimately leading to transcendent states of pure awareness, joy, peace and love, and as extending beyond the "individual human being" as normally understood in the west (Assagioli, 1976, p 5).

The metaphor Jacob Moreno uses for parts is drawn from the theatre. By "role", he refers to "the functioning form the individual assumes in the specific moment he reacts to the specific situation in which other persons or objects are involved." (Moreno, 1977, p iv). Moreno points out that the role, with its strategies, its emotional state etc, evolves independently from the individual's interaction with the world. "Role playing is prior to the emergence of the self. Roles do not emerge from the self, but the self may emerge from roles…. It is possible, as we see with infants and psychotics, for the individual to operate with several alter egos." (Moreno, 1977, p 153). Part of the task of therapy, then, is to help individuals to reduce role conflict, to harmonise the functioning of roles, and to allow the smooth transition from role to role as required by the situation. The ability to produce roles which respond adequately and effectively to unprecedented situations (spontaneity) is a highly valued aim of Moreno's work (Moreno, 1977, p 85-89), and parallels the aim of parts work in NLP. In Psychodrama, a role is said to have five components. These equate to some extent with the TOTE: so that Context = the Trigger, Behaviour = the Operation, Belief = the Test, and Feeling and Consequences = the Exit. (Williams, 1989, p 58).

Parts Integration In Body Therapies

Alexander Lowen describes the healthy individual after body-oriented psychotherapy in physiological terms. "He is aware of his contact with the ground and feels more rooted. He says he feels connected with his body, his sexuality and the ground. To be so connected is not an ideal of health; in my opinion it is the minimum of health." (Lowen, 1972, p 61-62). What stops this connectedness, Lowen argues, are patterns of chronic muscular tension which prevent contact between the various layers of body tissue. Each layer, he suggests holds a state and the strategies which express it. Body tension is the key way people inhibit the activation of what are literally important "parts" of their experience. "In effect, the area of the body that would be involved in the expression of the impulse is deadened, relatively speaking, by the chronic muscular tension that develops as consequence of the continual holding pattern." (Lowen, 1972, p 81). By enabling full flowing breathing and movement, the body therapist creates access between the various "parts" of the person.

Arthur Janov evolved a model of Primal Therapy which is closely based on brain research. He says that the aim of his cathartic therapy is to release pain impulses which have been locked in lower brain circuits. Once the original events are re-experienced consciously, connection between these memories and the conscious mind has a profound healing effect. He says "Unconsciousness represents a breakdown in the integrative capacities of the brain as it mediates bodily processes. It occurs when the system is overloaded so that impulses (resulting from action potentials mediated by synapses) which normally have specific innervations with the cerebral cortex to make us conscious, overwhelm the integrative faculties and become shunted into alternate cerebral pathways rendering us, in that sense,

unconscious," (Janov, 1977, p 4-5). Janov says "It is consciousness which finally conceptualises and interprets these deep pains and makes sense of them." (Janov, 1977, p 35).

The concept of parts as used in NLP was present directly in the work of Fritz Perls. Perls explains "If some of our thoughts, feelings, are unacceptable to us, we want to disown them. *Me* wanting to kill you? So we disown the killing thought and say, "That's not me -that's a *compulsion*," or we remove the killing, or we repress and become blind to that. There are many of these kinds of ways to remain intact, but always only at the cost of disowning many, many valuable parts of ourselves…. You do not allow yourself -or you are not allowed- to be totally yourself." (Perls, 1969, p 11). He adds, "So what we are trying to do in therapy is step-by-step to *re-own* the disowned parts of the personality until the person becomes strong enough to facilitate his own growth…." (Perls, 1969, p 38).

Parts Integration In Humanistic And Cognitive Therapies

The other models for early NLP also used an explicit "parts" theory. Virginia Satir's way of dealing with parts issues was through a psychodramatic method she called the "Parts Party". She explains "We all have a number of different parts, each with expectations of fulfillment. These parts often find it difficult to get along withy each other and may have inhibitory influences on one another…. The process of the parts party offers a person an opportunity to observe these parts and to learn how they can function more harmoniously when they co-operate rather than compete." (Satir and Baldwin, 1983, p 258).

Client centred therapy developer Carl Rogers is far more cautious about suggesting that there may be organised "structures" within the human psyche, but he makes it clear that he is working with what NLP would call parts, when he says: "From a descriptive clinical point of view… we may say that successful therapy seems to entail the bringing into awareness, in an adequately differentiated and accurately symbolised way, those experiences and feelings which are currently in contradiction to the client's concept of self." (Rogers, 1973, p 148-149). A central result of therapy, Rogers notes, is "Increased unification and integration of the personality" (Rogers, 1973, p 178).

Behavioural psychotherapy began by carefully avoiding any speculation about the inner "structuring" of the mind. In the 1980s, cognitive behaviourists evolved the concept of schemas to account for many of the phenomena which we are discussing here. A schema is defined in two ways: "On the one hand, the term *schema* has been used to refer to a hypothesised *structure* of cognition, such as a mental filter or template that guides the processing of information…. More regularly, however, we use the construct of *schema* in reference to the *content of fundamental, core beliefs*: the basic rules that an individual uses to organise his or her perceptions of the world, self and future, and to adapt to life's challenges (Layden et alia, 1993, p 7). Such schemas can be restructured (creating a whole new way of responding), modified (altered so that there are times the schema need not apply, for example) or reinterpreted (reframed as having a positive meaning rather than a limiting one); all methods that clearly relate to NLP parts work (Layden et alia, 1993, p 11-12).

Summary

I began by examining the way that new learnings, new strategies, are laid down in neural networks in the brain. When strategies are laid down during a very unique emotional state, such networks can be poorly connected to the rest of the person's brain. Psychotherapy involves

reconnecting such networks so that the person can function in an integrated way. In NLP, a variety of methods have been developed to meet this outcome, including finding new solutions for a part with six step reframing, and creating oneness between two parts through parts integration. Other methods of psychotherapy have their own metaphors for these processes, including:

- Psychoanalysis: teaching the ego managerial skills to co-ordinate needs and life tasks.
- Transactional Analysis: allowing each ego state to express itself without exclusion or contamination
- Analytical Psychology: forging an individual out of the interaction between conscious and unconscious elements of the mind
- Psychosynthesis: integrating separate energies and functions into one unitary wholeness
- Psychodrama: reducing role conflict and allowing roles to spontaneously express themselves
- Reichian Body Therapy: releasing muscular tension so that impulses stored in all areas of the body are able to be fully expressed
- Primal Therapy: allowing the release of feelings locked in lower brain pathways to create connection and full awareness
- Gestalt Therapy: re-owning the disowned parts of the personality
- Satir's Family Therapy: learning how parts can function harmoniously and co-operate
- Client Centred Therapy: bringing into awareness unaccepted experiences to create increased integration of the personality
- Cognitive Behaviourism: restructuring, modifying or reinterpreting schemas to enable more useful cognition

This article represents one small contribution towards a mental map of the field of psychotherapy from NLP perspectives. My belief is that all psychotherapy has been a search for ways to heal the same challenges. Neurological research will continue to refine one metaphor of how that happens. Having flexibility in the ways we conceptualise such change enables us to communicate with other therapists, as well as to do a better job ourselves.

E. Depression

The Epidemic of Depression

In the Psychiatric manual DSM-IV™ (American Psychiatric Association, 1994), a major depressive episode is identified by the person having symptoms such as feeling sad or empty, lack of interest or pleasure, fatigue, feelings of worthlessness or guilt, inability to think, recurrent thoughts of death, insomnia or hypersomnia, weight loss or gain, and body agitation or slowing down. This is a life-threatening psycho-physiological disorder. Studies show that people who score highly on these indicators of depression have lowered lymphocyte responsiveness and immunoglobulin levels in their blood –ie their immune systems are damaged and they are more likely to get ill (Thayer, 1996, p 30-31).

The rate of depression varies from social group to social group, and from time to time. Carefully adjusted studies (Seligman, 1991, p 64-65) show that the incidence of depression has increased more than tenfold in the last century. This has reached the point where at any given time, 25% of people are at least mildly depressed (Seligman, 1991, p 55). These and other statistics indicate that most "depressions" are a result of experience, not genetics (Yapko, 1992, p 3-4). Alongside this apparent epidemic of depression, has come an epidemic of drug usage to attempt to treat depression. Studies show that even when drug treatment is deemed successful, "relapses" (later recurrences of depression) are more common than when psychotherapy or psychotherapy plus drug treatment is deemed successful (Yapko, 1992, p 4). This strongly suggests that drug treatment by itself is an inappropriate solution (inappropriate in the sense that it leaves the person at a higher risk of recurrence).

Through research, we know a great deal about what kind of outside assistance works with depression, and what kind of "assistance" does not work. We also know that 80% of individuals suffering major depression will "spontaneously" cease to be depressed in between 4-10 months (Yapko, 1992, p 16). People normally find their own way out of depression. This also means that if any type of "assistance" continues for ten months it will seem to have solved the problem in 80% of cases. Genuinely successful strategies for assisting are those that can show benefits in the short term.

Denominalising Depression

Firstly, we will summarise a number of things people can do that, collectively, lead them to feel depressed. By describing these depression strategies using NLP terms, the NLP-based solutions will become rather obvious. This does not mean that ending depression is easy. Most of these solutions have been written down for thousands of years. The challenge is in getting people to actually stop doing the things that don't work, and start doing the things that do. The very thinking styles that cause depression are used by the depressed person to convince themselves that they cannot or should not change. In fact, depression could be *defined* as the belief that a person cannot or should not change! Professor of Psychology Dr Martin Seligman calls this belief a "permanent, pervasive explanatory style" (1991, p 40-48). He says it is part of the structure of "learned pessimism". It is, as we shall see, the very first thing to challenge in working with the depressed person. It is also the reason why "one person doing therapy on another" is not the appropriate metaphor in helping someone rediscover happiness.

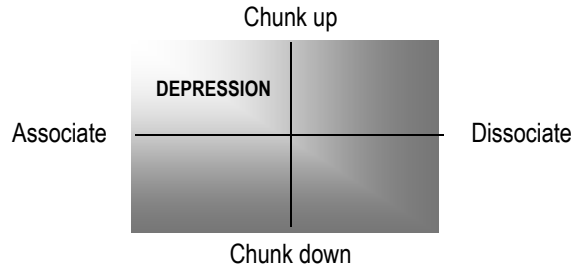
Ericksonian therapist Dr Michael Yapko describes depression as the result of the combination of two things. One is a style of thinking which includes the permanent, pervasive explanatory style. The other is life. We'll have a go at defining these two things. Of course, life is pretty hard to define; in a sense nominalisations don't come any more general than "life". Yapko points out that life is like a giant Rorschach inkblot. It's so undefined that you can read anything into it. By dividing up the story of your life into certain pieces you can prove that events in life always turn out for the best. By dividing them up in another way, the depressed person can prove that events generally turn out for the worst.

Neither map IS the territory. Neither is objectively "real". Both are strategies for creating a person's subjective reality. That is, both are forms of self-hypnosis. Stephen Gilligan (1987, p 44-46) explains that the same strategies which can be used to produce therapeutic trance (hypnosis) can be misused to create "symptomatic trances". The depressed person, for example, can negatively hallucinate (ie not notice) loving individuals close by them, and can hallucinate obstacles which no-one else sees. They can numb their body so that touch no longer comforts, and regress themselves so that they relive a painful moment a million times. These are very powerful trance phenomena.

One important thing to understand about life, before we move on to considering the learned pessimism style, is that life is cyclical. That is to say, challenges happen every so often. Rejection, disappointment, loss, and embarrassment do occur in any life. When they do, a person with a "learned pessimism" style of thinking will get depressed. In one of Seligman's studies (1997, p 78-79), he followed a group of 400 school students through several years of their life. Those who started out with a pessimistic style were the ones who, when an event like a divorce happened, were likely to get depressed. The divorce (ie the life event) did not cause this depression by itself, and those with an optimistic style rebounded quickly from such events. What caused depression was the combination of painful life events plus a style of thinking. Because such events happen every so often, the person will appear to have a cyclical mood problem. In fact, it is not depression that is cyclical; it is life. Believing in "the cyclical nature of depression" is part of the permanent pervasive explanatory style of certain psychiatrists (Yapko, 1992, p 124). This style itself is part of the cause of depression.

Personal Strengths

In the Personal Strengths model, the person who tells you that their life feels hopeless is demonstrating skill with chunking up (to "their life") and associating into the experience. The Permanent Pervasive explanatory style is a result of chunking up and associating into painful memories.



Metaprograms and Strategies of Depression

In NLP terms (with more widely accepted terminology in brackets), the six key metaprograms and strategies which generate the negative trance of learned pessimism are (from research in Yapko, 1992 and Seligman, 1997):

- **Chunk Up In Problem Situations** (Permanent, Pervasive Explanatory Style)
- **Associate into Pain, Dissociate from Pleasure** (Traumatic response)
- **Temporal Orientation Towards the Past**
- **Auditory Digital – Kinesthetic Loop** (Negative self-talk)
- **Kinesthetic Shutdown** (Psychomotor retardation)
- **Not at Cause** (Lack of a sense of control)

♦ **Chunk Up In Problem Situations** (Permanent, Pervasive Explanatory Style). Imagine the situation where a person fails to get a job they apply for. The person with a permanent, pervasive explanatory style might say "No-one would employ me." Or "Why do I always do something wrong?". The person with a temporary, specific explanatory style might say instead "The panel didn't understand how skilled I was in that area." Or "I hadn't allowed myself the time to prepare well enough for the interview." The person who gets depressed uses a permanent pervasive explanatory style dealing with problems. Since they mainly think about problems, this means they specialise in chunking up, and linguistically in the use of universal quantifiers. Note that the aim of therapy is *not* to have the person believe that "everything" is wonderful. Trying to "cheer up" a depressed person in this way leaves them vulnerable to the same style of thinking that caused their problem. The depressed person frequently chunks up in their goals for therapy as well, setting unrealistic outcomes for permanent, endless happiness (Yapko, 1992, p 11). The aim of successful therapy is to teach the person to make more distinctions about what has happened and what could happen *specifically*.

♦ **Associate into Pain, Dissociate from Pleasure** (Problem focus). The submodality distinctions between the depressed cognitive style and the happy person's cognitive style are enormous. The happy person tends to have their pleasant experiences stored in "impactful" submodalities. The pictures tend to be large, close, and fully associated. On the other hand, their unpleasant experiences are stored with submodalities such as dissociated, small and distant. This means that for the happy person, pleasant memories seem very real, and very significant. The depressed person does it the other way round. For them, the unpleasant experiences are real, and the pleasant ones almost seem like false memories (because the person isn't inside their own body as they recall them). In this way, the depressed person "sees" and "feels" their problems much of the time. Solutions and positive experiences are harder to find, and harder to believe in. This is the first part of the submodality structure behind the permanent, pervasive negative explanatory style. Again, because the depressed person is mainly re-experiencing unpleasant memories, the key change required is to teach them the skill of dissociating from those. Understandably, the depressed person often fears that this is "tampering with reality" (the "reality" of misery, as opposed to the "unreality" of happiness).

♦ **Temporal Orientation Towards the Past**. Temporal orientation is the second part of the submodality structure behind the permanent, pervasive negative explanatory style. Yapko (1992, p 118-121) suggests that it is the key to understanding depression. The depressed person is stuck looking back towards the past. By way of contrast, the anxious person is stuck looking towards the future, and the impulse disordered (eg addicted) person is stuck looking at "now". Mental health involves some degree of flexibility in temporal orientation. The

depressed person thinks of their present and future in terms of the past ("I know why I'm unhappy; it's because I never got over my mother's death", "My future is ruined because I'll always suffer from the confusion that I felt during sexual abuse."). Yapko emphasises that psychotherapies which encourage a past temporal orientation are very attractive to the depressed person, but simply encourage them to do more of what they are already doing. Spending the first session of such therapy by discussing the past is a sure way to reinforce the hopelessness of the depressed person. The key to healing is to have them turn around and look towards the future.

♦ **Auditory Digital – Kinesthetic Loop** (Negative self-talk, Rumination). Seligman (1997, p 82-83) points out that people differ in the amount that they pay attention to their internal self talk. Those who attend to auditory digital a lot are called "Ruminators" in cognitive psychology. Rumination in itself (using the auditory digital sense a lot) is not a problem. But combined with a permanent, pervasive explanatory style, this pattern cements depression in place. Seligman says "The expectation of helplessness may arise only rarely, or it may arise all the time. The more you are inclined to ruminate, the more it arises. The more it arises, the more depressed you will be. Brooding, thinking about how bad things will be, starts the sequence. Ruminators get this chain going all the time." In NLP terms, this is an auditory digital-kinesthetic loop. The person feels an uncomfortable feeling (K). They then talk about how permanent that will be and tell themselves off (Ad). They then check how they feel now (K). Not surprisingly, they feel worse. They then talk about that (Ad). This strategy is quite clear in the eye accessing movements of the depressed person. It presents a challenge in the running of NLP processes, because the depressed person tends to talk to themselves about how the process "won't work for them" even as the process is being run.

♦ **Kinesthetic Shutdown** (psychomotor retardation). Psychomotor retardation (Yapko, 1992, p 94) refers to the slowing down of motor responses in the depressed person. The depressed person often ensures this slowing of motor responses by avoiding exercise. This sets in place a cycle where lack of exercise increases insomnia, which increases exhaustion which causes a further reduction in exercise. In NLP we understand that state is affected by both internal representations and by physiology. Just ten minutes of brisk walking lifts mood for 60-90 minutes after (Thayer, 1996, p 23-24). The depressed person comes to the NLP consultant in an unresourceful physiology. They may slump down in their chair, may breathe shallowly, and may have barely moved over the last 24 hours. Attempting to work with them in this state is like attempting to work with a drug addict while the addict is high.

♦ **Not at Cause** (Lack of control). Yapko points out (1992, p 130) that the person who is depressed often does not have a sense of themselves as able to initiate causes of future results. They do not think "If I engage in this behaviour, that consequence is quite likely, whereas if I engage in this other behaviour, this other consequence is quite likely." Instead they tend to think "That behaviour will happen, and I will just suffer the consequences." This is a result of the permanent, pervasive explanatory style in relation to problems, combined with a lack of future orientation. Since sometimes unfortunate things do happen, the depressed person becomes convinced that they "always" will. The global style of thinking means that the depressed person fails to look for more precise distinctions about how they could adjust their behaviour based on the feedback they are getting, in order to reach their goal. They might complain "What's the point in falling in love; men (or women) will always leave you in the end, no matter how hard you try." Attempting to assist the person to change runs up against the same question. "What's the point of us doing NLP processes. I always end up back at the same place."

How Do We End Depression?

Clearly, the structure behind depression presents a dilemma for someone wanting to assist the depressed person. Depression is generated by the belief that things can't change. Having the person experience themselves as "at cause" in their life is the first task (and in a sense the only task) in assisting a depressed person. For this reason, often our first comment with the client is to explain that we are not intending to do "psychotherapy" or "counselling" as they have known it. Instead, we plan to be the person's coach or consultant.

The depressed person is hiring us to give them advice and support to put into action a plan that will change their life. This will be a collaborative relationship, in which they will need not only to "help", but also to experimentally follow the advice we give. We have no magic way of solving their problems for them. But if they do the things we suggest, we believe that they will experience change. This is the same deal a consultant in the business setting makes. We often say "NLP doesn't work. *You* work…. NLP just explains how you work, perfectly.". The other side of this is that if we are not hired as a consultant, we accept that. We do not carry on trying to "sell our services".

Others in the depressed person's life have tried to rescue them from depression. They may have tried to cheer them up, to give them gifts of time and objects, to take the load off their shoulders, to convince them that life is worthwhile, to defend them against those who demand more of them…. But one human being cannot *make* another human being happy. In the end, these attempts only lead to the rescuer getting more resentful, and the depressed person feeling worse. Rescue is a dangerous game, leading to increased risk of suicide as the depressed person seeks ever more frantically to indicate their need for more help, or to prove that the help has not worked. To repeat, one person cannot *make* another person feel good, even when that one person knows all the tricks of NLP. The depressed person's belief that they need another person to save them *is* depression. It is not a side effect. Co-operating with it would be keeping them depressed.

In the following section, we will first present a toolbox of NLP techniques to reverse the specific metaprograms and strategies described above. These techniques will be effective when they are used within the consulting context described above. To use them in a rescuing context would be dangerous.

1. Pacing The Person's Skills

As a general principal in NLP we begin by pacing the skills that a person already uses, and then develop these. In the case of depression, where the person has skills in associating into experiences, in chunking up, and in paying attention to past experience, this may include:

♦ Anchoring resourceful states from past experiences. It often takes time for the person to find any experiences that they can feel good about. Trust that no person has had 100% miserable days every day of their life. At some time (even, let's say, in their childhood) this person laughed, felt proud of something they did, and enjoyed experiences. The fact that they can walk, talk to you in a language, and dress themselves proves that. Hypnosis is an excellent situation in which to reaccess such resourceful states (Yapko, 1992, 144-148). Once the person *can* access resources, change may be swift. We had one woman come to an introductory NLP training and learn the collapsing anchors process. She rang us back nine

months later to say that these had been the first nine months in her life where she had not felt depressed. She said she had never sought help before, because her mother had also had a lifetime depression, and the daughter assumed that the problem was genetic. She was ringing us up to arrange a session for her mother.

♦ Using parts integration to chunk up on these experiences. In parts integration, the person associates into each of two opposing parts (eg the part of them that gets depressed, and the part of them that wants to enjoy life) and asks what the higher intention of each part is (ie chunks up) until a shared higher intention is found.

♦ Having the person keep a depression diary for the first week, cataloguing all the times they were depressed, and rating these on a scale from 1-10. This diary provides a useful basis to explore the "exceptions" later (times when they were less depressed).

2. Ask The Person To Chunk Down.

♦ Use metamodel questions. The metamodel is a valuable NLP tool for teaching a person to chunk down. It consists of a series of questions matched precisely to certain types of client comment. The questions ask for sensory specific information. For example, when a client complains that "No-one likes me!" the metamodel would suggest asking "What specifically do you see or hear that leads you to believe that?" or "Everyone? Which people specifically do you believe don't like you?". Consultants need not only use the metamodel themselves. They can show their clients how to challenge their own global thinking. The risk with the use of the metamodel is that many metamodel questions taught in NLP support the depressed person's problem focus. Rather than asking "Would *no-one* employ you?" it can be an advantage to ask the question focusing on the counter-example "When has there been a time that someone *did* employ you?". Rather than ask "How specifically does everything go wrong in your life?" it can be more useful to ask "How specifically would something not "go wrong" in your life, if you succeeded?"

That is, the most useful questions to ask the depressed person are often solution focused. Steve de Shazer, Insoo Kim Berg and others have developed a model of change called the Solution Focused approach, based on this understanding (Chevalier, 1995). The following categories are examples of their questions, which guide the person to identify what they want and how to get it. Where someone has an "adverse reaction" to the use of NLP change techniques in general, we have used solution focused questions as the full consulting process. As de Shazer reports, this results in 75% success over four to six sessions.

♦ Ask for a description of the person's outcome. This is a very standard NLP outcome elicitation. Questions might include:

"What has to be different as a result of you talking to me?"
"What do you want to achieve?"
"What would need to happen for you to feel that this problem was solved?"
"How will you know that this problem is solved?"
"When this problem is solved, what will you be doing and feeling instead of what you used to do and feel?"

♦ Ask about when the problem doesn't occur (the exceptions). For example:

"When is a time that you noticed this problem wasn't quite as bad?"
"What was happening at that time? What were you doing different?"

♦ If there are no exceptions, then ask about hypothetical exceptions using the "Miracle" question: "Suppose one night there is a miracle while you are sleeping, and this problem is solved. Since you are sleeping, you don't know that a miracle has happened or that your problem is solved. What do you suppose you will notice that's different in the morning, that will let you know the problem is solved?"

After the miracle question, you can ask other followup questions such as:

"What would other people around you notice was different about you?"

"What would other people around you do differently then?"

"What would it take to pretend that this miracle had happened?"

♦ Have the client ask themselves solution focused questions in their daily life. We set this as a standard task for all clients who are depressed. Before they get out of bed in the morning they are to ask themselves "What are three things that I am looking forward to today?" When they go to bed at night they are to ask themselves "What are three things I valued in what happened today?" We have had two cases of depression fully resolved where the only intervention used was to set the person the task of identifying three things they were looking forward to each day. The potency of these questions is extraordinary.

♦ The person needs to know that globalised beliefs continue to be a risk even after making changes. To believe "I've done some NLP now, so I'll never feel bad again." Is setting the person up for failure. Use the metamodel to encourage more specific expectation patterns.

3. Change Submodalities So That The Focus Shifts To Happiness

♦ Teach the person to make standard submodality shifts changing their enjoyable experiences into more useful submodalities. This may involve teaching the person to step into enjoyable experiences (associate), bring the images and sounds closer, and brighten up the memory, for example. After doing two or three examples, suggest that the person generalise this change. This process is part of showing the depressed person how to access resources.

♦ Use the NLP Trauma cure to dissociate the person from traumatic or distressing memories. This method reprograms the brain by having the person re-view a distressing memory from a dissociated position (eg watching a movie of the event). After doing two or three examples, suggest that the person generalise this change. One elderly woman we worked with had been a Jewish child in Germany in the 1930s. When we ran the trauma cure on two incidents in her childhood, her depression lifted. The next week she reported that she was now sleeping through the night (nightmares had kept her from sleep), had more energy, and was feeling more confident. Her Time Line also changed direction as a result of this intervention, so that the past shifted to being behind her (it had been in the same position as her future). This one process essentially solved her "post-traumatic depression".

♦ Continue asking questions that help the person sort for what is going well. At any session after the first contact with the person, ask them what has gone well since you last met or talked. "So what has changed in your life (or in your experience of the situation that was a problem)? No matter how small the changes seem at first, what is different?" Secondly, genuinely congratulate them - "Wow, that's great. How did you do that?" and then thirdly, keep asking "And what *else* has changed?"

4. Create A More Flexible Temporal Orientation

♦ Continue using the solution focused questions with a future orientation (for example "What are three things that you're looking forward to today?" "What do you want to achieve today?" "What will enable you to achieve that?") These questions teach the person to plan ahead. All gains made in the consulting session can be carefully futurepaced into real life ("Imagine a time in the future, when in the past this would have been a problem, and tell me how it feels different now.").

♦ Time Line techniques such as the Time Line Therapy® are a great pace and lead in regard to temporal orientation. The process for healing the past in the Time Line Therapy® processes begins with the suggestion that the problem needs to be dealt with in there (as the depressed person suspected). But, surprisingly, the person floats into the past and then *turns* and looks towards the future. This is precisely the reverse of orientation that they have been missing out on before. Time Line Therapy® processes can be used to clear the emotions of anger, sadness and depression from the Time Line.

Interestingly, we had one case where depression ended after a person cleared only anger from the Time Line. No other interventions were used. The woman rang us back a week later to report that her mood had lifted immediately and remained steady. Intentionally altering the Time Line direction has been an effective one session treatment for at least one client of ours also (where the past Time Line had been in the same place as the future). As noted above, the treatment of depression by other means tends to alter the Time Line direction anyway

Creating rich images of goals and installing them on the future Time Line is also important. Sometimes the depressed person will report having no future Time Line, and the creation of one sends an important signal to the brain. In one case our colleague worked with a woman told she had only a few weeks to live. He installed a future Time Line as well as doing other NLP interventions. She lived a further three years, and reported that the envisioning of a future Time Line inspired and gave her hope immediately.

5. Alter The Client's Auditory Digital Strategies

♦ Alter the submodalities of the internal voice. Yapko (1992, p 177) reports the use of submodality shifts in the person's self talk, as an effective intervention for depression (eg making the voice like that of Donald Duck). We have worked with one depressed client where the only overt NLP technique used was to have him do an auditory swish. The man reported that he got depressed by hearing his father's voice on the left hand side, telling him that he would never be any good. The swish involved this voice fading away into the distance, as his own voice, powerful and affirming, came in telling him more rational beliefs. Repeating this swish several times solved the problem in the session, which was tested by the consultant (Richard) shouting his father's comments at his left ear. The man explained that he ran the swish himself a few times after the session, and felt that while his depression was still "possible", he had a way to solve it immediately now.

♦ Create a new strategy for the auditory digital input. Our colleague, NLP Trainer Lynn Timpany, has developed a comprehensive process for doing this. She calls it The Esteem Generator. Many of our students report that it has enabled them to end depressive processes which have been resilient in the face of other interventions. The Esteem Generator has three steps. Firstly, it involves altering the submodalities of the unsupportive internal voice experimentally first, to loosen the strategy. Secondly, the process has the person identifying

the positive intention of the internal voice and using a sequence such as Core Transformation™ (Andreas, 1992) to deal with the part that has been generating the voice. A critical internal voice may have the positive intention, for example, of motivating the person to be their best, or of protecting them from embarrassment. New, more effective ways can be found to meet these intentions. Thirdly, the Esteem Generator involves installing a new strategy which begins with the old triggers for the unsupportive voice, has the person say a key interrupt phrase (like "Think positive!" or "Hey wait!"), has them say something more resourceful to themselves, and then has them congratulate themselves and give themselves a positive feeling about how they changed their thinking. Lynn has the person run through this sequence with every example they can recall, while she chains it on their knuckles.

6. Create The Physiology Of Happiness

♦ Have the person design an exercise program that involves them in at least 15 minutes strenuous movement a day. Thayer (1996, p 191) cites a study where depressed women were given the task of walking briskly 15 minutes a day. Those who completed the task reported elevation of mood, but only 50% completed the task. This emphasises the importance of pacing and leading carefully, and of ensuring the person experiences themselves as "at cause" (see below).

♦ Have the person laugh vigorously on a daily basis. One of our colleagues was working with a depressed and suicidal young man. He was discussing the hopelessness of his life in such sombre terms, and for so long, that the situation began to feel absurd to our colleague. She began to laugh uncontrollably. Her client was first shocked, then puzzled. Finally, he joined her in laughing fully. When he stopped, his eyes lit up and he said "Thanks! That's what I needed!" and left. Dr Robert Holden (1993) runs the Laughter Clinic at West Birmingham Health Authority in Britain. He quotes William James' insight that "We don't laugh because we are happy. We are happy because we laugh." Holden sites evidence that laughter boosts immunoglobulin levels, restores energy, lowers blood pressure, massages the heart and reduces stress (1993, p 33-42). 100 laughs a day is the equivalent of 10 minutes jogging.

7. Keep The Person At Cause

♦ Build expectancy of change from the first session. Indirect suggestion does this much more effectively than direct suggestion, or attempting to argue with the person (Yapko, 1992, p 139-142). Setting a time limit on the consulting process gives an important indirect message ("I expect this to be solved in four sessions").You can use paradoxical suggestions such as "You can be just self-critical enough to really want more for yourself… the kind of things you can *feel really good* about." And "Don't entertain, even for a moment, that you could be feeling better sooner than you might expect." Experiential evidence of the possibility of change can be given using an exercise. At our trainings we have people do a visualisation exercise. They turn around and point behind them with their arm, and then come back to the front. Next they imagine themselves going further, and notice what they would see, feel and say to themselves if their body was more flexible and they could turn around further. Then they turn around again and notice how much further they go (Bolstad and Hamblett, 1998, p 81). This exercise is quickly followed up by a discussion about how the person's internal representations determine how they feel and what they achieve.

♦ Have the person set and achieve goals. Outcomes for the sessions are set with the person, based on the specific problems they are having, and the specific metaprograms and strategies they are using to create these problems. It is also an important learning for the person to set small and more-than-realistic goals, and have the undeniable experience of achieving them (starting with the exercise described above, and moving on to small daily tasks to be achieved in their own time, and in their usual life environments). For us, assisting a depressed person without the person completing tasks at home would be a contradiction in terms. Clients do not come to us to have their consulting sessions improve. They come to consultants to have their life improve. Tasks, such as identifying three things they are looking forward to each day, are a crucial reminder to the client that the consultant is only a consultant.

♦ Reframe experiences based on the presupposition of being at cause. From the very first comment the consultant makes, to the most advanced metaphors and NLP techniques she or he uses, everything said to the depressed person is reframing. This is because the whole notion that *change can happen* is a radical reframe, which, once truly accepted, heralds the end of depression. The most powerful aid to successful reframing is the consultant's own deeply held belief that the person can change; that indeed they will inevitably change. Life itself is in constant change.

8. Take Steps To Prevent Suicide

♦ This is one place where asking about negative responses is worth the risk. Suicide is obviously serious. It is appropriate to check how far along the track of suicidal thinking a person has gone (from a sense that they would be better off dead > the decision to end their life > suicidal fantasising > concrete preparations for the act). If you find that the person is considering suicide, it is appropriate for you to consider what safety actions you need to take. Consult an experienced person to discuss your decision, which has legal implications.

♦ As a consultant, you have a right to ask that *during the period of your consulting*, the person will stay alive (otherwise your assistance is wasted). Make a "Staying Alive Contract" and check that they are congruently agreeing to this. Interestingly, depressed persons tend to keep such arrangements. The contract will include a method by which they can contact someone in a crisis. Decide whether that person is the consultant, a phone counselling service, or a friend or relative. In the session, rehearse this crisis contact (eg have them actually phone the person). Have them futurepace any possible excuses they might make for not doing this ("What would make you decide not to keep this contract?") and build in reframes to ensure that even that situation leads to them contacting the person.

If the client misses a session, has not notified you before, and has been suicidal, contact them to reaffirm the Staying Alive Contract, or plan other interventions such as ringing a phone counselling service.Remind yourself that as a consultant, you cannot ultimately *make* someone stay alive. The aim of this contract is just to maximise the chances that this will happen.

The RESOLVE Model And Depression

Depression, then, results from the person chunking up and associating into problem situations, orienting towards the past, shutting down their kinesthetic responses and tying themselves up in Auditory Digital – Kinesthetic loops. To summarise using the RESOLVE model (outlined in a previous chapter), our recommended interventions are:

1. Resourceful State

- Establish a collaborative, consultative relationship rather than a rescuing relationship.

2. Establish Rapport

- Acknowledge the person's pain.
- Assess and pace metaprograms (esp Towards-Away From, Time Orientation, Optimistic-Pessimistic Attributional Style, Chunking level, Association-Dissociation).

3. Specify Outcomes

- Set a time limited consulting contract with outcomes.
- Build expectancy of change, and explain the need for tasking.
- Assess the need for a Staying Alive Contract

4. Open Up The Client's Model Of The World

- Demonstrate the power of internal representations (eg Pointing Exercise)
- Teach presuppositions of NLP, and reframe based on these.
- Metamodel chunked up descriptions back to sensory specific data, and reframe.
- Give tasks to rehearse future orientation and positive attributional style:
  -Identify 3 things you're looking forward to and associate into them, each morning.
  -Identify 3 things you appreciate about your day, each evening.
- Use Solution focused questions

5. Leading To Desired State

- Pace and lead to more motivated state nonverbally.
- Reaccess and anchor resourceful states
- Time Line Therapy™ for all major emotions, plus "depression"
- Trauma cure for precipitating events (esp early in life)
- Rehearse new strategies; eg Esteem Generator to break Ad⇆K Loops
- Submodality shifts to store positive memories in powerful submodalities
- Place goals in the future Time Line
- Plan a daily exercise routine and laughter sessions

6. Verify Change

- Teach the person to search for and celebrate the differences in their life

7. Exit: Futurepace

- Teach person to limit their generalisation (especially that past=future) and teach them to expect the unexpected.
- Define success in achievable terms.
- Discuss ending of sessions clearly.

F. Anxiety

The Craze for Anxiety

Anxiety is the emotional state which will bring more human beings into psychiatric treatment than any other (Beletsis, 1989, p264). 33% of all people visiting their doctor have it as a key complaint, and a similar percentage of the general population will develop a "clinically significant anxiety disorder" at some time in their life (Barlow, Esler and Vitali, 1998, p 312).

In the psychiatric manual DSM-IV™ (American Psychiatric Association, 1994) anxiety is described in three ways. Firstly, prolonged anxiety is described in terms of symptoms such as feeling restless, fatigued, keyed-up, irritable, suffering from muscular tension, and being unable to sleep or concentrate. Secondly, acute anxiety attacks (panic) are described in terms of even more intense responses, such as heart pounding, sweating, shaking, difficulty breathing, chest and abdominal pain, nausea, dizziness, and extreme fear (of death, insanity or loss of control). Thirdly, it is acknowledged that many people suffer from one of the above types of anxiety, but cope with it in ways which then become other symptoms – alcohol and drug use, extreme and involuntary dissociation responses, eating disorders, compulsive rituals, violence and other behaviours designed to avoid the anxiety. Twice as many women as men report anxiety as such, and this seems related to men's preference for certain of these other behaviours (Barlow, Esler and Vitali, 1998, p 290).

Understandably, a plethora of medications such as Valium (diazepam) have been used to treat anxiety. There is little evidence that drugs, used alone, reduce the frequency and severity of anxiety, and users have been shown to exhibit the same level of fear and avoidance behaviour after the drug treatment as before (Franklin, 1996, p7). Again and again though, cognitive NLP-style change processes have been compared to diazepam and related drugs and shown far more successful (Barlow, Ester and Vitali, 1998, p 310). Unfortunately, the craving for a quick-fix (such as pills seem to offer) is implicit in the very nature of anxiety. On the other hand, longer term psychotherapy also feeds the nature of the problem, by creating dependency (Beck and Emery, 1985, p 171). What works is what NLP offers: short term change processes which give the person back control over their own state.

Denominalising Anxiety

We began by defining anxiety as a state, and you'll notice that the DSM-IV™ criteria for anxiety are almost entirely internal kinesthetic. And yet when the DSM-IV™ wants a synonym for anxiety, it uses a purely cognitive one: "apprehensive expectation". This is important. Anxiety is a physical response, and yet it cannot be generated without certain constructed internal representations (visual, auditory or kinesthetic) of "possible" future events. A person seeing a spider may make a huge internal picture of a spider crawling towards them, and then feel the resulting fear ($V^c \searrow K^i$). Another person may create the sound of an entire hall of people laughing and shouting at their humiliation and feel the fear of that ($A^c \searrow K^i$). Another may create the feeling of slipping off a high place and falling so well that they feel as if they are falling, and feel the fear of that ($K^c \searrow K^i$).

These are synesthesias: a representation in one sensory system is linked simultaneously to one in another system. The pictures, sounds or physical sensations simultaneously generate an internal set of sensations described by the person as "anxiety". Longer-term anxiety can be sustained by strategies which place A_d in the sequence. A person may imagine failing an

exam, talk to themselves about how terrible that would be, and pick up an increasing sense of panic about what they are saying ($V^c \leftrightarrows A_d \searrow K^i$).

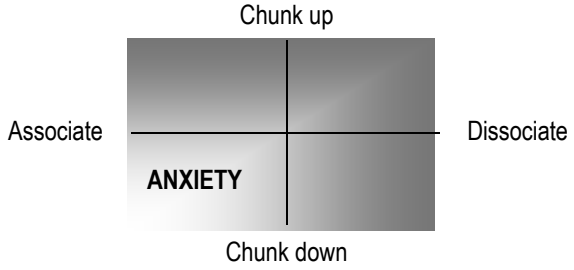
The initial results of the original synesthesias can also be fed back into the system. A pounding of the heart resulting from thinking about the spider can lead to speculation about a heart attack, and thus to increased pounding ($V^c \searrow K^i \rightarrow A_d \searrow K^i$). Such physical escalation is the source of panic attacks, as opposed to longer term anxiety.

Such synesthesias are identified by Bandler and Grinder (1976, p 101) as the source of most fears and anxieties. As they note, the person with anxiety is not necessarily sure what has triggered their kinesthetic responses. To them the response seems "automatic". At times their conscious theory about the cause is quite different to the unconscious strategy which you as an NLP Practitioner would elicit. For example, a person may tell you she has a fear of "success", but actually generate panic by internal images of social rejection and public failure (Beck and Emery, 1985, p213).

Like all such anchored responses, the original trigger for anxiety may generalise to related situations. The DSM-IV™ has a category called Generalised Anxiety Disorder, where the anxiety is considered to be "free floating" and not related to any specific trigger. Research by cognitive psychologists (Beck and Emery, 1985, p 94) suggests that this whole category is mythological. Triggers always exist, but are not always consciously recalled by the person. One reason is that the anxiety may be triggered by a set of situations which are apparently unrelated (though all often lead to the same ultimate feared consequences for the person – eg humiliation, death). Another reason is that often the internal representations used to generate the anxiety are of events which do not or did not exist in the real world. A person may have a phobia of snakes even though they have never seen a real snake. They do this by imagining what it would be like to be fatally attacked by a snake, stepping into that image and feeling the fear as if it had happened. A movie like *Jaws* is followed by a wave of new phobia sufferers for this reason. The movie is quite safe, but the internal images are not.

Personal Strengths

In the Personal Strengths model, the person who tells you they have a phobia of elevators is demonstrating skill with chunking down (to the details of the elevator) and associating into the experience. The synesthesias run from associated experiences (mentally stepping into a plane crash, for example). Very specific (chunked down) cue situations produce this result (as contrasted with depression, where "everything" feels bad).



The "As If" World

Why do anxiety "sufferers" run these annoying synesthesias? Ericksonian therapist David Higgins (in Yapko, ed, 1989, p 245-263) points out that all of us live in an "As if" world. In

order to act, we make certain guesses about what will happen. These guesses are all "hallucinations", but they have the potential to generate hope or fear, happiness or pain. This is an active ongoing self-hypnotic process, and is potentially healthy. In anticipating future challenges, we estimate the significance of the challenge, and the strength of our resources to respond to that challenge (Beck and Emery, p 3-53). Some fear is a realistic appraisal of serious challenge level, and usefully mobilises the body to deal with such challenge, by increasing the pulse and breathing rate, and mobilising the muscles etc. Severe anxiety is a disorder of the "As -if" process. The anxious person (as opposed to the person who is realistically afraid of a current threat) demonstrates certain "cognitive distortions" (to use NLP terminology, they make certain key submodality/strategy shifts). These are:

1) **Sorting for the future.** By attending to potential future events to the exclusion of present and past, the person is unable to access resourceful memories, or effectively use resources at hand. Thus, a person who spoke to a crowd of 1000 people and loved it last week may panic as they think about repeating that tomorrow.
2) **Sorting for danger.** The person pays more attention to potential risks and less to potential safeties. They do this by using focused "tunnel vision" and its auditory and kinesthetic analogues (eg a person afraid of public speaking may see only one angry looking person staring at them, and not notice those smiling. A person with chest tightness may pay attention to that and speculate about its cause, rather than feeling the comfort in their hands).
3) **Associating into their internal representations of danger.** This is the key submodality changed by the NLP Phobia/Trauma cure.
4) **Increasing the significance of the danger.** The anxious person increases submodalities such as size and closeness on the feared object/situation, so that the threat seems greater than their resources. They diminish submodalities on their own resources and memories of success. The person afraid of public speaking may see a room of huge eyes staring at them, as they shrink into the floor. They may do this in auditory digital by "talking up" the power of the audience to reject and humiliate them.
5) **Unrealistic evaluations as a result of 4).** Rather than grading risk (eg "On a scale of 1-10 how risky is this?") the anxious person tends to act as if any danger = total danger. Persons with a phobia of flying, for example, may estimate at normal times that the risk of harm from a flight is one in a million (1:1,000,000). At the time when the airplane takes off they may estimate it as 50:50, and with slight turbulence at 100:1 in favour of a crash (Beck and Emery, 1985, p 128). They may then bring into play a series of beliefs about what "has to happen" in such situations (eg "I have to get out of here.", "I have to take my pills."). Another such set of beliefs may involve the estimate of the importance of what others think of them and their responses. Doing something embarrassing in public may be estimated as likely to result in physical consequences every day for the next sixty years. Thus, in the state of anxiety, the person generates a whole separate set of beliefs to which they respond – in NLP terms, a sequential incongruity.
6) **Not being "at cause".** Synesthesias are available in all people. The anxious person runs them more frequently and with less conscious awareness, leading to a belief that their feelings just happen, or are caused by the environment, rather than being a result of their attention to representations of "danger".
7) **Physiological activation.** The anxious person acts in several ways to activate their body. They attend to their in-breath rather than their out-breath. They walk and move more, and often allow less time for sleep than other individuals. They breathe through their dominant nostril (Rossi, 1996, p 171-2). Ernest Rossi points out that this is part of their remaining in the alertness phase of the normal rest-activation cycle for prolonged times.

Where anxiety peaks at a certain time in the day, Rossi suggests that this indicates a damaged rest cycle reaching critical level at that time.

Anxiety and Depression

In a previous chapter we discussed NLP treatments for depression. Someone can run strategies which generate anxiety *and* strategies which generate depression. Both conditions involve the person sorting for what is wrong, and associating into unpleasant experiences. However the two sets are different, and it may help to distinguish them before we consider how to resolve anxiety.

In the case of depression, the focus is on past experiences – failures, losses and defeats which have already happened and are thus fixed facts. The depressed person may not even have a future time line to be anxious about, let alone to have goals in. Their comments about life and their own self are thus based on a "permanent pervasive style" of explanation ("This is the way I and other things are; everything is like this, and it always will be"). The depressed person has understandably little interest in doing anything, because they *expect* failure ("What's the point, it only gets you to the same place I've always been – nowhere."). They may get hopeful about specific tasks (and then use the patterns we are calling anxiety), but generally the depressed person has given up trying to avoid the kind of pain that the anxious person is running from.

In the anxious person, the focus is on potential future defeats, failures and losses. The anxious person considers these disasters as being possibly avoidable, if they can only escape in some way from certain feared events. Their style of explanation is thus more tentative, conditional and more focused on particular events ("If I can only avoid elevators / crowds / thinking about death, then I might be able to escape this terror."). The anxious person has objectives, then, but is unable to reach them. They *fear* failure. The anxious person does not give up on doing everything (unless they finally got depressed about their anxiety) but gives up on doing the things they fear (the triggers for their anxiety).

How Do We End Anxiety?

There's more to this question than meets the eye. Anxiety itself is driven by an attempt to avoid some feared consequence. The "simple" solution to anxiety for the person with a spider phobia seems to be never to think about or come into contact with anything to do with spiders. For the person with anxiety about loss of self-control the "simple" solution would be to never be in a situation where loss of self-control was remotely possible. Of course these are impossible goals, but many people with anxiety clutch at the illusion of such solutions in the form of drugs, distractions, lifestyles totally organised around their fears and dependent relationships where the other person cannot be out of their sight or reach. What is usually called "secondary gain" (the accidental advantages which the problem brings to the person's life, in terms of sympathy, avoidance of challenges etc) is really primary gain in anxiety conditions. It is often the immediate aim of the person who has anxiety.

As an NLP Practitioner, the first thing you need to get clear about is that your role is not to create such illusory solutions. One example of an illusory solution would be presenting NLP as a series of tools which will *automatically* solve the person's problem, regardless of what they do. Another example would be offering to be the person's total life support system ("Call me any time!"). Being a "magician" can be very satisfying, but this satisfaction is

small compared to the joy of empowering the anxious person to learn their own magic. Your role, then, is to be a kind of coach or consultant.

The anxious person is hiring us to give them advice and support to put into action a plan that will change their life. This will be a collaborative relationship, in which they will need not only to "help", but also to experimentally follow the advice we give. We have no magic way of solving their problems for them. But if they do the things we suggest, we believe that they will experience change. This is the same deal a consultant in the business setting makes. We often say "NLP doesn't work. *You* work…. NLP just explains how you work, perfectly.". This is a time-limited arrangement, and it is important to arrange at the start to meet for a specific number of sessions (we use either two, or four in most cases).

The other side of this is that if we are not hired as a consultant, we accept that. We do not carry on trying to "sell our services". This becomes important in practice if we suggest some task (such as having the person, at the end of each day, identifying three things they achieved that day) and the person does not actually do the task. In this case, we don't carry on suggesting other such tasks hoping to "find one that works". Often, in that situation, we will explore with the person what they did *instead* of the task, and help them discover how that got them the results they complain about.

The following five sets of NLP tools are intended to be used inside this context, to reverse the "cognitive distortions" of anxiety. The tools are:

- **Reframe Anxiety and its Symptoms**
- **Access Resources/Solutions**
- **Teach Trance and Set Relaxation Anchors**
- **Alter The Submodalities**
- **Create More Integrated Beliefs**

1. Reframe Anxiety and it's Symptoms

♦ Point out the value of normal fear responses and explain the structure of problem anxiety as generated by perceptual distortions and synesthesias. Anxiety is simply a signal that the person needs to identify and adjust their perceptions of the situation, and behave differently.

♦ Elicit the triggers which the person has been using to generate anxiety, and find out the submodality distortions which increase the significance of the threat. We have solved anxiety about public speaking on a number of occasions simply by having the person notice that the image they had in their mind was narrowly focused on set people, and had their eyes distorted out of usual size. Once the person accesses their triggers, they can often change them without further explanation. The unrealistic evaluations being made by the person can be checked at this time (resilient beliefs will require some of the later techniques, but a person anxious about all the things they "need to get done immediately" may be intrigued to find that they have incorrectly evaluated the need).

♦ One fun way to produce submodality shifts even at this initial exploration is to use the playful type of intervention that Richard Bandler does in the book *Magic in Action* (1984 p1-31). Working with Susan, a woman who experiences panic when her family are late home, Bandler says (1984, p.9), "Let's say I had to fill in for you for a day. So one of the parts of my job would be if somebody was late I'd have to have the panic for you. What do I do inside my head in order to have the panic?" Susan replies "You start telling yourself

sentences like..." and Richard interrupts "I've got to talk to myself". She continues, "...so and so is late, look they're not here. That means that they may never come." Bandler asks, "Do I say this in a casual tone of voice?" This pattern has been modelled by Tad James and called The Logical Levels of Therapy

♦ Kinesthetic triggers which feed a panic cycle (eg $V^c \searrow K^i \rightarrow A_d \searrow K^i$) can also be reframed. You can point out that the feeling of faintness is just the same as the feeling of being "giddy" with excitement, the feeling of laboured breathing and dizziness is the same feeling as when dancing fast, the feeling of hot and cold flushes is like the feeling of being in a sauna and cold pool, anxiety-based numbness in hands or jaw is like having a hand fall asleep while leaning on it absorbed in TV etc (see p 214 in Russell Bourne's article "From Panic to Peace: Recognising the Continua" in Yapko ed, 1989)

2. Access Resources/Solutions

♦ Help the person identify and build inner resource experiences to cope with the situations they have found difficult. The anxious person sorts for danger, and when asked to find a resource experience they will often access instead the most challenging and scary times they have had. Teaching them that this is a metaprogram and can be changed by simple rehearsal is important. Two types of Solution focused questions can be used to elicit such times (Chevalier, 1995). They are described more fully in the previous chapter on depression.

1) Ask for a description of the person's outcome.
2) Ask about when the problem doesn't occur (the exceptions). If there are no exceptions, then ask about hypothetical exceptions using the "Miracle" question: "Suppose one night there is a miracle while you are sleeping, and this problem is solved. Since you are sleeping, you don't know that a miracle has happened or that your problem is solved. What do you suppose you will notice that's different in the morning, that will let you know the problem is solved?"

♦ Have the client ask themselves solution-focused questions in their daily life. Before they get out of bed in the morning they are to ask themselves "What are three things that I am looking forward to today?" When they go to bed at night they are to ask themselves "What are three things I achieved today?" The potency of these questions is extraordinary.

3. Teach Trance and Set Relaxation Anchors

♦ One simple way to build resources is to teach the person to relax physiologically. This includes showing them how to actually stop tightening muscle groups, to pay attention to the out-breath rather than the in-breath, to breathe through the non-dominant nostril (Rossi, 1996, p 171-2) and to orient towards enjoyable internal imagery. The aim is to teach the person to go into a trance on their own, using anchors under their control. Such anchors can be set by the person in the therapy. Working with students who have exam anxiety, for example, we have often completely solved the problem by inducing a trance, having the person make a gestural anchor with their non-dominant hand (which will be free when they are writing) and testing the anchor afterwards. The person then uses the anchor in the exam and tends to report "The most relaxed exam I've ever had in my life". Anchoring paces the anxious person's personal strength of associating into experiences.

Of course, many of our more generally anxious clients say after an initial 15 minute trance induction that this is "the most relaxed I have been". But for them this is only the beginning, because the person also needs to be committed to using this process on a regular basis. And regular, Ernest Rossi points out (Rossi 1996, p 279-313) means several times a day, so as to re-establish a natural ultradian rest cycle. Like Rossi, we have found that many anxious clients will have no further problems if they arrange every 90 minutes to rest for ten minutes lying on their dominant side (thus opening the non-dominant nostril).

4. Alter the Submodalities

♦ There is no doubt that the submodality change techniques give us a phenomenal flexibility in removing the triggers of anxiety. We have already discussed altering the submodalities of an experience so that it is coded more normally (eg so that the eyes of people in a feared audience are normal size). Other submodality changes can be used to do this with flair. In *Magic in Action*, Bandler demonstrates the use of a visual swish to end a woman's panic about her family dying in an accident (he has her rehearse through seeing the image of the accident replaced instantly by the image of her being more resourceful, and confident), and a dissociation trauma cure to resolve a woman's agoraphobia. Versions of these processes have also been used outside the field of NLP by cognitive psychologists (see Beck and Emery, 1985, p 215-231) and Ericksonian therapists (see Russell Bourne in Yapko ed, 1989, p 217)

♦ Simply changing the submodality of time perspective will, in our experience, solve most one situation (eg exam) anxiety problems. Remember that the anxious person is looking towards the future. In this technique from Time Line Therapy™ (James and Woodsmall, 1988, p 45) Tad James uses that fact. "If you would, I'd like you to think of an event about which you're fearful – fearful or have anxiety about. When you have one, I'd like you to float up above your Time Line again. Go out into the future - one minute after the successful completion of the event about which you were anxious. (Of course make sure the event turns out the way you want.) And I'd like you to turn and look towards now. Now where's the anxiety? Notice how you chuckle. Fear and anxiety have no existence outside of time."

♦ The dissociation trauma cure is the most well researched of all NLP interventions for panic (see Einspruch, Allen, Dennholz and Mann, Kosiey and McCleod, and Muss for examples). We have taught this process to psychiatrists in Sarajevo for use with survivors of one of history's most horrific wars. Margot took one woman through a trauma cure on the entire war experience. She began quite tearful, announcing in English, "I hate the war; and I hate talking about it!" She said she had had nightmares every night since the war. For her, sounds were powerful anchors, and the sound of explosions produced uncontrollable panic. The previous week someone had organised a fireworks display in Sarajevo. Rationally, she knew she was safe, but her panic put her right back in the war situation. She ran into a nearby house and hid in their basement until the display was over. After attempting unsuccessfully to explain the trauma process to her (her knowledge of English was limited), Margot simply asked her to imagine being in a movie theatre and ran the process. Her movie went from the time before the war to the time after it, a period of over three years. Then Margot asked her to think of the fireworks and find out how it felt now. She laughed. Next, Margot asked her to remember some of the worst times from the war, and check how they were. She gazed ahead with a dazed expression. "So how is it?" we checked. "Well, she said, with a smile, "I'm seeing the pictures, and it's as if they're just over there, and I'm here." The entire process had taken twenty minutes.

5. Create More Integrated Beliefs

♦ Anxiety and panic responses are incongruent with the rest of a person's life. They are, in NLP terms, the result of "parts". It is as if the part of the person which is in control at the time of the panic or anxiety has its own intentions, its own beliefs and its own behavioural choices, all quite different to the intentions, beliefs and choices the person uses when calmer. There is no reason for a grown man or woman to be afraid of elevators, for example. But when they get near the elevator, the person with elevator phobia responds with a whole different set of beliefs about what might happen, and chooses from a range of behaviours she or he does not normally use, while not accessing skills he or she usually values.

♦ Several techniques allow information to flow from the rest of the person's neurology into the areas where anxiety is being generated. One of the simplest is the Eye Movement Integrator (Andreas, 1992, p 9-11) in which the person accesses their memory of a situation of anxiety (visually, auditorally and kinesthetically) and follows the practitioner's finger movements as they move from one side of the client's face to the other, horizontally, vertically and obliquely. A similar technique is marketed outside of NLP as EMDR (Shapiro, 1995). Francine Shapiro explains, "One of the simplest ways of describing EMDR effects is to say that the target event has remained unprocessed because the immediate biochemical responses to the trauma have left it isolated in neurobiological stasis. When the client tracks a moving finger or attends to a hand tap, tone, or even a fixed point on the wall, active information processing is initiated to attend to the present stimulus." In other words, your brain knows how to fix stuff as soon as you access both sides of it at once. Our experience is that even highly anxious individuals can be taught to process their own material at home by using a variation of the technique, such as accessing anxiety triggers while juggling.

♦ Several other techniques in NLP generate integration by starting with the behaviours of the "part" active during anxiety, and chunking up until the general resources of the whole neurology are accessed. One is the mind backtracking technique (Hall and Bodenhamer, 1997, p 35) in which you begin with the irrational auditory digital thought and ask repeatedly, "And behind that thought whirling in your mind lies another thought…. So as you allow yourself to notice, what thought do you find back there?". Our own version of this process is Ascending States (Bolstad, 1998, 17) in which the person attends to the kinesthetic experience of anxiety and asks repeatedly, "As you are aware of that, what arises from underneath that?" We've also used this as a one-session treatment for anxiety.

♦ Another set of integration techniques includes Core Transformation™ (Andreas, 1992, p 3-5) and Parts Integration. In these, the person identifies the intention of the problem behaviours and then asks repeatedly, "And if you have that intention fully and completely, what even more important thing do you get through having that?" Our colleague Lynn Timpany's Esteem Generator technique combines this with the installation of a new auditory digital strategy for those who have run a self-critical internal voice. Lynn's new strategy begins with the old triggers for the unsupportive voice, has the person say a key interrupt phrase (like "Think positive!" or "Hey wait!"), has them say something more resourceful to themselves, and then has them congratulate themselves and give themselves a positive feeling about how they changed their thinking. Lynn has the person run through this sequence with every example they can recall. Using this technique before we get people to do group presentations on our Master Practitioner course has solved most of the anxiety problems we used to cope with.

♦ Finally, a wealth of NLP techniques for changing beliefs can be used to alter the irrational beliefs once they have been accessed (notice that while they are kept separate in the panic part of the person, the person does not experience them as real and does not "need" to change them). Some level of integration needs to occur for belief changes to access the part of the neurology generating the problem belief.

Summary

Anxiety is the most common undesired state in psychotherapy, and is generated by a number of synesthesias from representations of potential future dangers to kinesthetic activation. The anxious person sorts for potential future dangers, associates into them, and exaggerates their submodalities. This results in unrealistic evaluations of the danger, and in a sense of the person's emotional state being out of their control. Using our RESOLVE model of therapy (Bolstad and Hamblett, 1998, p 107-108) we could summarise the responses we have found effective thus:

Resourceful State
- ♦ Establish a collaborative, consultative relationship rather than a magical or dependent one.

Establish Rapport
- ♦ Acknowledge the person's difficulty.
- ♦ Assess and pace metaprograms (especially Towards-Away from, Time Orientation, Association-Dissociation) and physiological arousal.

Specify Outcomes
- ♦ Set a time-limited consulting contract with outcomes.
- ♦ Build expectancy of change and explain the need for completing tasks at home.

Open Up the Client's Model of the World
- ♦ Teach the person the structure of anxiety and elicit the triggers the person is using, demonstrating their power using the "Logical Levels of Therapy".
- ♦ Reframe anxiety and its physical symptoms as manageable.
- ♦ Use solution-focused questions to build resources

Leading to Desired State
- ♦ Practise and teach physiological relaxation, including muscle and breathing control.
- ♦ Set relaxation anchors.
- ♦ Alter the submodalities of the triggers using standard shifts or swishes.
- ♦ Use the trauma cure on all triggers.
- ♦ Teach person to alter time perspective to looking back from the future.
- ♦ Teach the person the Eye Movement Integrator or a variant such as juggling.
- ♦ Use techniques which chunk up to core states (Mind Backtracking, Ascending States, Core Transformation™, Parts Integration)
- ♦ Consider using belief change or strategy installation to complete a new response setup

Verify Change
- ♦ Teach the person to celebrate their new ability to relax.

Exit: Futurepace

- Use the new time perspective to have the person in the future looking back towards now and seeing the changes.

G. Schizophrenia

In 1973 psychologist D.L. Rosenhan published a study in which his psychology students went to prestigious Psychiatric hospitals in their community and claimed to have one symptom out of the ordinary (e.g. hearing a voice in their head). They were all admitted, and most were diagnosed schizophrenic, although in every way apart from their one symptom they behaved normally. After one week, they reported the symptom gone and asked to be discharged. Their experiment was over. Unfortunately, the hospitals would not release them, until finally Rosenhan rang up and explained the situation. Rosenhan then told the hospitals there were others who had not been named, who were in the experiment. Within a few days the hospitals found and released other patients whom they now realised were sane, although in fact there were no more psychology students (Rosenhan, 1973). These other patients, apparently as sane as Rosenhan's students, would otherwise have remained under treatment, diagnosed as having lifelong "incurable" illnesses. There may or may not be a real thing called schizophrenia. But at the very least, all that glitters is not gold.

The West's Most Expensive "Disease"

Schizophrenia is the most frequently discussed of the psychoses (disorders where the person is assessed by psychiatrists as out of touch with reality). Many psychiatrists consider that there may in fact be a number of different and overlapping syndromes which are being described under the one label of "schizophrenia" (Perris, 1989, p 4). Perhaps one of the clearest areas of agreement though, is that schizophrenia is a separate disorder entirely from split or multiple personality, with which it has previously been confused in the public mind. Schizophrenia is perhaps best described as a disorder of thought and perception. The DSM-IV™ (American Psychiatric Association, 1994) lists its symptoms as delusions, hallucinations, disorganised speech, disorganised behaviour or immobility, and loss of emotion or will. To be diagnosed, two of these symptoms need to be present in such a way as to damage achievement in social, career or self care areas, over at least 6 months duration. This requirement has been included partially as a result of concern over studies such as Rosenhan's (above).

The cost of current schizophrenia treatments is enormous. In the United States 0.5% of the gross national product goes into the treatment of schizophrenia (World Health Organisation, 1996, p 3). In Canada (and probably elsewhere in the west) 8% of all hospital beds are taken up by people with this diagnosis, using up more hospital beds than any other single disorder (Long, 1997). 6.2% of prisoners in US jails have been diagnosed schizophrenic, and an estimated one in three homeless persons suffer from the condition (Kopelowicz and Liberman, 1998, p 192). Schizophrenia is not often enjoyable. Depression and self medication with drugs or alcohol are common amongst those diagnosed, and are associated with poorer chances of improvement. 25% of schizophrenics attempt suicide, and 10% succeed (Kopelowicz and Liberman, 1998, p 192).

What Gets Someone Diagnosed Schizophrenic

Cognitive research shows that in persons diagnosed schizophrenic, there are major problems with cognitive strategies (Perris, 1989, p 22-23).

1) **Living In Castles In The Air:** Schizophrenia is associated with difficulty "chunking down" in NLP terms (Perris, 1989, p 43, p 148-151, p 157 and Arieti, 1948). The person

with this problem is not identifying the distinctions between situations fully. Rather than chunk down to the sensory specific details of a problem event, they talk vaguely or metaphorically. One client, discussing this very problem with the authors, said "Some days it hurts when I walk on the earth. I need to keep up in the air." This is a good example of metaphorical communication. I might say that same sentence metaphorically, but this young man experienced it as a sensory fact. He was unable to explain what days, specifically, or how specifically it hurt, but he believed it to be true in the same way that one might say "Some days my legs are a little stiff in the morning, and I need to stretch them out and exercise." He believed that at times he physically floated in the air because the ground was too painful. In NLP terms, this man was unfamiliar with metamodelling his experience. Having a conversation with someone diagnosed schizophrenic can be like immersing oneself in a festival of Milton model patterns: mind reads, layered presuppositions, lost performatives, deletions, nominalisations etc. We have often had the experience where one sentence said by a client takes 15 minutes to carefully unpack before we can actually move on usefully. One person, for example, came up to Richard at the start of a training day and said "Thank you so much for what you did last night. It was beautiful." Richard had not had any contact with her the previous evening. Another time, a client told us "I know what you are doing here. I know you've called down Pavlov's dogs." In Ericksonian terms, the person diagnosed schizophrenic is experiencing a profound trance state (Donan, 1985, p 27-28). It's a standard joke in Psychiatry that neurotics build castles in the air, whereas psychotics actually live in them (and Psychiatrists collect the rent!).

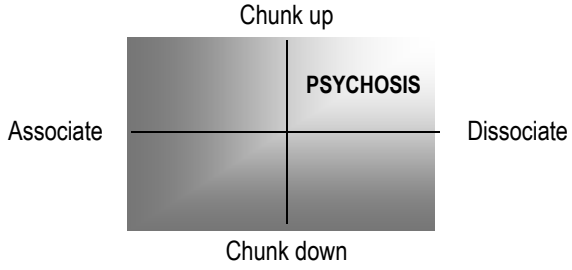
2) **Not Thinking About Thinking:** The person diagnosed schizophrenic is often also unable to adequately *classify* situations from a metaposition (for example to distinguish a real memory from a hallucinated one, or an internal thought from an external voice). Many cognitive psychologists consider this the core of the disorder (see Jacobs, 1980). Much of such metacommenting on experience in "non-psychotic" persons is done using the auditory digital sense. This sense is the one most commonly experienced as "out of control" by the person diagnosed schizophrenic. Contrary to popular belief, the most common form of hallucination in schizophrenia is auditory, and "uncontrollable" internal thoughts are also a frequent complaint of persons diagnosed schizophrenic. In NLP terms, the person diagnosed schizophrenic does not have adequate submodality distinctions between real and unreal, self and other etc. In a sense, the schizophrenic person is well dissociated from their internal experience (so that their own thoughts may not feel like "theirs"). But this dissociation is not a clear meta-position. To use L. Michael Hall's terminology (Hall, 1997), we might say that Schizophrenia is a disorder resulting from the failure to develop adequate meta-states. In our discussing this article with Michael, he pointed out that this view of Schizophrenia has references back to the Bicameral theory of Julian Jaynes (1976). Jaynes proposed that until quite recently in human history, most people experienced much of their auditory digital self talk as coming from real, externally existing voices (eg the voices of the "gods") and acted accordingly. He proposed that these external voices might be generated in the non-dominant hemisphere (though we now know that the person experiencing auditory hallucination has the "normal" speech areas of the brain active). For our discussion, the important claim Jaynes made was that during most of human history, "hallucinated" voices were not meta-commented on by the hearer, but were accepted as the result of separately existing minds. This capacity is often rediscovered by the person diagnosed schizophrenic, says Ryan DeMares (1998) who describes his own experiences with auditory hallucination using Jaynes model.

3) **Missing Social Subtleties:** Interpersonally, the person diagnosed schizophrenic behaves much like you would if you were unexpectedly placed in a totally foreign culture. Their attempts to communicate subtly mismatch the cultural norms. Often they mistakenly assume that others share their own unique sensory experiences, values, beliefs and metaprograms. They may use "socially unexpected" gestures, body postures, proximity, facial expressions, voice tonality and phrasings, without apparently noticing that these meta-communications appear or sound odd to others. Such mismatching is so profoundly culturally determined that we as authors doubt the ability of a person from one culture to diagnose schizophrenia accurately in a person from another culture. People who move from one culture to another are in fact far more likely to be diagnosed schizophrenic (Pomare and de Boer, 1988, p 120). On the other hand, many people working with schizophrenia note that their own way of diagnosing the condition is not primarily by the classical symptoms but by the very strange feeling that they get when they are with the person diagnosed this way. This feeling is described as a "lack of affective resonance" (Perris, 1989, p 5), and equates, in our experience, with the person diagnosed schizophrenic having great difficulty using socially normal rapport skills. Often, this difficulty emerges quite early in life, and some cognitive psychologists consider its effects on the parent-child relationship to be central in the development of schizophrenia (Perris, 1989, p 33-34). It leaves the person especially vulnerable to confusion in any situation that involves meta-communication. An example is the "*double bind*" identified by Gregory Bateson (Perris, 1989, p 51-54), where a person might for example say to the client "Come and give me a hug." while grimacing at the client with anxiety. Research has since shown that most families generate double binds; but the person diagnosed schizophrenic cannot process the two communications from a meta-position.

4) **Other Symptoms:** In persons diagnosed schizophrenic, there is also often a reduced attention span, reduced memory, impaired goal achievement skill, flattened emotional response, and reduced ability to learn from verbal sources (while visual and kinesthetic skills seem relatively good). This cluster of disabling symptoms could be considered the result of the primary difficulty metacommenting and metamodelling. Schizophrenia often is first diagnosed when the person has an "acute" or "florid" state where delusions, confused activity and hallucinations are marked. This acute state often occurs in response to some social stress (such as starting a new job), and more fully approximates common expectations of "insanity". A prolonged cognitive confusion and social "ineptness" is the more fundamental pattern out of which this florid state emerges. Medication often reduces the florid state without affecting the core problems at all.

Personal Strengths

In the Personal Strengths model, the person who tells you that they can't touch the ground, or that they know you're sending energy beams to attack them is demonstrating skill with chunking up and dissociating from experience.



Causes?

Schizophrenia Societies, often set up as support groups for families of Schizophrenics, are not always a reliable source of information about Schizophrenia. In their drive to remove blame from families, they have frequently publicised erroneous and reductionist claims about the biological origins of the disorder. For example, most say that Schizophrenia is a disorder seen in the same prevalence throughout the world. World Health Organisation statistics show that Schizophrenia does not occur equally around the world. When diagnosed with the same careful standards, its prevalence ranges from one in a thousand, in many non-western countries, to one in a hundred in the west. Many non-industrialised societies have no incidence whatsoever (Kleinman, 1991).

Within western society, it is dramatically more prevalent in cities. A recent Danish study followed up 1,750,000 people born to Danish women between 1935 and 1978 (Mortensen et alia, 1999). In this group there were 2669 cases of diagnosed schizophrenia. The "population attributable risk" was 5.5% for a family history of schizophrenia, and 34.6% for having an urban place of birth. That is, living in the city has over six times more effect on the development of the disorder than genetics and family upbringing combined! Even season of birth was twice as significant as family and genetic factors (the highest risk births are in late winter; February-March). The social and physical environment in which a person is raised is extremely significant in the development of the problem. It now seems clear that some kind of vulnerability from family/genetic and perinatal (around birth) factors leads to schizophrenia in the presence of social stresses which occur far more in some cultures than others.

Recovery rates from schizophrenia also vary depending on where people live. World Health Organisation studies show that in Nigeria, 58% of diagnosed schizophrenics fully recover within two years, and in India 50% recover within two years. In Denmark, only 8% recover within two years, despite having vastly more drug treatment. (Jablensky et alia, 1992). Nonetheless, if we follow up even western people with "well diagnosed and severe forms of schizophrenia" we find that within 20-30 years a full 50% will be functioning normally (Kopelowicz and Liberman, 1998, p 191). Schizophrenia is certainly not usually a lifelong disorder. Most people with schizophrenia will recover fully. Western levels of drug treatment do not enhance their recovery (and may inhibit it). Family and social support, as well as simplicity of lifestyle, are clearly associated with more successful outcomes. With support, a calm lifestyle, and helpful feedback, the person diagnosed schizophrenic will learn new skills which fully resolve their "problem".

There are differences in the child development of people who will later be diagnosed schizophrenic (Jones et alia, 1994). The British national child development study followed up almost all children born in Britain in one week in March 1959. From these, 17,000 individuals diagnosed schizophrenic have now been identified, and their childhood results studied. At age 7, these children had unusual difficulties pronouncing words and reading. At 11, they had less hemispheric dominance than the rest of the population (they could just as easily tick squares with their left as with their right hand). This suggests that something unusual is happening in the "schizophrenic" brain long before it is identified as unusual, impairing the auditory digital sense in particular. New brain scan studies are beginning to shed further light on the differences. When a person diagnosed schizophrenic is having an auditory hallucination, the area of their brain called Broca's area is active (as shown on PET

scan; Barnaby, 1995). This is true also for a "normal" person as they talk to themselves. But interestingly, if the "normal" person imagines an "alien" voice talking to them, a region of the temporal lobe is activated to monitor and distinguish between internal-external speech. This area is not activated by the brain of the person experiencing an auditory hallucination. Note that none of this tells us "how" these problems emerge. We know that they emerge more in the countryside than in the city, more in Europe than in Africa.

People also have different opinions about the precipitating factors that lead to the acute symptoms of schizophrenia. Those diagnosed schizophrenic tend to describe their primary concerns as involving identity and fundamental beliefs about life; issues which may well be raised more intensely in industrialised city environments. Psychiatrist Peter Breggin says "so called schizophrenics, especially during their initial crisis, almost always are preoccupied with the meaning of life, God, love and their own personal identity, often with cataclysmic implications about the end of the world or the disintegration of their own personalities." He says that their metaphorical communication and behaviour "can be understood as conflicts or confusion about ... identities, values and aspirations rather than as biological aberrations". In a sense, the issues which the person is struggling with are meta-commenting issues.

Medication, Anyone?

Since 1954 a large number of medications have been used to treat the symptoms of schizophrenia. In general, American studies show that, given a placebo, about 20% of people diagnosed schizophrenic will have their perceptual symptoms such as hallucinations disappear (Sheitman et alia, 1998, p168). Treatment with "antipsychotic" drugs pushes this percentage up to around 60%, but does not generally affect the other symptoms of thought disorder and lack of interest in life. Furthermore, it is important to understand that the extra 40% who benefit in this way from the drugs have only been given temporary relief. If they stop taking the drugs, their symptoms are likely to return. For this reason, we wish to emphasise that those on antipsychotic medication should not come off that medication without medical supervision. On the other hand, several studies show that those treated with placebo show greater clinical improvement and less overall functional disturbance than those treated with antipsychotic drugs (Breggin, 1992, p 77-83). In one study re-admission rates for those given placebo were 8%, compared to readmission rates of 47% for those given the actual medication.

The other concern with drug treatment is that typical antipsychotic drugs are associated with long term with brain damage. The 1986 Manual of Clinical Psychopharmacology says that the brain damage of tardive dyskinesia occurs in 50-60% of chronic users of these drugs. The June 1990 Clinical Psychiatry news updates this, saying that exposure for 15 years or more leads to "almost certain" tardive dyskinesia. (Breggin, 1992, p 95). This causes the odd rocking motions, tremors, bizarre postures and twisting tongue movements we often imagine as features of long term psychiatric clients. It's the clinical end result of interfering with the flow of dopamine and other neurochemicals between the lower brain and the frontal lobes of the brain – a process which could be termed chemical lobotomy.

Long-term stays in the hospital environment are also clearly unhelpful in the treatment of schizophrenia. When someone is admitted for acute schizophrenia, assigning them to an 11 day hospital treatment with follow-up leaves them with better results than a 60 day hospital treatment with the same follow-up. Social functioning even two years later is better for those who return to normal support networks in the community (Kopelowicz and Liberman, 1998,

p 202). Traditional psychodynamically oriented therapy (exploring the "causes" of the person's problems and their unconscious "dynamics") has also been shown to have little or even adverse effects on the course of schizophrenia, although occasional, rare cases of sudden success do occur, with any treatment tried, perhaps because they would have occurred anyway (Kopelowicz and Liberman, 1998, p 202 and Perris, 1989, p 64-69).

Modelling Sanity in Insane Places

Surely, you might be thinking, someone will have studied how the vast majority of people diagnosed schizophrenic are recovering! Surely, someone will be organising rural retreats with a promise of 50% recovery in two years! Not quite. However, there is increasing evidence that approaches based on cognitive and social education are successful in increasing the percentage of complete "cure".

So what has been shown to work? Studies beginning in the 1960s show that behaviour therapy (giving rewards for "appropriate behaviour") produces change in the in-patient situation but the gains prove very difficult to transfer to community life where the rewards are no longer controlled (Kopelowicz and Liberman, 1998, p 197). Training in Community Living programs (where training in life skills and direct assistance is given to people living in the community) have resulted in increased social functioning and less readmission. Training in social skills combined with family assistance often reduces readmission to zero (Kopelowicz and Liberman, 1998, p 200-203). Training in the cognitive functions which are damaged in schizophrenia (attention span, verbal learning, memory, etc) and training in identification of perceptual distortions (such as hallucinations) has been successful, but there is as yet little evidence that it affects social interaction and other outcomes. Shifting to teaching new skills by using the (unimpaired) visual and kinesthetic senses has also been tried with some success (Kopelowicz and Liberman, 1998, p 198-199, 205).

Traditionally, therapists have avoided the use of hypnosis with persons diagnosed psychotic, on the grounds that it may increase their dependency and confusion. As with depression, psychosis need not be considered a containdication for hypnosis; rather it is an indication to use hypnosis educationally, to build inner resources, and to pace and lead the person carefully to reality based experiences. Joan Murray-Jobsis (previously publishing under the name Joan Scagnelli-Jobsis; see Scagnelli-Jobsis, 1982) has reviewed the literature on the use of hypnosis with psychosis, and proposed a (non-Ericksonian) model of assisting the person to learn new ways of responding to life. She notes that while some studies find that persons diagnosed psychotic do not respond to hypnosis, others find that they respond normally, and still others find that they respond with a wider than normal variation. Ericksonian therapists have pointed out that this is because the person diagnosed psychotic is already in a deep trance state (Dolan, 1985, p 128).

In the history of Ericksonian and Neuro Linguistic psychotherapy, there have been a range of interventions used with people diagnosed schizophrenic. The anecdotal and research evidence from these suggests several useful strategies to assist the person in creating the type of successful change that naturally occurs in over 50% of "schizophrenics" world-wide.

Rapport: The Medium Is The Message

From the core issues identified earlier, our goals with the person diagnosed schizophrenic will tend to include helping them 1) chunk down, 2) make metadistinctions about their

thinking (to “reality check”, as it’s called in Psychiatry), and 3) learn rapport skills. Unfortunately, when we meet these people, *their* goals will often be chunked up, unrealistic and totally out of rapport with everyone around them. Yet if we respond to these chunked up, confused and mismatched goals by imposing our “vision” of sanity, we respond insanely (in an unrealistic and mismatched way) to the people who need sanity most. A therapist is unlikely to “win an argument” with a schizophrenic client about what is real. While you may choose to make it clear that you do not yourself perceive and believe what the client perceives and believes, it remains important to respect their “map of the world”. The most successful initial move must convey powerfully your intention to get rapport with the client.

Many of the accounts of successful therapy with persons diagnosed schizophrenic begin with dramatic rapport building. Dr Karl Whitaker gives an interesting example of such an approach: “For instance, in one first interview with a family with a schizophrenic girl, I turned to the girl after I’d been talking fairly emptily with the parents and asked, “What are you here for?” She said, “Contact is good for colds.” I said, “How long have your parents been cold?” and she said, “Twenty years.” We went on talking schizophrenese like this without any hesitation.” (Haley and Hoffman, 1967, p 272). In NLP terms, Whitaker used the girl’s own chunked up and dissociated (metaphorical) style of communication.

Yvonne Dolan identifies a similar pattern in the work of Milton Erickson (Dolan, 1985, p 58-61). One case involved a man who had only spoken 6 sensible words in the five years he was in hospital. Otherwise he spoke in "word salad" - a long jumble of sounds, words and syllables in no apparent order. Psychiatrists, nurses and others made numerous unsuccessful attempts to talk to him, or even find out his full name (his 6 words included "My name is George"). To begin, Erickson had his secretary record, in shorthand, a sample of the man's "speech". Erickson then studied this sample until he could improvise a word salad similar in form. Now he was ready. He sat down next to George and introduced himself. George spat out an angry stream of word salad. Erickson replied with an equally long stream of the same type of noise. George appeared puzzled and added more word salad, and Erickson responded in kind.

A few days later Erickson returned and again George spoke in word salad, this time for four hours. Erickson, aware that George was watching a clock on the wall facing them, replied in kind for another four hours, missing his lunch. George listened carefully, and they then traded another two hours. The next day George gave only two sentences of word salad. After Erickson returned his own two sentences, George did an extraordinary thing. In plain English, he said "Talk sense Doctor!"

"Certainly, I'll be glad to. What is your last name?" Erickson asked.
"O'Donavan, and it's about time somebody who knows how to talk asked. Over five years in this lousy joint ..." and he lapsed back into word salad. But this was the breakthrough. A few months later, George O'Donavan left the hospital and found himself a job. Erickson followed his progress for some years and he was not readmitted.

Erickson’s Pace and Lead To Sanity

Jeffrey Zeig identifies a sequencing in Milton Erickson’s work (Erickson, M.H. and Zeig, J. “Symptom Prescription for Expanding the Psychotic’s World View” p 335-337 in Rossi 1980) Erickson explains: “No two people necessarily have the same ideas, but all people will

defend their ideas whether they are psychotically based or culturally based, or nationally based or personally based: When you understand how man really defends his intellectual ideas and how emotional he gets about it, you should realize that the first thing in psychotherapy is not to try to compel him to change his ideation; rather, you go along with it and change it in a gradual fashion and create situations wherein he himself willingly changes his thinking. I think my first real experiment in psychotherapy occurred in 1930. A patient in Worcester State Hospital, in Massachusetts, demanded he be locked in his room, and he spent his time anxiously and fearfully winding string around the bars of the window of the room. He knew his enemies were going to come in and kill him, and the window was the only opening. The thick iron bars seemed to him to be too weak, so he reinforced them with string."

"I went into the room and helped him reinforce the iron bars with string. In doing so, I discovered that there were cracks in the floor and suggested that those cracks ought to be stuffed with newspaper so that there was no possibility (of his enemies getting him), and then I discovered cracks around the door that should be stuffed with newspaper, and gradually I got him to realize that the room was only one of a number of rooms on the ward, and to accept the attendants as a part of his defense against his enemies; and then the hospital itself as a part of his defense against his enemies; and then the Board of Mental Health of Massachusetts as part, and then the police system - the governor. And then I spread it to adjoining states and finally I made the United States a part of his defense system; this enabled him to dispense with the locked door because he had so many other lines of defense. I didn't try to correct his psychotic idea that his enemies would kill him. I merely pointed out that he had an endless number of defenders. The result was: the patient was able to accept ground privileges and wander around the grounds safely. He ceased his frantic endeavors. He worked in the hospital shops and was much less of a problem."

The same pattern is clear in the work of Dr Patch Adams (Adams, 1998) as seen in the film *Patch Adams* staring Robin Williams. Himself a client in a Psychiatric hospital, Adams helps his roommate Rudy to deal with his terror of hostile chipmunks (which no-one else can see, but which prevent Rudy getting to the toilet or leaving his room). After acknowledging that he himself cannot see the chipmunks, Adams achieves success by joining Rudy in an imaginary shootout with them.

Zeig cautions "If such an initial intervention were made in a sarcastic manner, or from a frame of reference of trying to trick the patient out of his symptom, the positive outcome would be limited. An attitude of empathy and respect on the part of the therapist is crucial to ensure successful change." (in Rossi, 1980, p 336). He explains, "This pattern can be divided into three major elements, which occur in the following sequence: (1) meeting the patient where the patient is; (2) establishing small modifications that are consistent with, and follow from, the patient's behavior and understandings; and (3) eliciting behaviors and understandings from the patient in a manner that allows the patient to initiate change."

What If You're Not Erickson?

Erickson and Adams were both willing to go to considerable lengths to pace the metaphorical world of their clients. The same basic *principle* can still be applied where ethical or personality restraints inhibit you from talking word salad or shooting chipmunks with your client.

Steve Lankton gives a great example in his work with a client named Greg (Lankton and Lankton, 1986, p 128-135). Greg believed that the doctors at his hospital were killing people for experimentation purposes. He had never dated (he had decided that he wouldn't date until he had a Master's degree), and he couldn't read or write. But that isn't why he came to see Steve Lankton. He came because he wanted to be an ambassador. Lankton took on this goal. In twice weekly, three hour trance sessions, he had Greg practice reading and writing. One of the first things he had Greg do outside the therapy sessions was to go to a restaurant and order two desserts. After this he was to write a report on the two desserts. After all, one of the things an ambassador has to do is take out other diplomats and be able to tastefully recommend a dessert. In this way, Lankton had followed Erickson's model of (1) meeting the patient where the patient is; (2) establishing small modifications that are consistent with, and follow from, the patient's behaviour and understandings; and (3) eliciting new behaviours and understandings. At the time Lankton was writing this, Greg had a Master's degree in Administration and Policy, and an MBA.

Another example of entering the client's model of the world with respect is given by Richard Bandler in his work with Andy (videotapes of his three sessions with Andy have been published by NLP Comprehensive). Bandler recounts the story thus (Bandler, 1993, p 107-108): "One schizophrenic I worked with hallucinated people coming out of the television set and following him around. Think about that. When I heard this, I said, "Wow! That's great!" He looked at me and said, "What do you mean it's great?" I said, "Well, what do you watch?" He said, "*Little House on the Prairie*." On that show there's a snippy little bitch named Mary. She kept coming out of the screen and following this guy around going, "Aarrhh, aarrhh, aarrhh" just like she does on the program. She would bitch and moan until he would freak out and start screaming. Of course he was a paranoid schizophrenic!…. I said to him, "This is a multi-million-dollar disorder!" The guy looked at me and said, "What are you talking about?" I said, "Does the term 'Playboy Channel' mean anything to you?"…. I said, "Think about it. We could run courses and train travelling salesmen in this. They could be monogamous and have the best time they ever had. This is a multi-million-dollar disorder that would give people the ability to never be lonely again." I told him, "I want to know how to do this." And this guy, who had spent five years trying to get rid of a problem, began by saying, "Well, maybe I'll tell you and maybe I won't." Now that shows a changed attitude."

Notice that in this case, Bandler does not claim that the people from the television are "real" –merely that seeing them could be useful. In NLP terms, he offers a reframe. In the same way, Yvonne Dolan describes reframing episodes of catatonic immobility as a great way for a client to give himself some space. This results in the client almost immediately reducing his catatonic sessions from 4-5 hours down to 15 minutes at a time, and then even discovering that he could talk while still "giving himself some space" (Dolan, 1985, p 90-106).

This pacing and reframing of the "problem" can be done very lightly. When a therapist demonstrates that they can understand the inner world of the client, they do not have to talk as if they are stepping on eggshells. Carlo Perris encourages therapists who are challenging schizophrenic cognition to lighten up. If the client claims their disorder is "always there" for example, he asks "Do you mean you are crazy even when asleep?" When a client says during a phone call that she had previously believed that she was telepathic, but is now over the delusion, Perris says "Then you could have saved the cost of the telephone call and got in touch with me telepathically." While arguing with the person's "delusions" is clearly counterproductive, aligning with the person to consider the delusions light-heartedly can be

very effective. It communicates that the therapist is willing to "act normally" around the client. (Perris, 1989, p 141, 138)

Building Rapport With Metaphorical Communication

As mentioned earlier, schizophrenic communication itself can be thought of as metaphorical. Yvonne Dolan discusses the therapeutic use of metaphor with psychotic clients (1985, p 128-140). Her goals include relaxing the person, providing a context to intersperse positive suggestions, and allowing the client to respond to suggestions at their own pace. She emphasises two practical points about telling metaphors to persons diagnosed schizophrenic. The first is that being relaxed and confident yourself is a crucial starting place. The ability of psychotic clients to "pick up" anxiety or incongruity in therapists and others (their sensory acuity) is well known. The second point is that the topic of a metaphor told to a schizophrenic client is most usefully an actual life event, rather than a "fairy tale" or fantastical/theoretical story.

Dolan gives an example of her work with a client named Nathan, whose first psychotic episode had happened when he was 17 years old. Nathan hallucinated an experience where he received a message saying "Your future is your past." He believed that this showed that he was going backwards in life, and became extremely anxious and obsessed about this. Dolan told him a story about another therapist, Kate, who had lived out in the country when she was 17. At this time, her parents went away for the weekend, leaving her with instructions not to use the family car to go to a party. Kate and her friends eventually found a way to get to the party without it registering on the car's odometer. They drove carefully backwards on the quiet country roads. Dolan emphasised "You know country roads, so you know that you can carefully and very comfortably go pretty far backwards while going in the actual direction in which you really want and need to go forward." (Dolan, 1985, p 136). Immediately after being told this story, Nathan got his first good night's sleep since his hallucinated experience. His obsession stopped from that point.

The basic principle of therapy with clients diagnosed schizophrenic is the same as with all clients: to pace and lead. So far, we have considered four main ways of doing this:

- Accept the client's metaphorical communication, and enter into it with them. Eg Erickson's use of word salad with George, and Whitaker's comment about how long the girl's parents have been cold.
- Assist the client in reaching their goals (however "delusional" they may seem) in such a way as to offer a subtle shift in focus to more useful skills. Eg Adams joining the struggle with the chipmunks, Erickson helping the man to reinforce his windows with string, and Lankton getting Greg to write a report on the two desserts.
- Accept the strategies with which the client is generating "schizophrenic symptoms" and reframe them as useful skills. Eg Bandler's offer to market Andy's hallucination skill, and Dolan's advise to the catatonic man to give himself some space.
- Use real-life stories as metaphorical communication. Eg Dolan's story of going backwards into the future.

Overview of Therapy With Clients Diagnosed Schizophrenic

From our earlier comments about the nature of schizophrenia, it is clear that three central goals of consulting with someone diagnosed schizophrenic are likely to be:

- **To learn to chunk down**
- **To make metadistinctions**
- **To use rapport skills**

The successful therapy process with clients diagnosed schizophrenic (as described by Lankton and Lankton, 1986; by Dolan, 1989; or by Bandler, 1993) is an educational one, rather than a therapeutic one in the traditional medicalised sense. . In the following sections we will consider each of these three central goals in turn and give examples of the more detailed "educational tasks" which can assist a person to reach them. Education is a respectful process. It does not require the therapist to assume that their client is "sick" or damaged". Merely that there are things they could learn.

1. Chunk Down

♦ Cognitive therapists such as Carlo Perris recommend teaching the client the structure of their thinking, so that they can challenge their own meta-model patterns. Perris (1989, p 148-151) recommends starting with less emotionally laden areas, rather than the central delusions. For example, earlier we mentioned one person (diagnosed schizophrenic) who attended our training and came up to Richard one morning to thank him for "what he did last night" (a time when Richard had no contact with her). As Richard looked puzzled, she quickly responded using the knowledge she had learned over the training, saying "Oh; I know! I'm using Mind Reading; thinking that you know what I was thinking about last night, aren't I." Having practised metamodel questions in neutral situations, she was able to quickly unpack and metamodel what would previously have been a bewildering "delusion".

Garis Hagstrom (1981) studied the use of such confrontation by a therapist working with a single schizophrenic client over a two year period. The communication was analysed for NLP metamodel patterns. Sessions later in the therapy showed that the client's communication changed to include more complete sentence structures (less use of deletion, distortion and generalisation) as well as more congruent linking of nonverbal and verbal signals. Several studies of cognitive therapy show that the extent of delusional thinking can be markedly reduced in less than ten sessions (Perris, 1989, p 162-163). In short, there is evidence that persons diagnosed schizophrenic benefit considerably from metamodelling their own communication. Perris identifies several types of "thought disorder" which benefit especially from metamodel-style challenges. These include:

- **Generalisation.** Perris points out that, when asked how they came to stay in bed all day, the person diagnosed schizophrenic will simply reply "Because I'm lazy." or "Because I'm a schizophrenic." Such comments are very amenable to requests for specificity using the NLP metamodel.
- **Identity assumed on the basis of identical predicates.** This type of thinking is actually the basis of metaphor. One might say, using this type of thinking, that a) people grow and expand, and b) flowers grow and expand, so c) people are flowers. In schizophrenic thinking, this is treated, not as a metaphor, but as a fact. In the sentence "People grow and expand", "grow and expand" is the "predicate". The person using this type of thinking assumes that if the predicates are the same, the subject of the sentences are identical. One of our clients gave a simple example of this when he claimed that he was Jim Morrison of the Rock Group the Doors. He explained that he reached this conclusion because Jim Morrison was born on

December 8th and he also had a significant experience on December 8th. In NLP terms, this type of thinking is expressed in complex equivalents.

- **Premature assignment of meaning.** As a person begins to say a sentence, the person using this type of thinking quickly assumes they know the end of the sentence and responds to their guess as if it was reality. In this case, this is a form of mind reading. The same premature assignment of meaning could be done in response to any sensory information (eg on seeing a car with writing on it, the person may assume that the car is a police car). In such cases, the result would be challenged, in NLP terms, as a complex equivalent.
- **Egocentric overinclusion.** This refers to the schizophrenic tendency to assume that all events have meaning in relation to them (as, for example, in our client's comment about Jim Morrison's birthdate). Generally, this pattern will be stated as a complex equivalent.
- **Failure to distinguish personal meanings from causes.** In NLP terms these are cause-effect patterns. In schizophrenic thought, the person assumes that some quality they attribute to a situation is actually the cause of events in that situation. Thus, they may assume that the reason they "didn't win the raffle" (an event) is because there exists "a world-wide opposition to the spiritual truths they promote" (a quality they attribute to the situation).
- **Loss of symbolic thinking.** Metaphorical statements may be taken literally. For example, on overhearing someone say "I can see through you." the client assumes that this refers to a concrete fact.
- **Thoughts transformed to perceptions.** Just as in a trance state, thoughts produce sensations and motor activity (like finger signals); so in schizophrenic thinking, thoughts produce sensory images, sounds and sensations which seem real and externally produced. In this sense, schizophrenic thinking is trance-like. Perris lists this with the other cognitive patterns to be challenged metamodel-style. It is the special subject of our next section.

It is worth emphasising that all these thought patterns also occur in people not diagnosed schizophrenic. They are normal results of generalisation, deletion and distortion. Nothing the person diagnosed schizophrenic does is "bizarre" in itself. Any normal person could learn to produce all the results of schizophrenia; generally, they have found better things to do with their life.

It is also important to emphasise that the aim of challenging these patterns is to give the client the ability to challenge their own beliefs and perceptions. It is not to argue with specific delusions which the therapist disapproves of. Arguing with delusions, which are by definition "fixed ideas", is rarely useful. One of our clients was obsessed with a belief that he had been a Nazi in his previous life. He believed this because he had a nightmare where he was at a Nazi rally. In an attempt to prove how unlikely his conclusion was, Richard asked him how he felt at the rally. He said he was terrified. Richard then argued that "Nazis do not feel terrified at their own rallies. The dream may be an expression of a fear you have, but is unlikely to result from your having been a Nazi in some other life." The man agreed. The next week he returned, pre-occupied with his new delusion –that he had been a German Jew in his last life.

2. Make Meta-distinctions

♦ All of us engage in daydreams and flights of fantasy on occasion. When we are communicating with others, or when we are performing a set task, we usually manage to detect such thought streams and stop them. This requires a form of meta-awareness which training in NLP enhances (an awareness of ones own internal strategies and submodality use). Several research studies from Cognitive Psychology also show that within ten or so sessions,

clients diagnosed schizophrenic can be taught to identify cognitive distortions (such as delusions and hallucinations) as they are happening, and to interrupt them. This training in meta-awareness is often called "cognitive rehearsal" (Perris, 1989, p178-182). Its use reveals that there is a strategy to hallucination (Perris, 1989, p 166-167). For example, auditory hallucinations are preceded by an expectant "listening attitude". The client actually turns up the submodalities of their internal voice until it can be heard. Once they become aware of this, they can just as easily be taught to turn the voice down or even off. This can be practised in the therapy session, until the person is skilled at interrupting their old strategy.

In his work with a young man named Andy, diagnosed schizophrenic (Bandler, 1988), Richard Bandler has Andy experiment with the submodalities of "Mary", a hostile person who Andy sees and hears in front of him in stressful situations. Bandler has Andy shift the visual position of Mary, put her on a screen and smash the screen, and otherwise alter the submodalities.

In his book "Time for a Change" Bandler describes Milton Erickson's process of teaching a schizophrenic client to make metadistinctions between real and unreal (Bandler, 1993, p 7-9). The woman and her psychiatrist made a two hour trip by airplane down to Phoenix to visit Erickson. However, when Erickson said to her "And you left your house and drove here in a green station wagon and saw the countryside on the way, and how long did it take you to get here?" she replied "Twenty-six hours." In this way, Milton determined that the woman was unable to distinguish between the images she made when he told her his story, and the images she saw when she remembered actual events. By contrast, Erickson had her psychiatrist review in his mind three things that he knew were true, and then go inside and make up three events. Erickson then asked the man how he knew which ones were which. The therapist said of the real ones "They seem square, whereas the other ones are vague and transparent and don't have a shape."

Erickson then shifted back to the woman. "He turned around and began to instruct her to review the events then occurring. He told her to put them into square pictures. Then he made up fantasies and told her to make them vague and transparent and without any shape. He began to instruct her unconscious mind to start to sort out all events this way. Nowadays, TVs being mostly square, I recommend you make sure you have other ways to sort real from not real."

Fairly standard NLP techniques can be used to change submodality distinctions in this way. One man we worked with found it very disturbing to hear (ie to "hallucinate") his father's voice yelling in his left ear, telling him he was no good. After having run an auditory Swish a few times (having his father's voice fade into the distance while his own, more supportive voice came in from the same side), he reported that his feeling of depression disappeared (he had been diagnosed both schizophrenic and depressed). This example brings up an important point. Nothing in the rules says that a person who uses schizophrenic thinking styles can't also use strategies of depression and anxiety. Read the earlier chapters to get ideas about dealing with these problems separately. We have often found that when anxiety is solved, the diagnostic symptoms of schizophrenia are also dramatically reduced.

3. Use Rapport Skills

♦ Much of the suffering of the person diagnosed schizophrenic comes from their difficulty building and maintaining rapport. This occurs in the specific situation of talking to someone,

and in the more general situation of living in a social community. The person diagnosed schizophrenic is frequently puzzled by their inability to "get on" with people. However, when their actual mismatching is pointed out, they may become very defensive of it. Examples of social mismatching include not washing or dressing to the standards of the social group they belong to, avoiding contact with people by staying in bed all day or staying at home, and using socially unusual mannerisms and ways of talking.

It's easy for a "socially liberal" therapist to assume that such behaviours are the person's unique way of being, and should not be questioned. While everyone has the right to be odd, the question is what results they actually want. The person diagnosed schizophrenic does not always realise how precise their playing of the "social rules" needs to be for them to get the social results they want. Unfortunately, very few people in the client's social world will challenge these mismatched behaviours openly. The more unusual the client's behaviour is, the less useful feedback they will get! Furthermore, clients who have recovered from schizophrenia often tell us that keeping out of rapport was a way that they protected themselves from a feared engulfment by others.

♦ Careful goalsetting is crucial for the therapist to have permission to challenge this social mismatching on behalf of the client, rather than attempting to change it as some sort of "social policing". Where the person would not themselves set "rapport skills" as a goal, training in this area must make sense for the client's other goals (as in the story of Steve Lankton working with the man who wanted to be an ambassador). Once goals are agreed on, the person can be taught the strategies they need to succeed. For example, Perris describes the elicitation of a person's strategy for staying in bed all day, and it's replacement by rehearsing through a new motivation strategy (Perris, 1989, p 144). He also describes the cognitive rehearsal and roleplaying of specific social skills. In our experience, the person diagnosed schizophrenic often needs considerable practice to maintain basic rapport skills such as matching body position. These skills can be practised both in the therapy session, and then (once they are fluent enough) in home tasks.

It is important to respect the challenge that such new skills present to a person who has never used them. In particular, being able to adopt second position in social situations can be a rather scary experience. Cognitive therapists note that the person diagnosed schizophrenic will often assume that they know how others feel and think, because others feel and think just as they do (Perris, 1989, p 174). Much of paranoia is a result of assuming that others' attention is focused on the client with the same intensity as their own attention is. It's the fear (which we have all had at times especially in social situations) that a stain on one's clothes is as obvious and central to others perception as it is to our own perception. Most of us can pull out of this cognitive distortion with a brief reminder that other people live in their own world and have their own concerns; that people do not usually spend all evening scrutinising every detail on everyone else in the room. The person diagnosed schizophrenic has had less practice with the ability to take second position which is presupposed in this self-reassurance.

♦ Another important aid to enabling social success is the anchoring of resource states for use socially, but this may reveal particular difficulties with clients diagnosed schizophrenic. The cognitive distortions of "schizophrenic thinking", described above, make the accessing of resources a challenge. Yvonne Dolan gives a number of useful suggestions (Dolan, 1985. P 74-89). These include the therapist modelling the state desired, describing the state desired to the client in detail, asking hypothetically "What would it be like if you *could* remember those good feelings?", describing someone else relaxing and feeling good (what Erickson

called the “My friend John” technique), and asking what the client does for “fun”. Dolan points out that when the client is good at dissociating from positive experiences, the best way to access one may be to actually go with them for a walk, to a restaurant, to a sports event, etc

♦ Like the person who is depressed or anxious, the person diagnosed schizophrenic often has a metaprogram of sorting for problems. A key to therapy is to help them identify small successes and magnify these. Many times I have seen a client tell me that “nothing has changed” one minute, and then report that they have actually achieved every goal they set for our time together. What causes the shift? My willingness not to assume that their memory of events *is* reality, but instead to ask persistently, firstly... “So what has changed in your life (or in your experience of the situation that was a problem)? No matter how small the changes seem at first, what is different?” and then secondly, to genuinely congratulate them - “Wow, that’s great. How did you do that?” and then thirdly, to keep asking “And what *else* has changed?” These three questions come from Solution Focused Therapy (Chevalier, 1995).

An Example of Transformation

In preparing this chapter, we were fortunate to have the assistance of a skilled NLP Master Practitioner who had previously been diagnosed schizophrenic. Let’s call him John. Through John’s childhood, he had the problems identified in the child development study –he was unable to spell despite numerous specialist attempts to teach him; and telling left from right was an occasional challenge up until his teenage years. As a young adult, he was under considerable stress, living in the city, with no money and little food, but access to large amounts of marijuana and hallucinogenic mushrooms. He said he felt like a fuse inside him could pop, and everything hardwired would need to find its own way. The result, insanity, was what he recognised as his best option to deal with the pressure at the time. It created a safer, more enjoyable inner world for John to live in.

Living increasingly in “his own world”, John became preoccupied first with the hopelessness of the world political situation, and then with a belief that he was one of the holy trinity of father, son and holy ghost. He was on a search to create the unity of this trinity and to heal the world. Music and TV seemed to contain visual and auditory messages directed at him specifically; he actually heard different lyrics to songs and saw different words written. He also had frightening kinesthetic hallucinations where he believed he was electrocuting himself (the metaphor about a fuse popping becoming a physical reality at these times).

After an episode where John attacked someone violently, he was admitted to psychiatric treatment, and eventually diagnosed schizophrenic. He resented the approach of his Psychiatrist, whom he felt was transparently trying to build rapport with him (by playing pool etc) in order to change him. The first drug he was prescribed (chlorpromazine) had a paradoxical effect on him, keeping him awake and unable to sleep at night. The second, Stelazine, produced a marked reduction in his hallucinations. He also appreciated those individuals he met inside the psychiatric system who seemed motivated by a real love of human beings; people who were there for him when he needed support.

After almost a year, John began gradually to “loose the ability” to hallucinate. We asked what happens now when he imagines a strange voice talking inside his head. He explained that he never does that now; in fact that he *could not* do it! Any voice he imagines, even any song or music he hums, is translated into his own internal voice. In this way, he is incapable of confusing imagination with external reality. His only regret is that he also has reduced his

auditory-visual imagination. Currently, finding sane ways to improve this is one of his interests. John's story is a dramatic and clear cut example of re-coding the submodalities of imagined experiences differently, and using auditory digital as a meta-system. When asked how he changed, John explained that he knew while he was "schizophrenic" that it was he himself who was running it. It gave him a sense of the power of his own mind, which eventually drove him to explore new ways of running his brain, and new ways of relating to others. Eventually this led him to study the cognitive and rapport-building skills of NLP.

Now, John's psychiatrist has told him that he could not have been schizophrenic, and re-diagnosed his problem as a drug induced psychosis. In fact, John clearly fitted the DSM-IV™ definition of schizophrenia. Re-diagnosis is a way of avoiding facing the fact that someone can be diagnosed schizophrenic and then become fully "normal" again a couple of years later. It is comparable to the situation with cancer which, when "spontaneously" healed after NLP work, will often be re-diagnosed as a benign tumour. To someone who understands NLP, John's recovery is not so mysterious. It is a tribute to the skill of human beings to learn ever better ways to resolve inner challenges and find happiness.

Summary

Schizophrenia is a psychiatric nominalisation for a cluster of thinking processes including difficulty chunking down, a lack of metathinking enabling distinctions between real and unreal, loss of rapport skills, and resulting life impairments. It occurs less and disappears faster in rural societies, and may be exacerbated by long term psychotherapy. Working with the person diagnosed schizophrenic requires an ability to pace unusual behaviours, goals and metaphorical communications, and then lead the client to new possibilities. New possibilities include the ability to metamodel ones own thought, the ability to recode the submodalities of experience so as to usefully distinguish real from unreal, and the ability to match others' behaviour and respond based on a realistic appraisal of others' experience. In terms of our RESOLVE model for therapy, the sequence of steps is:

Resourceful State:
- Be clear that most people diagnosed schizophrenic will have their problem spontaneously disappear.
- Your ability to remain calm and expectant of change is picked up quickly by the client.

Establish Rapport:
- This may involve matching unusual behaviour (eg word salad or metaphorical communication).

SPECIFY Outcomes:
- This may involve accepting unusual goals (eg to be an ambassador). It requires reaching agreement on some type of outcome which enables learning to chunk down, develop meta-distinctions and learn rapport skills.

Open Up Model Of The World:
- Defining the "schizophrenic process" as the use of cognitive strategies implies that these strategies can be changed, and also that they may be useful in certain contexts.

Leading: This is an educational process including tasks to:
- Metamodel the clients own communication with themselves and others, especially

-generalisations
-identity based on predicates
-premature assignment of meaning
-egocentric overinclusion
-confusion of personal meanings with real causes
-loss of symbolic thinking

- Mark out the unreality of hallucinations and delusions using submodalities
- Change problem strategies such as critical internal voice using Swish etc
- Teach the use of a realistic 2nd position in social situations
- Elicit and improve motivation strategies
- Access resource states and memories of success
- Use NLP rapport skills consistently

Verify Change:

- Teach the person to celebrate successes, however small; to focus on solutions.

Exit:

- By using a model of therapy as educational, prepare for client autonomy.

H. Borderline Personality

Your Therapy Won't Work With Me!

When people are depressed or anxious, they often seek therapeutic help. When people are psychotically out of touch with "reality", others often seek help *for* them. But when someone is angry or hyper-critical (with themselves and others) they don't necessarily believe they need help, and others don't necessarily want to help them. If they do seek help, their therapists frequently wish they hadn't, because their "critical", "hostile", "resistant" approach quickly emerges in response to the therapy itself. Over and over, they communicate to the therapist that "Your therapy is bullshit, and your tricks won't work with me!"

Early on in our work with NLP, we naively believed that NLP change processes would work with all our clients much as they did with us. The clients would do the process, and then they would change, and then they would thank us and leave. Instead, a small group of people told us that none of the processes worked, that NLP was just a set of tricks, that they felt really angry with us for promising things we didn't deliver, and that they wanted to come back and do some more. We apologised and tried to do better (which made the problem far worse). Since then we've learned to detect such responses earlier and respond in ways that quickly enable these people to turn around 180º.

Searching for a name that isn't too blatantly insulting, psychiatrists have tended to call such people "personality disordered". The focus of this chapter is on helping persons who would be diagnosed by the DSM-IV™ with "Borderline Personality Disorder", defined by emotional impulsivity, instability, emptiness and anger at both self and others. Much of what we say here will also be useful in work with persons diagnosed with Dependent, Antisocial, Histrionic, Narcissistic or Obsessive-Compulsive personality disorders. The term "Borderline", by the way, referred to an old, pre DSM belief that someone with this disorder was on the borderline between sanity and insanity. We make no claim that Borderline Personality Disorder "exists" as a separate physical "condition". We are simply proposing that where a person suffers as a result of emotional impulsivity, and feelings of emptiness and anger, there are processes that can help.

What's So Fucking Wrong With Being Borderline?

In NLP terms the core characteristic of the person who gets diagnosed with BPD ("Borderline Personality Disorder") is a severe sequential incongruity. In external relationships this is expressed in swings from idolising another person and desperately wanting to be with them, to despising them and wanting to escape the relationship. In the person's relationship with themselves it is expressed in swings from apparent arrogant self promotion to self-hatred and disgust. Cognitively, this means constant polarity responses; the person mismatches their own and others' experience continuously. Emotionally this creates confusion about who they are and what they want, resulting in feelings of frustration, anxiety, depression, emptiness and hopelessness. The person's final behaviour may be deliberately self destructive (eg suicide attempts, self mutilation), destructive of others (eg physical fighting, smashing objects, explosive shouting) or dangerously impulsive (eg drug abuse, binge eating, reckless driving). It is as if they are at war with themselves, and with anyone else who gets in the way of this primary target.

People with higher "hostility" scores on the widely used Minnesota Multiphasic Personality Inventory (MMPI) are more likely to smoke, drink alcohol excessively, be obese, have high cholesterol levels, and consume more caffeine (Williams and Williams, 1993, p 80). They are also five times more likely to die before the age of fifty (Williams and Williams, 1993, p 54). This fits with the results we see in persons diagnosed with BPD. 56% have anxiety disorders, 41% have a major depression (Crits-Christoph, 1998, p 545) and 69% have an addictive disorder (Santoro and Cohen, 1997, p 90). These other problems, which may first bring the person to an NLP therapist, are also harder to change using cognitive (NLP style) therapy when the person has a BPD diagnosis (Crits-Christoph, 1998, p 549), because they mismatch the therapy process itself.

Why Does This Shit Always Happen To Me?

Research so far rules out even a genetic *component* in the development of BPD (Crits-Christoph, 1998, p 546). Neurological studies show that the BPD person has more right brain activity (perhaps more emotional processing than logical processing) and an over-responsive noradrenaline system. But that's just another way of saying they're angry! The most significant thing known about the origin of the problem is that 70-79% of these people have suffered severe physical or sexual abuse or endured serious trauma in very early childhood (Crits-Christoph, 1998, p 545; Santoro and Cohen, 1997, p 4). Traditional psychotherapists have proposed (Kernberg, 1986, p 142) that during these traumatic early events, healthy repression (we might say in NLP terms, healthy dissociation) was not possible because the child had not developed the skills to manage it. Instead, the state dependent memory of each traumatic event has been fully split off from the rest of the personality. The result is a vast array of parts conflicts. For once, this psychoanalytic proposal fits an NLP frame exactly!

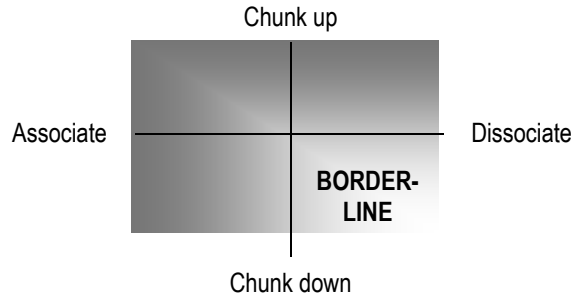
The problem is what to do about it. Results of treatment with antidepressant, anti-anxiety and anti-psychotic drugs has at best been inconsistent, at worst useless (Woo-Ming and Siever, 1998, p 562-564). Behavioural therapy has been shown to reduce impulsive behaviour but not the emotional instability of people with BPD (Crits-Christoph, 1998, p 547-548). Interestingly, one study revealed that 12 months after a year of psycho-dynamic therapy (based on the "*Self* Psychology" model) 30% of clients no longer met the BPD criteria (Crits-Christoph, 1998, p 548). This is an impressive result, and emphasises several points that Cognitive Therapists (therapists using techniques similar to NLP) have made about the disorder. They describe it as an Identity level disorder (Layden et alia, 1993, p 7) based on core beliefs about the self, such as "I am unloveable", and "I am broken". Because the person believes that "This is who I am", they resent therapeutic attempts to change less central beliefs such as "I can't manage this particular task". They are inclined to say "If you think *a person like me* can change that, you don't know how serious this is!" The Self Psychology model (Kohut, 1971) sees problems such as "borderline personality disorder" as resulting from damage in the healthy development of a "love of self". The model holds that when a 3 year old child says "Look at me! Aren't I great!", a functional parent will often respond by mirroring this excitement (eg "Wow; that's amazing!"). If the mirroring available is seriously inadequate, the child becomes fixated at this "level of development". By creating an empathic environment, the practitioner of Self Psychology also aims to create a relationship in which the person can explore their swinging between idealisation of others and grandiose, self obsessed rage, and grow beyond their child-like responses.

Cognitive therapists point out that the person with BPD has whole areas of their life where they function in a successful, adult way. On the other hand, the state dependent memories

which have been split off (the "parts" generating the BPD symptoms) function with a thinking style similar to that of a pre-school child. Even the sensory system used to store the traumatic responses is determined by the early age of the events which created it (Layden et alia, 1993, p 28-33). Events before age 12 months are usually stored kinesthetically and auditory tonally, and events before age two years are stored kinesthetically, auditory tonally and visually. Only after this time does effective auditory digital information get layered into the memories. Mary Anne Layden and colleagues recommend using kinesthetic experiences (such as relaxation and kinesthetic anchors), guided visual imagery (such as the NLP trauma cure), and techniques based on voice tone (eg trance) to access and heal the earlier memories.

Personal Strengths

In the Personal Strengths model, the person who tells you one minute that they want you to save them from a catalogue of shitty situations, and then the next minute tells you you're causing one of those situations is demonstrating skill with chunking down (to "the shitty details") and dissociating from their experience.



Don't You Tell Me I Mismatch!

The key metaprogram/strategy variables in a person being diagnosed as Borderline Personality Disordered include:

1) **Sort by self.** The person is convinced that almost everything happening is happening for them. This leads at times to paranoia ("Why did you say that? What are you trying to tell *me*."). At other times it leads to interpersonal conflict ("You knew *I* didn't want you to do that. Why did you do it?"). The person is not fully separating out first position (seeing through their own eyes) from second position (seeing through the other person's eyes), to use one NLP description. In communication theory terms (Bolstad and Hamblett, 1998, p 73-77) they have confused problem ownership, and in traditional psychotherapy terms, they have "diffuse boundaries".
2) **Sorting For Differences (Mismatching).** The person sorts for what they disagree with, and what doesn't fit. Generally, this means they are continuously aware of how life doesn't live up to the ideal. In therapeutic relationships this results in them identifying even very small differences between what a therapist said and did ("You said you'd tell me the truth; how come you never mentioned before that you…"). Much of the person's auditory digital processing is taken up with mismatching themselves (telling themselves off). Originally in their early life, mismatching was an important skill that protected them from being totally overwhelmed by powerful others. Now, it has become an uncontrollable reflex response to almost every event. Sorting for differences is a useful metaprogram essential to creativity, and to psychological independence. As with any metaprogram, its compulsive use creates problems.

3) **Chunking Across.** Part of the process of mismatching involves what is called in cognitive psychology "transductive reasoning" (Layden et alis, 1993, p 38). As the person leaps from one state to another, and one opinion to another, they fail to chunk up and identify general principles behind these separate events. There is a lack of meta-analysis, and, to use Meta-State terminology, an absence of meta-states such as a strong sense of self (Hall, 1996)
4) **Either-Or Thinking.** Another result of mismatching and polarity based thinking is to perceive things as either perfect or ruined. ("My haircut was a disaster today. I'm going to kill myself."). This is connected to chunking across, because the person has no chunked up category to experience the specific event as "a part of". In the example, the haircut is all there is. There's no "self" above and beyond the events of the moment, so that the bad haircut *is* the only evidence of self to measure success by. In the person's strategies to check "Am I loveable" or "Am I competent", at the Test phase only the immediate evidence is assessed. The danger in relation to other people is that one "mistake" can provide enough evidence to the person with BPD that their very life is threatened by this other human being.
5) **Present Temporal Focus.** The previous example demonstrates how the person assesses most decisions by reference only to the present moment. ("Do I want to use this heroin? Why not? It'll stop the pain right now!"). They respond based on the principle "Out of sight; out of mind". In developmental terms, this is described as "lack of object permanence". The same process often creates anxiety about relationships, because as soon as the other person in the relationship leaves the room, the person with BPD feels abandoned. It also results in the person having what NLP calls a Consistent Convincer strategy, where they never feel fully convinced by what they have experienced previously. In traditional therapy this would be called a "lack of trust".
6) **Away From Motivation.** Many decisions, such as decisions to commit suicide or use drugs, are a result of moving away from pain without any evaluation of what the person actually wants instead.
7) **Sequential Incongruity.** The combination of the above metaprograms makes it more difficult for the person to hold in their mind two differing responses (eg being annoyed at what someone did, at the same time as loving them). Such polarities are experienced sequentially, each one mismatching and moving away from the previous response. The person frequently feels split off from ("positive" or "negative") parts of their own experience.

Help Me Change (But Don't Make Me Do Anything Different!)

The system described above is a very resilient one! It had to be, to enable the person, with the limited resources of a young child, to survive severe trauma. Furthermore, the person does not identify this personality system as their problem. *Their* problem is anxiety, frustration, emptiness, depression, or even the endless succession of absolute bastards who seem to intrude on their life. The first step in helping them to get lasting change is for you as an NLP Practitioner to identify their extreme mismatching style. The second step is to set up a consulting relationship in which you have permission to help them identify and change this style, which actually generates the unpleasant states they want to change.

A man we'll call Bob came to one of our weekend trainings. At all our trainings we have people do a visualisation exercise near the start. They turn around and point behind them with their arm, and then come back to the front. Next they imagine themselves going further, and notice what they would see, feel and say to themselves if their body was more flexible and

they could turn around further. Then they turn around again and notice how much further they go (Bolstad and Hamblett, 1998, p 81). Unlike 99% of people who've done this with us, Bob wasn't impressed. Here's how his conversation with Margot went next:

Bob: Well, I think I went further the first time. It didn't work for me at all.
Margot: That's right, it didn't; because you didn't do the process the way I described it. I said to imagine what it looked, felt and sounded like to go further, and you talked to yourself inside about how this probably wouldn't work for you....Right?
Bob: Hmmm. Probably. Yeah, I guess so.
Margot: And that's probably the way you've been doing a lot of other things too. You're already good at talking skeptically to yourself. If you want to get a *different* result in your life, then it's worth using these exercises the way we actually describe them, and *only* do what we describe. You just did more work than you needed to. Now lets do that one more time, the new way.

What we have done here, with this pointing process, is to provide an opportunity for mismatching, before we get to doing the central change processes. This acts as a "mismatching detector", and we use the same process regularly with individual clients. We know that, in order to mismatch the instructions given, the person needs to overide the internal visual/auditory/kinesthetic representation suggested. The most likely way to do that is by talking to themselves, which Margot was able to then draw the person's attention to. Margot's next comment asks the person to mismatch their mismatching. She says that if they keep mismatching, then they are just doing the same old thing every time. The only way to mismatch is follow our (new) method.

This is actually a very simple application of the technique Milton Erickson identified for use in this situation. He says (Erickson, 1980, p 301): When sufficient material has been obtained from the aggressive, hostile, antagonistic, defensive, uncooperative patients to appraise their unfortunate behavior and attitudes and to judge their type of personalities, they are interrupted by an introductory paragraph of mixed positive and negative, seemingly appropriate and relevant remarks addressed to them in that form of language they can best understand at that moment. However, concealed and disguised in these remarks are various direct, indirect, and permissive suggestions intended to channel their reactions into receptive and responsive behavior."

So What's The Deal?

We tell the person explicitly that they need to change their metaprograms in order to get the results they want. In doing so we are setting up a very specific type of "therapeutic alliance" (to use the traditional term) which we would describe as consulting. We want to be the person's consultant, not their "counsellor". In this arrangement, we will make suggestions as to processes which they could use to change. If they follow these processes, they will, we believe, get the results they want. If they want to keep us hired as a consultant, they need to actually follow the recommendations. We emphasise that processes must be followed precisely, to get the desired results. This consulting arrangement needs to be very clearly described before we start "formal" NLP interventions (if we ever do). Consistently, we have found that the person with BPD is able to be more resourceful when helping someone else to change, rather than when trying to change themselves. We teach them to utilise this resourceful helping state by becoming their own therapist. We simply provide supervision of their therapy.

For example, in helping a person learn to sort for what is going well in their life we may ask them as a task to take time each evening and identify 3 things that went well in their day. We usually say that we've had people come back and tell us that they tried this task and it just made them feel bad. What we then found out was that they didn't do the task the way we told them. For example, they thought of the first thing that went well, and then thought about how hard it had been to think of that one thing… and then worried that they might not be able to think of two more… and then wondered what that meant about them as a person. *Then,* understandably, they felt bad. But they had not done the task we gave them.

In order to be this "confrontational", we need to do two other things simultaneously. One is to use rapport skills (subtly, because the person is on the alert for "NLP tricks" and will mismatch body posture if they detect attempts to match). The second thing is to genuinely tell the person what *behaviours* they have done that indicate to us the functional areas of their life. This is different to saying "You're wonderful", a claim which would directly contradict the person's Identity level beliefs (Layden et alia, 1993, p 60). We might say "I was impressed with the time you spent helping other course participants. It made our job easier." This positive feedback is itself a model of the sorting for positives that we want the person to learn. Even when the person disparages it, it still has usefulness as a genuine feedback, and as an example of how we come to believe that the person can change.

There are limits to our help as a consultant. Often, these limits actually exclude us from taking the person through standard NLP processes, where they would have the opportunity, or even the compulsion, to mismatch us. On occasion we have found it more useful to have the person run their own NLP processes, with one of us as a coach. Instead of saying, "See yourself in a movie theatre, and move back to the projection booth…" we say, "Here's how the NLP Trauma process works. Now, just run that through by yourself until you've solved the problem, and come back and check in with us then." Certainly, we need to set limits on how much time we are willing to spend with this person, who, remember, is capable of demanding and dismissing "endless" convincing and reassurance. Our aim is to model new strategies, such as self-reassurance, and then have the person run these strategies themselves.

The following change processes are only applied within the context of the consulting relationship described here. With them, we have found that many "personality disorders" can be reversed in weeks rather than years. If we do not set up this relationship at the start, however, we have sometimes found that we lost the ability to help effectively, because our presence became a powerful trigger for mismatching.

1) Crisis Intervention

♦ The person may have first contacted you for help in a crisis, where they are experiencing extreme anxiety, depression or frustration. See our previous articles (Bolstad and Hamblett, 1999, A, B and C) for models for dealing with the first two types of response. As we say in previous articles (Bolstad and Hamblett, 1999, B) it's appropriate for you to check how far along the track of suicidal thinking the person may have gone, and what violence the person has previously been involved in or contemplated.

Assess for yourself whether you feel safe working with this person. Being a consultant is different from being a martyr. You have a right to ask that during the time of your consulting the person commits themselves to staying alive, and to taking time out from being with others

if they feel anger escalating dangerously. Making these contracts work requires rehearsing the person (and possibly others who live with them) through the process of getting help in a crisis. We often ask the person, while they are in the session with us, to practice contacting a support person by phone. Ultimately, you as a consultant cannot make a person stay alive, or guarantee that they won't injure others. However in most countries you are legally responsible for having taken all reasonable steps to keep your client and others safe. If this is unfamiliar territory for you, talk to a counsellor for whom this safety process is familiar.

2) Accessing Resources

♦ A major aim of work with a person diagnosed BPD is to generalise skills from areas of their life that are functional to areas where their unresourceful states are triggered (Layden et alia, 1993, p 38). The challenge is that even to begin talking positively is an art with the person who mismatches. Yvonne Dolan (1985, p 29-43) discusses a number of ways to do this without triggering mismatching behaviour. These include the use of interspersed embedded suggestions and presuppositional language. Perhaps the most famous example is Milton Erickson's comment to an angry youth diagnosed with personality disorder "How surprised will you be when you find next week that you've completely changed?" (to which the young man replied "I'll be bloody surprised!" thus accepting all the positive presuppositions in Erickson's comment). Dolan explains her method of using such language within metaphor to enable the person to make internal representations of enjoyable experiences, without feeling that they are "required to" as part of some "technique". Such enjoyable experiences can be anchored and reaccessed later in the session.

Even direct utilisation of the person's most obvious resources can make a significant difference. Dolan tells the story of Alice, a 25 year old with a history of violence and suicide attempts (Dolan, 1985, p 146-149). While she refused to discuss "therapeutic" topics with Dolan, Alice eagerly discussed her interest in craft and needlework". Dolan told her "You can really find a way to use all your abilities in a way that lets you win." To which Alice's response was characteristically "You're nuts!" However, she began to smile and interact socially more frequently after this, and then excitedly came in one day to announce that she had found a job as a bouncer in a rough local bar. Her previous skill at fighting served her well! Within a year she was working in the same bar as a bartender, and had begun a college degree in Psychology.

3) Developing The Ability To Match and Move Towards

♦ Teaching the person to sort for agreement and positive results is an important base from which change processes can actually work, rather than being incorporated into a long line of failures. Dolan explains (1985, p 50-57) how to convert a person's habitual "No" responses to "Yes" responses by the careful use of restating the client's disagreement and concluding with a negative tag question. If the person says, for example, "I'd rather just give up on this.", the NLP Practitioner might reply, "You'd rather NOT be here?" or "There are lots of better places to be, are there NOT?"

♦ In our experience, mismatching can be directly confronted and reframed as a choice which, while important in childhood, is now being overused. We set the person the conscious task of deliberately sorting for agreement, by asking "What is going well for me?" and "What do I agree with here?". We will frequently ask the person to refrain from discussing any negative responses or experiences for certain time periods, making a commitment to discuss

only what is going well and what they agree with. Solution focused therapy questions also focus our conversation in this direction. Two types of Solution focused questions can be used to elicit such times and are discussed more fully in the chapter on depression (Chevalier, 1995).

1) Ask for a description of the person's outcome.
2) Ask about when the problem doesn't occur (the exceptions). If there are no exceptions, then ask about hypothetical exceptions using the "Miracle" question: "Suppose one night there is a miracle while you are sleeping, and this problem is solved. Since you are sleeping, you don't know that a miracle has happened or that your problem is solved. What do you suppose you will notice that's different in the morning, that will let you know the problem is solved?"

♦ Auditory digital mismatching of NLP processes, as they are run, can be interrupted in a number of ways. One is to have the person restate the therapist's instructions to them in their own internal voice. Another is to overload the internal auditory digital channel by having the person count down from 1000 in steps of seven, while the process is being run. We have found clients extremely excited to find that techniques actually work for them once they employ their auditory digital process in a useful way, rather than in self criticism.

4) Healing Early Trauma

♦ Use the standard NLP techniques for healing trauma, such as the Dissociation Trauma Cure (Bolstad and Hamblett, 1998, p 109-112, 118-120), Time Line Therapy® techniques (James and Woodsmall, 1988) and Reimprinting (Dilts, Hallbom, and Smith, 1990). These techniques address what both cognitive psychology and self psychology agree is the original problem in most cases of borderline personality disorder. However, these techniques will only be successful once the consulting relationship has been established, and mismatching has been effectively dealt with. Visualisation and anchoring meet the requirement of accessing non-verbal methods for change in BPD, as referred to by cognitive psychologists (Layden et alia, 1993, p 86-94). These techniques also give the person temporal flexibility (the ability to look into the past, present and future), which is a key to healing depression and anxiety as well as impulsive behaviour (see Bolstad and Hamblett, 1999, D, p 6).

5) Teaching The Person To Chunk Up And Integrate

♦ The Parts Integration process and the Core Outcome process (Bolstad and Hamblett, 1998, p44-49) are important choices in enabling the person to integrate split off areas of the neurology which have been operating separate from the resources the adult person has access to. They involve asking the person to identify the higher positive intention of any split off part. In order to answer the question "What do you get through that behaviour? What higher intention does it serve?" the person has to chunk up and generalise, rehearsing themselves through an important skill which is often underdeveloped in the person diagnosed with BPD.

Because these split off "parts" have previously expressed themselves sequentially, one challenge in integrating them is to ensure that they are available and accessed ready for integration. The person as an NLP "client" is often so good at accessing their resourceful states in the session that they don't really have full contact with the "parts" that generate damage in their life. As a guide, it's useful to check that you have in fact re-accessed fully the

part that was separated out (eg by having the person step back into a time when that part "that caused the problems" was running things).

6) Teaching Clear First And Second Position

♦ This will usually come up as a priority in terms of managing the consulting contract between the NLP Practitioner and the person diagnosed with Borderline Personality Disorder. This relationship provides a great opportunity for both people to develop more effective ways of experiencing relationships in general. We teach the person the problem ownership model from our Transforming Communication course for co-operative relationships (Bolstad and Hamblett, 1998, p73-77). This model is most important for the NLP Practitioner to have on board too, as we discuss in the following paragraphs. NLP Practitioners who lose track of problem ownership put themselves at risk of various sorts of destructive relationships with clients (confusing sexual relationships, explosive conflicts and ever-more-frantic attempts to "rescue" the client from their own personality, being examples).

Clients who are upset, worried, resentful, frustrated, angry, fearful, or otherwise unhappy with either the consulting situation or some personal issue are said in these terms to "own a problem". The appropriate approach for the NLP Practitioner is to shift into second position (thinking from the client's perspective). This includes using skills which maintain rapport (matching the client's behaviour, acknowledging their concerns, and listening). It also includes using verbal skills which help the client clarify their outcome and safely create their own solutions. Advice giving, criticism, lecturing, interrogating and other directive skills, which may be quite safe in the no-problem situation, are not appropriate first responses when the client gives signals that they "own a problem". They will meet resistance. The two most effective verbal skills for the NLP Practitioner in this situation are reflective listening (eg "So the problem you're experiencing is…", "You want to…") and open, solution-focused questions (eg "What would it take for you to have solved this?", "Can I just check, what needs to be different here?").

On the other hand, when we as NLP Practitioners are upset, worried, resentful, frustrated, angry, fearful, or otherwise unhappy with either the consulting situation or some personal issue, we could also be said, in these terms, to "own a problem". This doesn't mean it's our "fault" –simply that we are the ones who need to get something changed. When my problem is with some issue unrelated to the consulting situation, I use my own solution generating skills to solve it. But when my problem is related to some behaviour of a client's, I will of course choose to communicate to them in some way. In this case, I am responding from first position (thinking from my own perspective). Advice giving, blameful criticism, lecturing, interrogating and similar skills are again not very effective. The most useful verbal skill for the situation where I "own a problem" is to describe my problem clearly. In doing this, I will give the client information about the sensory specific behaviour that has generated the problem, rather than my theory about their internal intentions or my judgement of that behaviour. Instead of saying "You were careless about our agreements", I'd say something more specific such as "You arrived half an hour after the arranged start time for this session.". I can also tell them about any concrete effects the behaviour has on me, and about the nature of the undesired state I'm in. My communication will thus be an "I" message, using a format such as: "I have a problem I'd like some help with. When… The effect on me is… and I feel…" (For example; "I have a problem I'd like some help with. When you arrive late to the session, I find I need to re-plan what we're doing. I get quite frustrated.").

In real life, problem ownership is constantly changing. In the middle of assisting a client to solve her relationship problems, I may discover that she has values and attitudes which I deeply resent. I need to monitor the situation, to identify when it becomes appropriate to shift from reflective listening to I message. Certainly, if I send an I message, my client may well feel uncomfortable about that; they may even feel "angry", "humiliated" or "insulted". Therefore, before re-sending or re-explaining my I message, I now need to respond to this new client problem with reflective listening. I do this until the client indicates that they feel understood (usually by nodding). We are then back in rapport enough for me to send a revised I message. The result is a kind of "dance" which we term "the two step", and which leads towards win-win conflict resolution. This dance moves clearly between second and first positions, in NLP terms. Here is an example:

NLP Practitioner: "There's something I wanted to mention before we start. The last two sessions we've started half an hour later than arranged and I've needed to replan what we're doing. It's starting to frustrate me." [Practitioner describes her problem in an I message, from 1st Position]
Client: "Shit! So now I have to clock in or get my pay docked? What is this crap!" [Client indicates he now owns a problem, having heard the I message]
NLP Practitioner: "You think I'm being over the top" [reflective listening, from 2nd position]
Client: nods [feels understood and so is back in rapport]
NLP Practitioner: "Well I guess it may seem silly. I want to find a way to get the feeling that we're achieving what we plan to." [re-sending a modified I message]
Client: "Well I just can't handle this. It's like school. Sometimes I have a bad day, and I don't find it easy to get up for these early morning sessions." [Client indicates he still owns a problem]
NLP Practitioner: "It's the morning sessions that make it most difficult?" [reflective listening]
Client: nods [feels understood and so is back in rapport]
NLP Practitioner: "Okay; I'd really like to solve this so that it works for both of us. So one way would be to change the time of the sessions. What other solutions would work for you?" [Beginning win-win conflict resolution]

Summary

As this last interchange demonstrates, helping a person diagnosed with borderline personality disorder and other severe mismatching personality responses is often personally challenging. However, since using the model described here, we have found it far easier to invite these people on board and enable them to benefit from the richness that NLP changework offers. Many of these clients have expressed profound gratitude for the personal transformation they have then initiated. They have shifted from feeling despair about their life to feeling confident that they can have all the benefits they see others around them getting. To summarise, the process involves:

Resourceful State For The Practitioner

- Identify strongly mismatching clients early on using the pointing exercise.
- Be clear about your own problem ownership issues.
- Check your own safety working with this person.

Establish Rapport

- Use rapport skills subtly.
- Use tag questions when restating the person's concerns.

SPECIFY Outcomes

- Contract as a consultant rather than a "therapist".
- Set limits on your input.
- Ensure the resolution of any immediate crises.
- Include safety arrangements in your contract.
- Use solution focused questions.

Open Up The Person's Model Of The World

- Access positive resources indirectly using metaphor, congruent compliments, presuppositional language and embedded suggestions.
- Help the person identify their mismatching strategy.
- Reframe mismatching and other metaprograms as the best choice at earlier traumatic times.

Leading (Change Techniques)

- Heal trauma with the Trauma Cure, Time Line Therapy™ and Reimprinting.
- Heal parts conflicts using parts integration and core outcome processes.
- Teach clear second and first position, problem ownership and communication skills, and use these in the consulting relationship.
- Set the person tasks to install more useful metaprograms.

Verify Change

- Have the person verify their own change, as a task, using solution focused questions.

Exit/Futurepace

- Have the person futurepace their own changes as a task.

I. Addiction

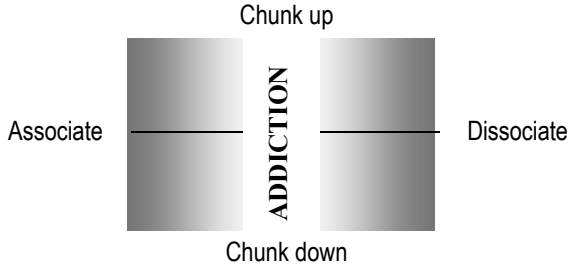
Defining Addiction

At any given time, 6%-7% of Americans show diagnostic signs of substance dependence (O'Brian and McKay, 1998, p 127). In this research, substance is used in the strict sense of substances such as alcohol, cocaine, cannabis, or opiates. The research excluded nicotine and caffeine dependence, as well as behavioural dependence such as compulsive gambling. In this article, we will focus on substance use, but the same interventions will work with any addictive problem. There's no doubt the level of addiction in our societies is a serious problem. Alcohol alone is implicated in half of all driving fatalities, a quarter of all suicides, a third of all assaults, and in the medical cause of death for 100,000 Americans a year (Dorsman, 1997, p 2).

In trying to define dependence, psychiatrists and others refer to more than just excessive use, and to more than a psychological sense of needing the substance (American Psychiatric Association, 1994, p 108-9). They refer to what counsellors call ambivalence (Miller and Rollnick, 1991, p 36-47) and what NLP Practitioners would call sequential incongruity (Bandler and Grinder, 1982, p 179-188). The person accesses the part of their neurology that wants to use the substance, and then the part that doesn't want to use, in an ongoing sequence. For example they may take more of the substance than they originally planned to. They may make attempts to stop, or say they want to stop using the substance, and then carry on using it. They may abandon other activities which are important to them, as a result of using the substance. They may continue using the substance despite actually suffering persistent, painful problems as a result of this use. They may even have tried to stop using the substance, and experienced extreme discomfort (called withdrawal). In short, an addiction occurs where one part of a person wants them to stop, but (and that word "but" is used intentionally) another, apparently more powerful part wants them not to stop.

Personal Strengths

The person who has an addiction may present with any of a number of general personality profiles. The key is their tendency to associate into and out of the addictive process sequentially. In using the Personal Strengths model it would thus be more appropriate to work with the more intact skills of chunking up and chunking down.



People Naturally End Most Addictions

There are a large number of programs offering to assist people in stopping using substances they have been addicted to, including the famous "12 Step" programs such as AA (Alcoholics Anonymous). However, contrary to popular belief, most people break free of addictions on

their own. Several surveys by the institution for Health and Aging (University of California) show that drinking problems up to the level where blackouts occur almost always disappear before middle age, without medical assistance, as do most teenage drug addictions (Peele, 1989, p 66). Over two thirds of those addicted people who stop drinking alcohol, do so on their own with no help. 95% of the 30 million Americans who have quit smoking in the last decade or so, did so without medical or AA style help. (Prochaska et alia, 1994, p 36). These people have better long term success than those who choose treatment programs: 81% of those who stop drinking on their own will abstain for the next ten years, as compared with only 32% of those who are going to AA (Trimpey, 1996, p 78; Ragge, 1998, p 24).

The same seems to hold true for lifestyle based "addictions". In 1982, Stanley Schachter announced the results of a long term study into obesity. He set out in the early 1970s with the idea that while most overweight people can lose weight, few ever keep it off. In two separate community based studies, what he actually found was that 62% of obese people succeeded in taking off an average of 34.7 pounds and keeping this weight off for an average of 11.2 years. Those who never entered weight loss programs showed better long term weight loss. Incidentally, he stumbled on the truth that many smokers give up smoking on their own. He followed up this variable too, and again found that those who attended treatment programs did not do as well as those who gave up on their own! (Schachter, 1982, p 436-444).

What about so-called "hard" drugs? In a 1982 study of morphine use, 50 surgery patients were given uncontrolled use of morphine for 6 days. Though they used far more than street addicts, they all decreased the use of the drug and stopped with no problems after their discharge from hospital. Of U.S. soldiers who used heroin in the Vietnam war (and most did) 73% became addicted and displayed withdrawal on return. Authorities were terrified, expecting a huge surge in addiction numbers. In fact, 90% simply stopped once they got back to America. Researchers noted "It is commonly believed that after recovery from addiction, one must avoid any further contact with heroin. It is thought that trying heroin, even once, will rapidly lead to re-addiction ... Half the men who have been addicted in Vietnam used heroin on their return, but only one in eight became re-addicted to heroin." (Peele, 1989, p 167-168; Trimpey, 1996, p 78).

How Medicalisation Reinforces Addiction

Addiction has been described by AA as an uncontrollable physical disease, and alcoholics are told that just one drink sets off the uncontrollable disease process again. Research consistently invalidates this claim. In 1973, Psychologist Alan Marlatt gave alcoholics heavily flavoured alcoholic drinks and found that – as long as they believed the drinks were alcohol free – they drank only normal amounts. On the other hand, alcoholics who were told their drink contained alcohol began to drink compulsively, even though their beverage contained none. Such studies have been repeated numerous times under varying conditions. Those who *believe* that they are powerless once they have had a drink of alcohol, do far worse in long term studies. One four year study followed up 548 diagnosed alcoholics initially treated at 8 different AA centres, and found that while only 7% had managed abstinence, 18% were now social drinkers with no instances of drunkenness. In this study, those who most strongly agreed with the AA disease model of alcoholism were the most likely to still be heavy problem drinkers four years later (Ragge, 1998, p 32-34).

Consider the 90% of Vietnam veterans who gave up heroin use after their return. What caused them to become addicted in the first place? Did they have a disease that other

Americans their age missed the gene for? No; they were placed in a situation that produced extreme incongruity. One part of them kept them in a war zone, where another part of them suffered extreme pain. They suppressed the awareness of that pain with heroin, just as the surgical patients in the hospital study cited above suppressed their pain with morphine. After their return to the United States, 90% of the veterans found that they no longer had the pain. Just over 10% still had severe unmet needs on their return. The others simply stopped, because the need had stopped. They were never "powerless" over the drug, they were overwhelmed by their own inner yearnings; remarkably sane, understandable yearnings. No "disease" is required to explain this process.

Stanton Peele emphasises "When narcotics relieve pain, or when cocaine produces a feeling of exhilaration, or when alcohol or gambling creates a sense of power, or when shopping or eating indicates to people that they are being cared for, it is the feeling to which the person becomes addicted. No other explanation – about supposed chemical bondings or inbred biological deficiencies – is required. And none of these other theories come close to making sense of the most obvious aspects of addiction." (Peele, 1989, p 151) The medicalisation of addiction has even more unfortunate side effects when the person actually stops using and terminates treatment. They are then told that their very feeling of being completely okay is proof that they have a disease! This is a classic double bind which is contradicted by the vast majority of addicts who recover permanently on their own.

How "Confrontation" Reinforces Addiction

Imagine a psychotherapist working with a client who has a sequential incongruity, where the client gets drunk and then wishes they didn't. The therapist decides that the part of them that wants to stop is "right", and begins to argue and "confront" the client from that point of view. The result is predictable. The client will argue from the other side. This has led to the belief that "denial" and "rationalisation" are personality characteristics of addicted people. Five decades of research has shown no correlation between denial and addiction (Miller and Rollnick, 1991, p 9-10). In fact, the only character trait associated with addiction is the ambivalence about the addictive substance! However, denial has been shown to increase as a result of confrontive treatment programs. In fact, the longer a person remains in a "12 Step" addictions program, the higher they score on measures of guilt, defeat, fear and other personality characteristics usually associated with addiction (Ragge, 1998, p 25).

To restate the basic NLP presupposition; resistance simply indicates lack of rapport! Several meta-reviews of research studies show that therapist style is more important than the content of the therapy, in predicting outcomes with addiction. The style which is most effective is *less* confrontational, more empathic and uses more communication skills (Finney and Moos, 1998, p 160; Miller and Rollnick, 1991, p 4-7). Even within one session, use of "confrontation" and labelling ("Face up to it! You're an alcoholic!") has been shown to increase client arguing and denial (Miller and Rollnick, 1991, p 9-10). This is extremely important to understand. At least one book claiming to present an "Ericksonian approach" to addictions counselling urges the use of extreme confrontation (Lovern, 1991). Addiction is not in itself evidence of a personality based on denial and argumentative rationalisation, and aggressive approaches such as John Lovern's actually create the problem they claim to solve.

What Works?

Glowing reports of success at addiction treatment centres often disguise the fact that over 80% of clients do not complete the programs (Trimpey, 1996, p 78). Because their own publicity is so pervasive, 12 Step programs tend to appear successful, but this success has been hard to demonstrate in research. Dr Keith Ditman, head of the Alcoholism research Clinic at the University of California studied 3 groups of alcoholic offenders randomly assigned by a court to AA, to a medical clinic or as controls (no treatment). In the follow-up period 69% of AA clients re-offended and 68% of clinic clients. Only 56% of the controls did (Ragge, 1998, p 21-22). Two studies emerged in 1997 suggesting that AA groups fared as well as cognitive behavioural approaches, but there is no justification for the claim that 12 Step groups are the only effective solution to addiction. They represent one of several choices now available for social support in the process of change.

Remember that most people recover from their addictions *on their own*. What has happened in these peoples lives? Research on 2700 British smokers showed that, at the time they stopped, they often changed their job, altered their relationship or otherwise solved some lifestyle problem. Also, they stop when they "lose faith in what they used to think smoking did for them" while creating "a powerful new set of beliefs that non-smoking is, of itself, a desirable and rewarding state." (Marsh, 1984).The program which show the highest effectiveness in meta-analysis of research on addiction is social skills training (training of the type offered in our Transforming Communication course; see Bolstad and Hamblett, 1998). Using roleplay and coaching, this training teaches people how to state their own concerns clearly and non-blamefully, how to listen effectively to others' concerns, and how to work towards solutions that suit both them and others. The most effective approach to addiction is not in fact to deal with "the addiction" but to solve the interpersonal problems in the person's life (Finney and Moos, 1998, p 157). To use an analogy, most addiction treatment is like setting up AA clinics for the soldiers in Vietnam. What works is bringing them home.

The second most successful treatment program for addictions, in meta-analysis of the research, is Brief Motivational Interviewing (Finney and Moos, 1998, p 157). This is based on a model developed by James Prochaska, John Norcross and Carlo Diclemente, who interviewed 200 people who quit smoking to find out what happened (Prochaska et alia, 1994). They followed up with studies of people who had given up a number of other addictions, finding the same patterns. Amazingly, Motivational Interviewing is delivered in a four session format, which makes it the briefest treatment available in the field! The methodology of Motivational Interviewing does not focus on the content of the addiction (eg by educating people about the dangers of drinking) but on the process of becoming motivated to quit.

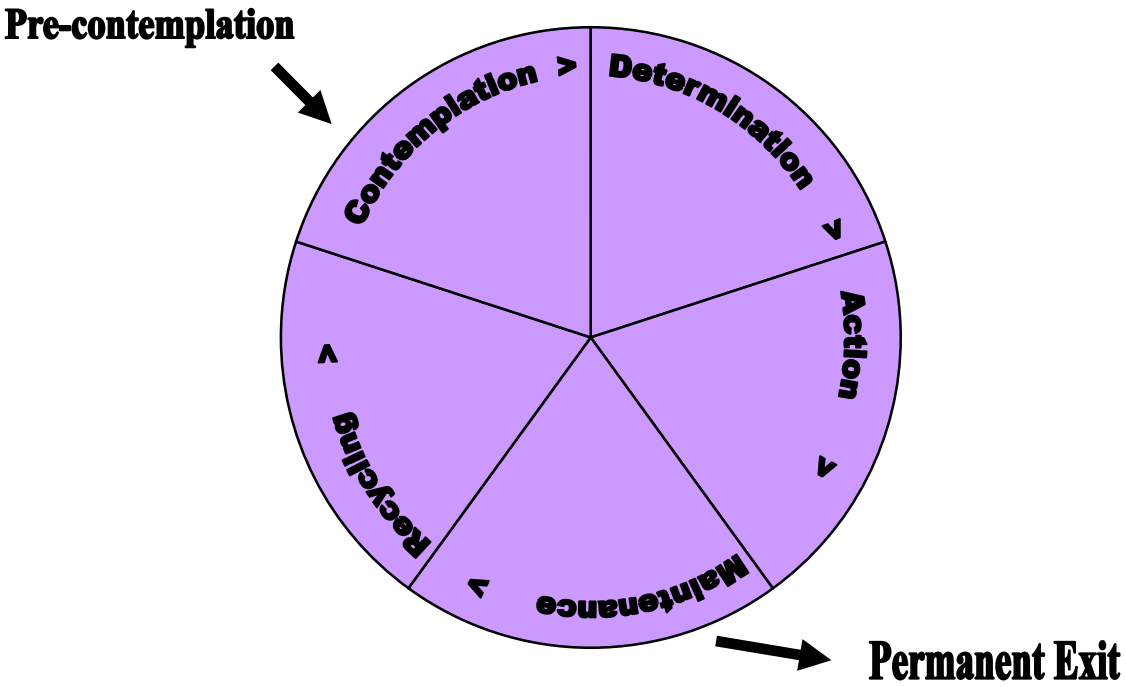
The Six Stages Of Change

Prochaska and DiClemente (Prochaska et alia, 1994; Miller and Rollnick, 1991, p 14-18) found that successful self-changers cycle through a series of six stages. Helping a person in one stage requires an entirely different approach to helping someone at another. The authors describe resistance as a result of applying a change strategy designed for the wrong stage of change (eg treating a person in the contemplation stage as if they should be ready for action). The stages can be diagrammed as below:

Summary of the Model

In the second part of this chapter, we will consider in more depth how to utilise NLP interventions in this sequence that has been shown to work with addiction. We will also discuss how to identify the stage the person is at. Summarising, the effective responses to each stage are:

Pre-contemplation. The person doesn't consider the addiction an issue at this stage. Refuse to collude with the problem, and simply seek permission to give information.
Contemplation. The person seesaws between wanting to change and wanting to use. Explore values and use NLP decision-making processes.
Commitment. The person says they really want to change. Help set goals, and provide tasks for the person, to check out their intention to act.
Action. Once the person is ready to act, elicit and alter their old strategy for using, and integrate the conflicting parts to resolve the problem.
Maintenance. Build a new lifestyle by integrating change at the level of mission, values, and time line; and teaching interpersonal skills, state changing skills, health skills.
Recycling. Futurepace the person through possible future lapses to a life beyond "recovery" to ensure that they can quickly respond to any new challenges.



1. Pre-contemplation.

At this stage the person is not consciously aware of the sequential incongruity that others might consider "an addiction". They do not "own the problem". Useful help at this stage is aimed at creating a situation where help is acceptable. The helper can:

♦ Get permission to provide information and act as a consultant. An effective consultant knows their facts, shares information respectfully, listens to the person's response, and leaves the decision-making to them.

♦ Refuse to cover up the incongruity for the person, while not trying to "convince them" to act on it. The aim is simply to assist the person to become more aware of what is happening. The use of effective communication skills by helpers and people involved with the client is crucial at this time. This includes the ability to send a clear I message (eg "When you arrived home two hours later than you arranged, it meant I ended up missing out on the movie we were going to. I felt really disappointed because I'd been looking forward to going with you.") and being able to respond to the person's reaction with reflective listening (eg "You think I'm over-reacting. You just forgot, and you're sorry about that.") before restating your concern in a new I message. These skills are discussed in considerable depth in our book *Transforming Communication* (Bolstad and Hamblett, 1998).

♦ Find ways to present advantages of changing to the person, rather than simply using away from motivation. Research shows that towards motivation is extremely important in shifting from pre-contemplation to contemplation, while reducing internal conflict is more significant in moving from contemplation to actual commitment (Prochaska et alia, 1994, p 162-171).

2. Contemplation.

This is the stage where the sequential incongruity is most obvious. The person is now engaged in the change process, and oscillates between wanting to change, and wanting to ignore the problem. They may say "Sure, it's a hassle; but I think I can manage it." The helper's goal at this stage is to assist contemplation. It is tempting to try and rush the person through the whole change process, but this is unlikely to be successful. Where incongruity is severe, the person can often present a plausible demonstration of readiness for action over the 30-60 minutes of a consulting session, but still demonstrate complete disinterest in change outside of the session. Particularly where the person has had experience before of confrontive "Recovery" programs, they have often learned to present only the part that wants to change, within your session. To be helpful, the session needs to contact both sides of their ambivalence.

♦ Values elicitation and goal setting help the person to identify what they want to do about the problem.

♦ Explore, without attempting to force a decision, the risks of continuing with the problem behaviour (elicit away from motivation) and reduce the perceived risks of changing.

♦ Have the person themselves state why change would be useful; this can be done by pointing out all the advantages of continued using, and asking why they'd want to change.

♦ At this time the process of Parts Integration can enable the person to access and integrate both sides of their ambivalence about changing (which is a step further back from using the method to actually change!).

3. Commitment.

Every so often, a window of opportunity opens within the contemplation stage, when the person shows evidence of commitment. This evidence might include:
- Stopping presenting reasons why the problem behaviour is "okay".
- Making motivational statements (eg "I need to change this!").

- Discussing what it would be like to have changed.
- Experimenting with change processes, or with stopping the problem behaviour.

The helper can strengthen commitment in a number of ways:

♦ Identifying and utilising the person's usual motivation strategies and metaprograms. Carol Harris offers an excellent assessment and utilisation guide in the context of weight loss (Harris, 1999), dealing with more than ten core NLP metaprograms. She suggests pacing each of these as you design goalsetting and visualisation.

♦ Enabling the person to set goals for change. Solution focused questions are extremely useful (eg "How will you know that this problem is solved?", "When is a time that you noticed this problem wasn't quite as bad?….What was happening at that time? What were you doing different?")

♦ Reframing the problem as changeable, perhaps using some of the information given above in this article.

♦ Negotiating a strategy for changing.

♦ Setting achievable tasks which presuppose commitment. Such tasks could include monitoring the behaviour to identify how often it occurs and when it doesn't occur. The person's response to these tasks allows you to assess whether they are ready for the action stage yet (see Overdurf and Silverthorn, 1995 A, p 29-32).

4. Action.

Once you have evidence that the person is acting, the action stage involves replacing the person's old "problem" strategy with a new one (called "countering" by Prochaska). This can be done on a number of different levels, including:

♦ Elicit the person's strategy/strategies for using the addictive substance (Overdurf and Silverthorn, 1995 A, p 32-34). This is the sequence of thoughts they regularly go through from the time they were not thinking about using, to the actual use. This strategy will involve being triggered by some external event which they see or hear, or by a physical sensation. Often it will involve some sequential incongruity (eg telling themselves they shouldn't use the substance, and then adding to the stress until they feel they have "justified" giving in to their desire to use). Using NLP strategy notation, and taking an example of someone who smokes cigarettes after each meal, the strategy might look something like this:

$V^e \rightarrow V^r \searrow K^i \rightarrow A_d \searrow K^i \rightarrow K^i / K^i \rightarrow A_d \rightarrow K^e$

Trigger	Operation	Polarity Operation	Test (comparison)	Exit (A)	Exit (B)
V^e	$\rightarrow V^r \searrow K^i$	$_P\rightarrow A_d \searrow K^i$	$\rightarrow K^i / K^i$	$\rightarrow A_d$	$\rightarrow K^e$
See meal finished	Remember cigarette and feel enjoyable feeling	Say to self "It's wrong to smoke! This is terrible!" and feel guilty	Compare feeling of guilt to feeling of smoking	Say to self "Damn it! Why should I have to feel bad!"	Smoke cigarette

This strategy can be interrupted at a number of different places, as described below.

♦ Design a visual swish from the Trigger image to an image of a resourceful person who no longer smokes. The power and the risk of this method are demonstrated by a case of a man who came to see us because he smoked while playing the piano. After a visual swish from the image of the piano, he reported that he no longer felt like smoking when he thought of the old trigger. A year later we met him and found that he had never smoked while playing the piano again (he found other places!). It is important to clear all possible triggers.

♦ Directly alter the strategy in some key way, such as having the person smoke a cigarette before the meal, or having them always smoke two cigarettes where they would have smoked one. Anything that disrupts the strategy will tend to work if the person has actually decided to stop. Milton Erickson, acknowledging that an alcoholic needed to be "sincere" before his work would succeed, gives several examples. In one case (Lankton and Lankton, 1986, p26-27) he worked with a man whocame in for treatment for alcoholism. Erickson elicited his strategy for drinking, and found that he would sit at a bar and drink a beer, followed by a whiskey chaser, and repeat this process until drunk., one drink at a time. Erickson told him that next time he went to the bar, he was to order three whiskeys and three beers and to line them up in a row. As he drank each drink, he was to curse Erickson, in prescribed ways (the tamest being "Here's to that damned Doctor Erickson; may he drown in his own spit!"). That was the end of the therapy. The man came back three months later to thank Erickson for curing his addiction. He was unable to drink with these alterations to his strategy.

♦ Provide more useful reframing and metamodeling skills for the person to challenge their auditory responses at either the polarity operation or at the exit. Instead of talking to themselves about how wrong it is to smoke, they might, for example learn to talk to themselves about how good it would be to have healthy lungs; or instead of saying "Why should I have to feel bad?" they might ask themselves "How could I feel even better than I feel when smoking?" Using these skills would lead the strategy in an entirely different direction. Cognitive behavioural therapy focuses most fully on these sort of auditory digital challenges (Lewis, 1994, p 117-146). The Rational Recovery system for changing addictions has the person identify the internal submodalities of the voice with which the addicted "part" speaks (eg when it says, "Damn it, why should I have to feel bad!"). This voice is called the "beast" in Rational Recovery. The person learns to identify that when it says "Why should *I* have to feel bad, it means itself (the part that wants the addiction) rather than the person. This is a technique which further dissociates the person from the addictive part. The only reason for doing this in NLP terms would be to prepare for the next intervention, namely…

♦ Turn the comparison into an integration of the two conflicting parts. Use the NLP parts integration process to integrate the part that feels guilty smoking on the one hand, with the part that enjoys the feeling of smoking on the other. This can also be done linguistically, using Tad James Quantum Linguistic patterns (James 1996, p 58). For example, one NLP Practitioner asked me how she could stop smoking, which she had attempted for some time. I asked her what the intention of the part that smoked was. She said to have her relax. I then said to her "Please listen carefully. Does that part realise that anything less than completely stopping smoking isn't totally getting you the relaxation you want?" She actually couldn't hear what I'd said (because to understand the question requires simultaneous accessing of both the conflicting parts). After I repeated the question several times, she went away none the wiser consciously, and reported some months later that she hadn't smoked since that moment. The structure of what I said is "Anything less than completely stopping [problem behaviour] isn't totally getting you the [higher positive intention of that behaviour] you

want". A third NLP method of resolving the parts conflict is the older Six Step Reframe, described in a 12 Step context by Chelly Sterman (1991).

♦ Use Time Line Therapy™ or Reimprinting to clear the cause of the addiction from the person's time line. John Overdurf and Julie Silverthorn clear three things using this method: the representation of the first use of the substance, the root cause of the addiction, and the unconscious decision to become an addict (1995 B, p 31-32). These may have all occurred at the same moment, or they may be widely spread apart in time. We have had the experience of simply clearing the root cause of addiction and having a person unable to access the craving for cigarettes any further.

5. Maintenance.

Maintaining change requires different skills from making the initial shift. For example, a person could congruently stop drinking alcohol in the NLP Practitioner's office, and then find themselves without any resources to cope with interpersonal conflicts at home. This is why actually teaching communication and conflict resolution skills is such an effective technique for ending addictions. Maintenance involves building a new life without the addictive process. Helpers can:

♦ Teach conflict resolution skills (Bolstad and Hamblett, 1998) including 1) problem ownership, 2) reflective listening, 3) I messages, 4) Win-Win solution finding, and 5) skills for resolving values collisions. Remember that this intervention alone is the most successful change program known for ending addiction.

♦ Release any other harmful emotions and decisions or beliefs from the time line using Time Line Therapy™ or Reimprinting. Albert Ellis points out that the addicted person may have self imposed limitations at several levels of Robert Dilts neurological levels model (Lewis, 1994, p 153). These could include environmental limitations (only having friends who use the problem substance), behavioural and capability limitations (eg not knowing how to respond to the feeling of craving), belief limitations (eg "It's not fair that I can't drink alcohol when I want.") and identity limitations (eg "I am a broken person."). These limiting beliefs can be elicited, cleared from the time line, and/or replaced using any NLP belief change process.

♦ Assist the person to create a new sense of mission for their life, and align values and goals to support this mission. The belief of AA is that this sense of mission needs to involve connecting to a "higher power". In her work, which challenges AA and its twelve step program, Charlotte Davis Kasl (1992) has invited clients to rewrite the twelve steps. However, even her re-writings of the last step seem remarkably similar to the original (which was "Step 12: Having had a spiritual awakening as a result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.").

♦ Teach the person state changing skills such as the use of a relaxation anchor. It is important to check that solving the addiction will actually solve the person's problems. It is quite possible for a person to have anxiety difficulties or depression at the same time as an addiction. In such a case, obviously, using the NLP trauma cure to heal the origin of anxiety may solve the addiction. Remember the 90% of Vietnam veterans who were cured of heroin addiction simply by returning home.

♦ Help the person explore how to keep their body healthy. Feeling healthy is a positive motivator psychologically, and many writers suggest that physical health problems may encourage cravings for unhealthy substances (Kasl, 1992, p 186-211).

♦ Run the person's old strategy for addiction with the new content of health. For instance, in the example above, the smoker's strategy after a meal was to think of how good a cigarette would feel, and then tell themselves off. Then, feeling guilty, they would compare this discomfort with the imagined pleasure of smoking, say "Why not!" and light up. To re-run this strategy healthily, I might say during a trance induction "Sometimes you may find yourself digesting the successes in your life, and imagining achieving an even healthier lifestyle. You can react against that, telling yourself you shouldn't ask too much of life; but when you compare how suffocating those limits feel, you'd probably just say "Damn it; why should I have to feel bad about asking more of life!" and find yourself reaching for the planning diary!"

6. Recycling.

It is unusual in NLP to recommend planning to recycle a change process at a future time. And yet that is exactly what is suggested for addiction treatment by Richard Bandler (Bandler, 1989, Tape 3) and by John Overdurf and Julie Silverthorn (1995 B, p 33) . Futurepacing the person beyond the possibility of a future "lapse" means reframing any time the person "uses" again as part of their long term success. The very concept of a "lapse", Bandler points out, suggests that the person will have not been using for some time. James Prochaska (1994, p 227) simply says "A lapse is not a relapse. If one swallow does not make a summer, one slip does not make a fall." Re-read that last sentence. To futurepace success, you may:

♦ Arrange a followup session some months into the future.

♦ Plan strategies to deal with stressful events, including recontacting you for help.

♦ Design reframes to remind the person that they can easily restart their new life with the strength that comes from their new learnings.

♦ Futurepacing is one thing, but the context of successful change is that when you look back on it, it seems almost silly to have been worried about how to maintain it. The 95% of smokers who give up smoking without any help don't spend the rest of their life in "recovery". They have better things to do. Charlotte Davis Kasl says she prefers the term Discovery for this final state, rather than recovery. She says "Dis-covering suggests opening, expanding and growing."

Summary:

Addiction refers to the existence of profound ambivolence about a behaviour, resulting in sequential incongruity. Most people faced with such a situation will recover on their own. Research shows that successful assistance of someone wanting to end an addiction is very different from the endless, confrontive, labelling approach of the recovery industry. The stages of the Motivational Interviewing model parallel the RESOLVE model for NLP consulting (Bolstad and Hamblett, 1998, p 107-108). In summary these are

Resourceful State For The Practitioner (Pre-contemplation).

The person is not aware of the incongruity.
- Get permission to consult before starting.
- Use clear communication to clarify who has what concerns.
- Present positive advantages of changing.

Establish Rapport (Contemplation).
The person alternates ambivalently between wanting to change and not wanting to change.
- Reflect their experience and ambivalence about change (eg using parts integration)
- Elicit values

SPECIFY Outcome (Commitment).
The person says they really want to change
- Help set goals
- Utilise metaprograms
- Reframe problem as changeable and discuss strategy for change
- Provide tasks for the person to check out their intention.

Open Up The Person's Model of the World (Action; A).
The person is ready to act
- Elicit and alter their old strategy for using.
- Metamodel and Reframe old auditory digital responses

Leading (Action; B).
- Integrate parts
- Time Line Therapy™ or Reimprinting

Verify Change (Maintenance).
The person builds a new lifestyle
- Teach conflict resolution skills
- Integrate change at the level of mission, values, and time line.
- Teach state changing skills, and skills for healthy living.
- Run new content through the old strategies

Exit (Recycling).
- Futurepace the person through possible lapses to discovery and delight.

Resolving Physical Pain: An Example

NLP and Physical Health Issues

NLP as a therapeutic approach is not limited to purely psychological problems. Even in the case of serious physical illnesses with clear genetic components, such as many cancers, there are clear psychological factors at work. For example, two key psychological factors associated with the development of cancer are: 1) loss of a crucial relationship perceived as a "reason for living", and 2) unexpressed hostility. In one study, 72% of cancer patients were identified as having lost a crucial relationship recently as compared to 12% of controls. In the same study, 47% of cancer patients were rated as having unexpressed hostility, as compared to 25% of controls. This enabled a researcher to predict which clients were likely to have cancer with 95% accuracy, simply based on these two variables. The probability that this number of correct predictions would occur by chance was less than one in a thousand. (LeShan, 1984, p 26-27).

Would NLP make a difference in such situations? Short term educational psychotherapy can increase both the percentage of cancer fighting T cells and their activity, by teaching the person how to respond resourcefully (Fawzy et alia, 1990, and 1993). These improvements due to short term therapy continue to intensify up to 6 months after the psychotherapy! Over this century, health professionals in the west rediscovered the incredible power of the mind to heal the body. The first research demonstrating this in relation to cancer treatment was published by Dr Carl and Stephanie Simonton from Dallas Texas, in their book *Getting Well Again* (1978). Working with 159 people considered to have medically incurable cancer (average life expectancy 12 months) the Simontons reported two years later that 14 clients had no evidence of cancer at all, 29 had tumours which were stable or regressing, and almost all had lived well beyond the 12 month "limit" (p 11-12). Essentially, 10% were cured and 20% were curing themselves. The Simontons used a combination of biofeedback, visualisation, exercise, goalsetting, resolving internal conflicts, letting go of resentment, and engaging family support. They explained their success based on psychoneuroimmunology (the way the mind affects the nervous system which in turn affects the immune system).

On the other hand, longer term, problem focused psychotherapy may have a negative effect on survival in such cases. Psychologist Dr Hans Eysenck has warned of the dangers of traditional psychotherapy for some time. He describes a longitudinal study of 7000 inhabitants of Heidelberg, from 1973 to 1986. This study was designed to discover the health effects of psychotherapy. Clients in psychotherapy were able to be matched by age, sex, type and amount of smoking etc with controls. This study showed that cancer and heart disease were most prevalent in the group who had had two years or more of "therapy", less frequent in the group who had one year or more in "therapy", and least frequent in the group who had no "therapy" (Eysenck, 1992). Talking about what's wrong with life once a week for years is not healthy.

There are dozens of anecdotal NLP studies of cancer cure. New Zealand NLP Master Practitioner Anthony Wightman (1999, p 42) describes his successful treatment of skin cancer and of leukaemia with skills developed during his NLP Practitioner training. He imagined a laser burning out the cancer cells, and filled his body with "a golden glow which imbued all cells with health and removed any unhealthy cells". He ran an imaginary hot iron over the inside of the vein next to the skin cancer to stop any spread and bleeding when it dropped out (which it actually did a week after he began visualising). Before treating his skin

cancer, he had it diagnosed by 3 separate doctors, all of whom claimed after his cure that they must have misdiagnosed a solar keratosis. His haematologist had a somewhat more difficult job explaining the change in his leukaemia. Anthony says "I believe we are only scratching the surface of our own capabilities and that the most promising area for research lies within our own minds, our own hearts, our own souls."

Creating "Placebo" Effects

In other major causes of mortality and morbidity, such as heart disease, NLP interventions are also important. The evidence suggests that the mind is at least as powerful as surgery itself in predicting heart surgery outcomes. In 1958, a study was done to evaluate the effectiveness of a new surgical treatment for heart disease (Cobb et alia, 1959; Diamond et alia, 1958; also reported in McDermott and O'Connor, 1996, p 75-76). The surgery has since been shown to be completely useless, but the effect for the patients in the study was wonderful. The patients were all told that their surgery would probably help, and indeed ten of the seventeen patients in the study reported great improvement. Their use of heart medication dropped to 1/3 over the next weeks. What is most interesting is that only eight of these patients had actually been given the surgery. Nine of them simply had a skin incision made and sutured up again. Of those nine, five reported they felt much better, and reduced their medication to 1/3. When doctors expressed disbelief, another surgery team replicated the study, with even better results. But the healing effect of surgery is dependent on how it is presented by the surgeon and other health practitioners. Psychologist Henry Bennett has collected several hundred studies showing that preparing patients psychologically before surgery will markedly alter the surgical and post-surgical results. Simple changes in what the doctor says will reduce need for pain medication, reduce blood loss, and result in fewer medical complications.

Consider an example. At the Department of Anesthesiology at the University of California, Bennett himself conducted a study on patients admitted for spinal surgery (Bennett, Bensen and Kuiken, 1986). Each patient received a 15 minute preoperative talk with a health practitioner from the centre. There were three subgroups. Group A received basic information about the procedure they were to go through. Group B received a brief training in how to relax their muscles before and after surgery. Group C were given an NLP style intervention. The health professional pointed out that everyone has experienced blushing as a result of a few words said by someone else, so we know that the mind can cause blood to shift around in the body. They then explained that it would help if the person's blood moved away from the spine during surgery (to prevent blood loss), and then moved back afterwards (to promote healing). They then slowed down their voice and said, "Therefore, the blood will move away from the spinal cord during the operation. Then, after the operation, it will return to that area to bring nutrients to heal your body quickly and completely." The result of this simple conversation was dramatic. Patients in Group A and Group B lost, on average 900 cc's of blood, which is the normal level of blood loss over the course of this operation. Patients in Group C lost an average of 500 cc's of blood during the operation –only half as much.

There are two key principles to apply in working with health conditions using NLP. Firstly, focus attention on all neurological levels, from spirit to environment. Dr Brendan O'Regan is a neurochemist who has collected a database of 3,500 medically documented cases of spontaneous remission of cancer. Dr Charles Weinstock leads the New York Psychosomatic Study group, and has commented on these cases that "Within a short period before the remission, ranging from days to a few months, there was an important change, such as a marriage, an ordination, the birth of a grandchild, or removal of a relationship that was

unwanted. There was a psychosocial rehabilitation of one sort or another, and then the cancer was healed." (Weinstock, 1997). Using parts integration, time line work and interpersonal interventions is important for such change to be duplicated by our NLP sessions.

The other principle of such work is to utilise physical movement and expression. The person who has a physical health issue is demonstrating skill in expressing their internal state physiologically. To match that, it is appropriate to use physical interventions such as Thought Field Therapy and chi kung (a type of moving meditation developed in China). To date, the most dramatic clinical results of chi kung are reported by the Huaxia Zhineng Qigong Clinic and Training Centre near Qinhuangdao, China. I visited this centre in 1998. Founded by western trained physician Dr Pang Ming, at that time it had over 600 staff, including 26 western trained doctors, and treated 4000-7000 people at any given time. Residents (called students because they are learning to use chi kung, rather than simply being "treated") were checked medically after each 24 day treatment period. Most of the people treated had been told that there was no orthodox treatment available for their condition. Most of them had inoperable cancers. Results at the Centre are classified as:

1) Cured (no symptoms of illness, and no signs on EKG, ultrasound, X-ray, CT etc)
2) Very Effective (almost no symptoms, and dramatic improvement on instruments)
3) Effective (detectable improvements)
4) Ineffective (no change or even worsening symptoms)

In the centre's first published results, (Huaxia Zhineng Centre, 1991; Chan, 1999, p vii) data on 7,936 students showed that 15.2% were cured, 37.68% very effective, and 42.09% effective. That is to say, after a month, 52% were cured or almost cured, and overall 95% had experienced some benefits. While the centre is using many NLP-style techniques (such as metaphor, trancework and reframing) clearly the physical movement involved in the chi kung exercises makes a significant contribution to their success.

Pain Relief and Hypnosis

There can be few tasks more satisfying than watching a person who has suffered physical pain for months or even years, as they suddenly discover how to create total inner comfort.

It's no surprise that we can learn a lot about pain relief from Neuro Linguistic Programming itself. NLP's origins lie partially in the hypnotherapeutic work of Milton H. Erickson, whose ability to alleviate pain was studied by Richard Bandler and John Grinder in one of NLP's first books (1975, p 26-50). As early as 1850, the English surgeon James Esdaile (1957) demonstrated that hypnosis could remove the acute pain of major surgery, reliably delivering an effectiveness comparable to chemical anesthesia. There have been plenty of experimental studies showing how and to what degree artificially induced pain can be relieved by hypnosis, but it is now well established that the *clinical* results of the method far exceed the experimental ones (Hilgard and Hilgard, 1994). Put simply, it's a lot easier to stop the pain of a person about to be cut up in real-life surgery, than it is to stop the pain you have experimentally induced by asking a volunteer to plunge their hand into ice-water for a few minutes.

This fact alone tells us something extremely important about pain relief by "hypnosis". It works best when the person really *needs* it to work. The technique of hypnosis is not a drug which will work regardless of the person's attitude. It is a technique for *utilizing* the person's attitude. In fact, pain, as we will show in both research and case studies, is heavily

determined by a person's attitude. This is why hypnotherapist Joseph Barber recommends (1996, p 20-21) that hypnotherapy for pain relief should only be used when:

1) The client will not take advantage of the hypnotic situation to injure themselves further (eg by avoiding needed medical assessment and treatment; obviously, someone with longstanding pain would benefit from having the physical causes checked out carefully *before* you remove their discomfort).
2) The client will not lose other benefits of being a pain-sufferer (eg financial compensation from legal action; these benefits are often called "secondary gain").
3) The client can manage the personal interaction involved in talking with a hypnotherapist.
4) The client is willing to take responsibility for initiating their own treatment.

Pain and the Brain

The research on pain itself is intriguing because pain is not the phenomenon most people think it is… or to put it another way; pain very much IS what people think it is. Let us explain….

The skin, muscles, bones and other tissues have nerve cells with endings specialized to respond only to stimuli strong enough to cause tissue damage. These endings are called nociceptors and they become more sensitive with continued stimulation (unlike most nerve endings, which become less sensitive over time of stimulation). Damaged tissues release chemicals such as prostaglandins, which make nociceptors more sensitive, and drugs such as aspirin inhibit prostaglandin production. When nerve cells themselves are damaged, nociceptors may misfire repeatedly, producing longer term (chronic) pain which no longer gives the brain useful information about a current injury or danger.

The messages from nociceptors are passed through their nerve cells into the spinal cord, where other specialized nerve cells act as switches, deciding whether the messages have priority enough to be sent to the brain. More urgent danger ups the priority of a pain message; but pain that accompanies safe and pleasant experiences may be classified as irrelevant and never reach the brain. Natural body chemicals called endorphins (released during exercise, massage or other positive experiences such as sexual activity) switch the pain off in these cases, and opiates such as morphine mimic the action of these endorphins. What this spinal gating process means is that a person who is happy for other reasons may feel no pain at all from stimuli that are apparently quite painful. These stimuli may not even get near the brain!

If the messages pass the spinal gating systems, they are transmitted to the thalamus in the brain and from there into the limbic system, where the person responds to them emotionally. A baby who bangs her or his head may feel extreme pain while alone, but relax and stop crying when held by a known caregiver. Such emotional contexts either enhance or reduce the pain signals long before they reach the cerebral cortex and are registered consciously. In the case of a baby being "comforted" after banging its head, the pain stimuli may be felt, but felt in such a context that they are not considered significant.

Pain which persists or recurs for over six months is called chronic pain. Chronic pain seems to alter the processing in the brain, so that there is abnormal activity in the nociceptors in the somatosensory cortex (the area of the brain that finally registers what kinesthetic sensations you believe occurred in what part of the body). When the brain is scanned using PET

(positron emission tomography) this abnormality is clear. Studies by Pierre Rainville, Catherine Bushnell and Gary Duncan (2001) show that hypnotic suggestions can increase or decrease this abnormal activity in chronic pain, and hence alter the pain experience. Other more recent studies, using fMRI scans (functional magnetic resonance imaging) show that the mere expectation of pain produces 40% of the response produced by "real" pain in the pain receptors in the cortex of the brain (Porro et alia 2002). Researchers Dennis Turk and Akiko Okifuji explain results of several studies showing that "In chronic pain, pain-related anxiety and fear may actually accentuate the pain experience…. When people with pain symptoms are exposed to a feared situation (eg walking up a flight of stairs), some experience a cascade of avoidance responses…. Fearful patients appear to attend more to signals of threat and to be less able to ignore pain-related information." (Turk and Okifuji, 2002, p 679-680).

In summary, "pain" as we know it is at largely a result of our thinking about it. Milton Erickson says "Pain is a complex, a construct, composed of past remembered pain, of present pain experience, and of anticipated pain of the future…. The immediate stimuli are only a central third of the entire experience. Nothing so much intensifies pain as the fear that it will be there on the morrow….Conversely, the realization that the present pain is a single event which will come definitely to a pleasant ending serves greatly to diminish pain. " (Erickson, 1980, Vol 4, p 238).

In the light of all this, here following is a case study of the use of the RESOLVE model in healing. I am working in this session with Janet, who has suffered severe chronic pain for nearly a year, at the time of our one session. Janet is quite sceptical of the chances fo solving this and this gives a good opportunity to understand the importance of the full RESOLVE model. The session is also available on videotape and DVD.

Example Session: Increasing Comfort

Transcript of NLP Session	Meta-comments by Richard
Resourceful State	
Richard: Okay, so you've got a couple of things that you wanted to change Janet. You've got the issue of some pain that you've had first of all, that may be quite simple to change,	We had two main issues to work on and one hour, so I begin by implying that the pain may be the simplest issue.
Janet: Oh great.	
Richard: ..but you've had that for some months.	
Establish Rapport	
Janet: Yes, yes I have.	I'm apparently asking questions to gather a case history, but actually just wanting to convey the sense that I can understand that this has been difficult and build rapport. I'm also doing this non-verbally by breathing in time with her etc. I'm relieved that she knows that the pain comes and goes. If she said it was always at 100%, I'd consider that an indication of her need to prove it was bad overriding her real life experience.
Richard: And is that something that is continuously there or does that change?	
Janet: It does change, however, I'm on codeine....	
Richard: Right, right.	
Janet: ...so the codeine allows me to function normally, and if I don't have that, then I find myself getting a bit irritable.	
Richard: Right, it's almost like when you don't have that it's at the back of your mind all the time – that discomfort. And so does it sort of come and go during the day? Like, when is it less obvious?	
Janet: Well, it's sort of less obvious when I'm drugged.	
Richard: Right. Is there any other time it's less obvious? When you wake up in the morning is it...?	
Janet: No, because the drugs seem to even the whole mood thing out with relation to the pain. I know that it's more extreme in the morning before I've taken my pills and if I don't sort of take them at 2 o'clock and leave it until 3, 4 or 5 o'clock, then my mood tends to...	
Richard: Got it.	
Janet: Yeah, okay, so it's more the discomfort comes on and it affects how I interact.	

Specify Outcome

Richard: Yeah okay. So your aim with that would be to have that completely go away. I mean that would be ideal wouldn't it? Or ah, certainly like obviously pain is a way that your body lets you know that something is happening, so you don't want to have no pain at all in your life, I guess, but you want to be able to know in a more comfortable way and not continuously through your life. You just want to know if something has changed or ....

It may seem obvious that her aim is to be pain free, but I want to check in more detail. Actually, our aim is not to take away all pain; just to remove one type of pain.

Janet: It's just this particular pain which is the result of surgery and scar tissue basically.

Richard: Right. So ideally then you would not notice that at all, or you'd have some way of making it go away each day.

Janet: Yeah exactly, so that I'd function basically normally without codeine.

Richard: Yeah. That would be an advantage then; not to have to have that codeine to do that and that would mean that I guess you'd feel more in charge of yourself then.

I check this outcome in these words at the follow-up two weeks later (see below).

Janet: Yeah totally.

Richard: Yeah, okay. I suppose I'm wondering as you describe that; it's come from something that has happened with surgery. That means that probably you've talked to a doctor about the pain. What kind of things have they said to you about it?

Janet: I've had some really interesting communication with different doctors who are really good at communicating and others who aren't and the worst experience was when one doctor said "Well, it sounds like it's neuropathic pain. You'll probably have it for the rest of your life so you'd better live with it." You're just going to have to learn to live with it, and that was horrible. Not nice.

Richard: That was shattering almost.

Just building rapport, ready to rechallenge this belief soon.

Janet: It was shattering, so I thought well thanks doc. You've showed me the bottom of the swimming pool and now I can push myself my way out. But I didn't. That's really affected the whole thing. And when I got my MRI results back, my cancer was all gone, but they said there's a lot of scar tissue from the radiation and the surgery showing and that news – that I would have this pain maybe forever you know, it overshadowed the fact that my MRI was clear from cancer.

Richard: Right. Like great, I'm alive for a long time and putting

up with that, was the sort of thing.

Janet: Yeah, so that's the impact that it's had on me.

Richard: Right. So when you heard that, that's what it seemed to mean, or that's what they told you it meant, that there was this large area of scar tissue there implied that it would be there forever.

Checking how she took that particular meaning out of finding the scar tissue was there.

Janet: They implied that that was the cause of the pain. They didn't sort of imply to the degree that the length of time that it would be there, but other doctors and people I'd spoken to had told me stories about people who have had this pain for a long time and others who had woken up after six years and it was gone. Which was wonderful but, 6 years?

She notices that even if scar tissue might have "caused" the pain, it could still go quickly, so

Richard: That seems silly doesn't it because if they could wake up after 6 years and have it gone, why couldn't they wake up next week and have it gone.

I'm actually already beginning to encourage her to open up her model of how the pain happens.

Janet: Yes, yes.

Richard: What do you think about that, that someone could wake up one day and have it gone?

She has given me her own version of the "miracle question" in Solution Focused Therapy: ie "What would it be like if a miracle happened and you were totally cured?"

Janet: Well, I think that sort of would be quite miraculous.

Richard: Yeah. Would you believe that! That those stories that they told you that people could wake up and it could be gone?

Janet: Well, I wanted to believe them, I wanted to believe them.

Richard: That means you wanted to but it was hard to with all the other stuff you'd heard.

Janet: Yeah. It was you know, I like to have knowledge about, I like to understand what's happening, and I guess my understanding gets me in trouble sometimes when if I didn't understand about it, I'd just accept that it could just go like that did, then it might just go like that and maybe my knowledge helps me to hold onto it a bit longer. I don't know.

Richard: Well ah see, one of the interesting things is which information people collect, who are health professionals. I mean, you know, I'm trained as a nurse, and one of the NLP trainers who works with me, Bryan Royds, his partner Susi is a GP so she's a doctor, and it was her who first explained to me this thing about lower back pain and she pointed out that in the research what they've found is that when people have lower back pain, they actually, by paying attention to it over some years, somehow

Rather than just say that I believe this I decided to raise my level of perceived "authority" by quoting my source.

that seems to instruct their body to grow new connections into that area with pain receptors on them, so that the pain actually gets more easy for them to notice. And she was pointing out that what that means is that there's a constant to-ing and fro-ing around the body and your body is deciding whether you want information from a particular place or not and making that decision it then supplies receptors there or removes them and so that's an important thing and one thing I guess it's part of is a whole new understanding that's developing about how the body deals with itself because you know, when a doctor talks to you and says "Well this is the way your body is so that's the way it will stay," it's almost sometimes, it seems to me, like what they might be saying is if we go in there and do something, things will change, but if we don't do anything that will stay the same. And it doesn't make any sense does it because I mean you know, it's your body. It's done so many things for you. Whenever you've cut your hand, it's healed up. You know you've had influenza so many times, and it's totally resolved the issue for you, cleansed your body completely, and you've had situations before of course, where you've had pain and your body has dealt with it in a different way to what they're telling you. Like you've even had situations where you've cut yourself and not noticed it until you got into a situation where you've had time to look at it and then realised "Oh wow, I've cut myself." And then it hurts. And it's intriguing to think "Why didn't it hurt until you noticed it there?" you know? And that's what they're saying. Not that your body is doing anything wrong. I mean it's trying to do the very best it knows how to do when it does that. Of course when it gets your attention by, I mean that's the whole point of pain isn't it? It's to get your attention. And so your body thinks it's doing a job by doing that. I wouldn't want to discourage it from making sure it has your attention when it needs to. It's just that this time it could actually completely let go of your attention from that area while it heals the scar tissue. You know that's another important thing isn't it, that scars of course can heal and in fact that that's something that does actually happen and that that's something that's part of your experience as well because you've had cuts on your hand and when you look at it as they heal that there's a little scarring there and your body removes that in a small way. And you expect that to happen in a small way of course with your hand, but because a doctor is the first person…. I mean you've never had this kind of surgery before.

I'm already doing quite a bit of pre-framing my change technique; explaining that the body can change and that she has reference experiences of that in her memories.

I want her to feel on-side with her body, to let go of any idea that her body has "harmed" her intentionally. One specific mechanism for change is suggested (her body could dissolve the scars). I then simultaneously say that her old views are not her fault (as she's in a new situation) and tell her she doesn't really know what is possible here yet. She agrees.

Janet: No I haven't.

Richard: So you've got nothing to compare it to so when you go to see the doctor it's easy to understand why you'd think "Well, she or he is probably an expert and probably knows." And it's quite interesting to realise that the main contact that surgeons in particular have with that kind of scarring is in the recovery period

soon after surgery, and they don't necessarily know what things happen afterwards or what things are possible in this fuller detail. But certainly one of the nice things would be if you could have a belief that this could change in that way. Because although we may have some way of affecting this, if you are going to allow it to happen, you can see that that thing that my friend Susi Kent is saying is really that your attention to something, the way you focus your mind on something, has something to do with whether your body heals in a certain way or another way.

Janet: Or whether that pain stays or goes.

Richard: Yeah. What that means is that your belief that it can go is the number one thing that's needed in order for it to go. Because if someone had the belief that it was going to stay there then it's almost like that was an instruction to their body. And an accidental instruction because I'm sure none of those doctors really intended to cause anything other than comfort when they – they just didn't know how it all works in there.

With this preframe she has now agreed that her mind is in charge of her body.

Janet: I think too that I visualise it, the scar tissue softening or something and the nerves all going through it as opposed to being blocked and sending back negative messages. I guess if I believe that if it's softening even now, then it's a very quick process. I presume possibilities.

Richard: Yeah, you know, you can probably experiment with it now, I mean the way that your attention makes a difference to it. Like for example I guess you can feel something in that area right now. Can you?

Janet: Yeah. I feel a bit umm..

Richard: Right. Now if you put your attention there. If you pay attention to that area like say we rate that at 100% now, the way that the discomfort feels now, then probably if you put your attention there, you could increase it by 10%.

I want her to test this belief as soon as possible. She demonstrates the mind-body connection and then explains that in her belief system this only influences the pain one way.

Janet: Yep.

Richard: That's pretty good. Just like that.

Janet: Just like that. (laughs)

Richard: That was interesting wasn't it? Because of course that means that you could now decrease it by 20 and reduce it to 90.

Janet: Mmmm. Harder to do that. Not as easy to go down.

Richard: Right. So it seems like it's easier to increase it?

Janet: Yes. Because for me attention focuses, but it's always an increase.

Richard: Right. So you expect that you would be able to increase it with your attention.

Janet: Mmm.

Richard: Right. How would it ever get back to normal then? To the way it was when it was 100?

Janet: Well, when I'm not paying attention to it.

Richard: Oh, okay. So you're saying the way that we could solve this would be if we could shift your attention so that your attention doesn't go to that area, then we'd be able to reduce it down to...

Janet: Yes, and I've worked on premises like that, with mindful meditation and I can't quite get the link between meditating and doing it, and actually interacting with the world and doing it.

Richard: Yeah, I see. So it's one thing to be able to do it when you're sitting still and having your attention under your control basically, but it's another thing when there's any number of other events happening around you.

Janet: Mmm. And I think it has, even in the short time that I've had it, in the 10 months that I've had it, it has served a useful purpose, you know.

Janet raises the issue of ecology, or secondary gain. Checking this is an important part of setting a well-formed outcome.

Richard: And what would that be?

Janet: Well, if people are ill then people know that they're ill you know; lots of people find out and ring up, ask how I am, how treatment is going and yeah, I've realised that it's quite nice to have that and all that sort of thing.

Richard: Right, so you have a background where you understand that idea of secondary gain?

Janet: Yes, yes.

Richard: Yeah, so it's kind of like you want some other way of having people, making sure that people contact you and stuff like that.

Janet: And that's fine, I mean you know. As you say, because of my background, I'm aware of secondary gain.

Richard: Yeah.

Janet: And I'm okay if I don't, I think I'm okay if I don't have it.

Richard: Yeah. You could let this go, phew, okay that's good. So you understand that whole idea and you understand like are there any places that it's important to have it? Do you need it to be able to talk to your doctor? It doesn't matter. It'd be okay to say to your doctor "It's gone. I was one of those people who woke up and it was gone."

I'm continuing to check out the ecology of this outcome, and then getting her to use an as-if frame to imagine what will happen when she has already changed.

Janet: That's why it didn't take me 6 years.

Richard: That's right. And then you'd make sure they tell the next person. Actually we had a woman and she came in and it was a few months!

Janet continues to future-pace the effect of her having changed.

Janet: Yeah, and I would actually include it in my thesis, and explain to them what damage they can do depending upon the type of personality they're dealing with.

Richard: Yeah. Yeah. It's interesting isn't it?

Janet: Mmm. It is interesting.

Open up model of the world

Richard: So you've done a bit of relaxation and meditation before and you've had the experience of being in a state that you'd call a trance like state?

I'm planning to use a trance technique and I am now introducing this technique. While I check her understanding of trance, I'm also beginning a trance induction.

Janet: Yes, I've....the last few days I've noticed that.

Richard: Oh good, okay okay. So when you're in a trance like state; can I ask you know, if you're in a trance like state, what happens to the discomfort then? Or you haven't noticed?

Janet: I have noticed that at times when – I guess when I'm focused on something else then it does so therefore if I'm focused on – if I'm dissociating and meditating then I'm dissociated from that, then that sensation can go with any other sensation I choose to.

To answer my question, she needs to re-access the trance experience.

Richard: Yeah. 'Cause I've had that experience too of having a splitting headache and sitting down at my computer and writing an article that I'm just totally fascinated with, and then stopping, after ¼ of an hour and suddenly realising "What happened – you – know – man that's really....."

Janet: And then the headache comes back when you stop.

Richard: It did actually, yeah. It did because I thought ah – you know- wow it was here! And then I checked for it you know, and I guess I looked for it again, and yeah, that's right. So that's an understanding we share about your brain and how it can do things. You know about trance then, so do you know about trance phenomena like arm catalepsy? Have you ever heard of it?

Janet: I've seen it on some of the videos we've been watching on Erickson's ones. Is that what you're talking about?

Richard: Oh yeah. Can I borrow your arm for a minute and show you that. Now of course (lifts up her left arm) I guess.....

Richard: So now ah, you can hold your hand there consciously right?

Janet: Yeah.

Richard: And this means, I guess..... do you know how many muscles there are between your brain and the hand there that's being held there? (lets go of hand)

Janet: No.

Richard: There's I mean – there's well over 100. There may be a couple of 100. But I guess the thing is, what that means if you don't know exactly where they are, then you don't know exactly how you're holding that up?

Janet: No.

Richard: And that means that your unconscious mind is holding that up, right? You decided to hold it up but it's your unconscious mind that is holding it up there. I guess that's why it's rising a little higher each time I move like this now (gestures up) – is that right? Because that would mean now that only your unconscious mind could hold it there. Now of course – do you notice that now?

(Shakes head) (arm rising)

Richard: Not yet. There it goes. That's right. Can you see that? It's a kind of a... it's a curious thing.

Janet: Well, Richard, I'm not sure if it's doing anything.

Richard: No, well, this is your hand is it.....here?

Before doing the change technique, I want to ensure that Janet has a more powerful experience of how her unconscious mind can run her body. I already know from the last test (of raising and then lowering the pain level) that she has doubts about this. These doubts are evidenced now as her hand begins to float up in the air without her conscious control. Like many more sceptical people placed in this situation, Janet's conscious mind alters the sensory data and she fails to "see" what is very obvious on the camera: that her arm is moving whichever way I point. This is a wonderful example of the power of beliefs to alter our perception of what is happening.

Janet: Well I think so.

Richard: Yeah. That's good, that's right.

Janet: I don't actually have a reference point for where it was when it started, but it seems to be rising, yeah.

Richard: It does, doesn't it? Yeah. Now of course it's hard to believe and obviously you don't have to believe in it, you know like, I mean, it doesn't make sense that it should be floating there on its own does it?

Janet: Not really.

Richard: No, and so someone must be lifting it up right, and it's not me because it's not my hand, it's yours, right? Now, that means of course that your unconscious mind is lifting it up right and what that means is that there's an area of your brain that's running this arm right now and it's not under your conscious control and yet it can happen and it can happen instantly – it can happen right in front of you like this, okay. Are you sure consciously that it'' lifted up by itself there?

Janet: Yeah.

Richard: You're positive about that?

Janet: I'm not sure that it's moving at the moment.

Richard: But it has definitely lifted up.

Janet: It has definitely lifted up.

Richard: Isn't that strange. Do you think it's going down now? (gestures down)

Janet: No. What would happen if I consciously tried to stop it going down?

Richard: Oh, you could stop it but it may be going down: Look.

Janet: Yeah, it's going down.

Richard: It is, okay. Do you think it's going across to this side right now? (gestures to her right, arm moves)

Janet: It's quite funny isn't it?

Richard: That's right it is. It's quite good at this really isn't it?

Once again, I want to make it clear that neither Janet's conscious mind nor some magician from outside her is going to achieve this change. An area of her brain that is fully out of her awareness will take charge of the change, provided she can "allow" that to happen. She continues to doubt the evidence that this is so, or that this change can be trusted to continue. Janet asks if she can over-ride the unconscious movement, and I reassure her that she can. She can then begin to relax and enjoy the experience more. I'm helping her learn all this here *before* we do the actual change process.

Janet: It is, yeah. I think it's getting better actually.

Richard: That's exactly right. That's the important point I wanted to make. At first your conscious mind was trying to control it, and you thought that you had to consciously control it or nothing would happen there, you see, and so what happened then was that your unconscious mind found it a little difficult at first to move it, but now your unconscious mind is learning to do it, and your conscious mind is learning, and that's even more important: to let it go. Now this is exactly what we need to happen. Because if your conscious mind can let go, and can allow things to change in your body at an unconscious level in just this way, then you could make a complete change with the sensation that you've had problems with. Do you understand that?

I now explain this learning process to Janet. Once I have her agreement that this is happening, I build on that agreement by pointing out all the possible implications of what she has agreed to, with regard to her healing. In essence I say "You've just done something much more challenging that the actual change technique, so you can know for sure that this next technique will work." Earlier, she told me her belief that all attention would increase pain. I now tell her that a certain kind of attention can stop pain.

Janet: Mmm. Mmm.

Richard: Your conscious mind, like, this is not just a sensation we're changing here, this is the entire muscle movement. And you see, that's right, there are many, many muscles we're changing the movement of here, and in order to do that, that means you had to .....and you weren't even noticing that happening at first, so there was all sorts of pressure at first that you usually feel in that arm that you weren't noticing they were happening at first because your unconscious was running them; and when you think about that, you realise that this is actually a more complicated task than you were hoping to have achieved here. Doing this is very sophisticated. You had to stop feeling the things in that arm, in order for this to happen, you had to stop moving the things yourself and allow your body to move things, and that's not just muscles but tendons and things as well, you know, and this is very much the kind of thing that you want like that, rather than the muscles tightening around a scar tissue, then, for them to relax, and allow something to be comfortable. And this is exactly what you've done in this arm here. Now it's much easier for me to demonstrate with this arm rather than lift up something that's more central in your body.....and you can understand how you can do this. And it's not just you that I want to show this to – it's your unconscious mind..... and I want to show your unconscious mind, that's right, now you the unconscious mind, who's running this hand, have complete ability to make these kinds of changes anywhere in the body – and you can listen while I talk to you as an unconscious mind – but what I want you the unconscious mind to understand is that you, I know, have been doing some really useful things for Janet and I know that letting her know when there's discomfort was something that you thought was important, but what I'd like you to understand is that the discomfort that she's been having each day for some time now is something that she could let go of, and

Now I'm talking directly to her unconscious mind and she is in the odd position of listening to a communication with part of herself that she has just found out

enjoy something else instead. And that you the unconscious mind have the ability to do that. Now if you the unconscious mind are listening to what I'm saying and you understand that I'd like you to give Janet a little twinge in that area where she's been feeling that discomfort, and let her know. You don't get that yet?

she does not control. That increases the sense of conscious-unconscious separation.

Janet: A little twinge. It wasn't a big one though.

Richard: That's right. Okay, well I'd better ask for....

I may sound pedantic, keeping asking for her agreement here. Janet is still not giving a congruent agreement that she is ready to believe that this can happen, which (as I told her) is the necessary pre-requisite for her changing. I almost threaten her with more and more demonstrations if she doesn't agree.

Janet: My arm's really sore at the time.

Richard: Would you like to put that down. You believe in that, now? (puts hand down)

Janet: Yeah, yeah.

Richard: Sort of?

Janet: Sort of.

Richard: Yeah. I mean you believe that the arm went up.

Janet: Yes, yes.

Leading

Richard: Okay, well that's all we need to do because, as you put that arm down there now, what that means is, it's a lot easier to lift a finger than to lift an arm, right? And now that we've got your arm moving, what I'd like to do is, I'd like to get this finger here to move.

Janet: Okay. Go for gold.

Richard: That's right. Now, that's right. Just like that. That's right, thanks. (index finger moves up)

(laughs)

Richard: This is fun isn't it?

Janet: Yeah. It is fun.

Richard: Yeah, and so, and see this finger here, that: what I'm going to use that finger for – that movement – is I'm going to use that as a signal for "yes", right, and I'm going to ask one of these other fingers here to move as a signal for "no". And your unconscious mind can choose which finger it is, and move that finger as a signal for "no". One of the other fingers on that hand.

'Cause this one is "yes", and one of these other fingers can be a signal for "no" and you can jerk that up in that nice (other finger moves).....that's right, thanks. You didn't do that did you?

Janet: No, I don't think I did.

Richard: No, that's right. So we have a yes and a no. This is the basis of communication of course. So I'd like you, the unconscious mind: I'd like to ask you some questions and the first question is "Do you understand that you have the ability – I mean you the unconscious mind – do you understand that you have the ability to remove that pain each day so that Janet feels comfortable? Do you understand that you have the ability? And just jerk one of those fingers up to let me know yes or no ("no" finger moves)..... No you don't. Okay, that's great. Well, what I'd like you to consider, unconsciously, - this is fun isn't it – what I'd like you to consider unconsciously is the way in which Janet has had those experiences where she hasn't noticed pain, in certain areas of her body like when she had a cut, until she looked at it. Do you remember those times? Do you remember those times when she has had those experiences where she hasn't noticed pain until she looked at it? And jerk one of these fingers as a nice clear signal: Do you remember that? That's right. Take the time you need to remember and just let me know. Do you, the unconscious mind remember? That's right, a nice clear signal. Move one of those fingers, either the "yes" finger or the "no" finger. ("no" finger moves) Okay. So you don't remember those times. Do you know that Janet remembers those times? You do. Move that finger in a nice clear signal. Do you realise that Janet remembers times when she has not felt pain until she's actually noticed visually that something has happened? Do you realise that Janet has had that experience? That's right. Move that finger in a really clear signal ("yes" finger moves). Great, that's right you do realise that. And that means that you the unconscious mind can realise that. You, the unconscious mind can realise that whether Janet feels pain or not is as much a process of how the information is being explored, where it's being channelled, how it's being represented to her, is much more in fact a result of those things than it is a result of specific things that happened at a particular place in the body. Do you understand that now? Now that you consider those examples, do you understand that you can process feelings in different ways? So that Janet feels comfort where she used to feel pain. Is that something you realise? That's right. And make an even clearer signal. That's great. Even more. Enough so that, that's right. ("yes" finger moves) Do you feel that one now?

Janet: Yeah.

Richard: I thought, I mean, I know your unconscious knows this

Now, finally, we have begun the official "change process". Notice that over half the session was spent preparing for this. I'm still checking at each step that she is aware that the trance phenomena that she experiences are not run by her conscious mind.

I assume that Janet's unconscious mind has been listening to her conscious belief system and has bought into some doubts about its own ability – doubts that simply do not fit with the known facts. I simply explain that to it.

I'm still checking every step forward with her conscious mind, and I explain this now.

now. I just wanted you to know that you know, you know?

Janet: Yeah.

Richard: So what that means is that it's possible for you to do this. (finger moves) That's right, thank you.

Janet: It's catching on.

Janet notices that her unconscious responses have become more clear and more aligned with her own outcome.

Richard: Yeah, that's right. And so what I'd like you to do now is I'd like you to check "Is is okay for you to do this?" Is it okay, and you understand secondary gain, right, so you know?.....("yes" finger moves). Okay, so it's okay for you to do this. Got the idea here? Okay. Now what that means of course is that right now you could make an adjustment in the level of comfort that Janet has. Is that right? ("yes" finger moves). Yeah. It is. And <u>you</u> know that as well. And this may come as a surprise to Janet, so what I'd like you to do is I'd like you to do some things that reassure her about this. I'd like you to reduce the feeling of discomfort gradually, I don't want you to rush at this and do it all instantly. But Janet certainly knows that someone can wake up in the morning and find that ("yes" finger moves) that's right, that their pain has totally gone. That's right, that's already part of her belief system. A doctor told her that, and, well a doctor would know wouldn't they? You're allowed to.

Again, I'm pacing Janet's doubt about her ability. In fact, immediately after this session concluded, Janet told me that she had no pain at all, so the change was much faster than I'm asking for it to be. Such mismatching of my less relevant suggestions is very acceptable!

Janet: It was a nurse. It was a nurse, so nurses know more than doctors.

Richard: Oh well, okay. ("yes" finger moves). Oh, your unconscious mind agrees with that. Okay. (laughing) Well, we've got enthusiastic support here from your unconscious mind and you know what that means of course is that it's possible for your unconscious mind to start right now to reduce the feeling of discomfort. Now I'd like you the unconscious mind to go right ahead and <u>do that now</u>. Begin reducing the feeling of discomfort – that's right. Good. Enough so that Janet can feel the comfort increasing as you reduce it. Just go right ahead and reduce it. And you can enjoy this.

This last piece ("And you can enjoy this") is said looking at Janet's face (ie to her conscious mind) whereas the rest is said looking at her hand.

Janet: Mmm.

Richard: I mean you waited long enough for this, what the heck. See I've done this before.

Janet: Oh yes, have you?

Richard: I had a guy come and see me one time and he could hardly walk in the door because you know he had back pain. What he did was, a few years before, he injured his back, and he

I'm now telling a metaphorical

was working as a farmer and that was his job. Well, he injured his back real good and he ended up lying on his back in bed for a year. He couldn't move for a year. And then he gradually got better you see and it scared the heck out of him. I mean he was really frightened by it: the thought that his body could do that. And he even began to think that his body was against him, you know. So he kind of got gradually better. He switched jobs. You know he started working as a counsellor actually and then he had a scary experience. As he got better he started going back to the gym, building up his body. And one day he pushed himself a little more than usual at the gym and suddenly, his back gave way and he couldn't move. And he had managed over the next few weeks, he managed to get so that with a bit of help he could walk. He struggled into my office you know. He sat down, and I got him to make finger signals like this. And I pointed out to him the stuff I've been telling you, that if you do this you can do pretty much anything.....so he – the problem was though that he thought that his back was causing that excruciating pain in order to punish him for something. And it's just not like that. Your unconscious mind is really trying to do the very best that it knows how to do to help you, and if it thinks you're in danger, then it will try and send you signals. And you know I told him I was sure that his back was sending him those signals because it wanted him to be safe from even worse things. And it really believed it was doing the best. And if it really understood that, then it could <u>do even better</u>. And it could do something so much better that he would feel completely comfortable immediately. And he stood up and he walked out of there fine. And I spoke to him a few months later and he just hadn't had any of those problems anymore. Now this is – you may have thought at first this is not all that good a news for chiropractors and so on you know, osteopaths and all that, but I think it's actually pretty good news, and I think it's pretty good news because what it tells us is that the unconscious mind is on our side. And you understand that unconscious mind don't you. That's right. You understand that what you've been trying to do is something that's in Janet's best interests. And just let us know by moving one of those fingers to let us know. You've been trying to do something that's in Janet's interest. That's right.

Janet: It's really building up to it.

Richard: Yeah. You can feel it can you? Isn't that interesting so

Janet: I can feel it building up to it. It's like it wants to.

Richard: Yeah, so now you're getting to the point where you can feel the.....and can you feel; sometimes you can feel the movement right down to (gestures to back of hand)

story. This story is true, and I am drawing attention to similarities between the story situation and Janet's situation. She can consider in this dissociated way that someone might be frightened by their unconscious responses, or that someone might have believed that their unconscious was hostile or unresponsive.

Having told her that such problems can totally disappear, and stay gone, I then move on to discuss whether this is a good thing or not. I don't care whether she disagrees with me about this or not; her thinking about it shifts her attention from arguing with the previous suggestions about the change lasting.

Janet: Yeah, it's like a buildup and it feels like it doesn't want to move.

Richard: I know, but see that's what unconscious movement is like. It's like, if it just moves instantly all the time, then probably the person's doing it consciously. But you can <u>feel</u> that the unconscious mind is organising its resources to reply yes, and you can feel the finger that it's moving that it's moving that "yes" signal to because.....

Janet: Yeah I can. It doesn't want to move.

Richard: So I'm just checking that you the unconscious mind remember that it's okay to move that finger because (finger moves) that's right it is. There you go. Sometimes they need reassuring, you know.

Janet: Mmm. They're not quite sure what they're answering.

Janet still has doubts that the process is reliable (either consciously or unconsciously). I simply reframe each response as evidence that things are working well. A fast response proves that the unconscious has learned; a slow response proves it's not just a conscious scam.

Richard: Right, well, you know how that is now, and how we're talking to your unconscious mind now? Well it turns out you're allowed to keep talking to it after I'm gone as well you know that you can keep doing this. And I think that's worth doing. Because now that you understand that you have control over all of those things – the sensations in your body. You have control over not just the sensation but also the muscle movements. You can cause muscles to move or relax instantly. And the more that you trust your unconscious – this is important. This is going to make a big difference.

Janet: I can see where it's very useful.

Richard: Yeah. If you could do the stuff you've been doing in your arm there, and you could do it anywhere in your body you want, <u>you've got this solved</u>.

Janet: Yeah.

Richard: There can't be any pain, any things like pulsing pain there or anything without muscle contracting. If your muscles relax there, if you can get them to do what you want, <u>it's gone</u>. And that's only the beginning. Because do you the unconscious mind understand that you can remove the pain receptors from any area where you don't need the information? You do exactly, and that means you can go right ahead and start that <u>now</u>. ("yes" finger moves)

I'm continuing to explain my model of how this works, while futurepacing Janet (having her think of how she will use the learnings from this session in future situations)

In my comment I emphasise the word "now" and use command tonality.

Verify Change

Richard: Thank you. And sometimes you have to talk a little

firmly to your unconscious mind and really tell it because you deserve to be comfortable and you've got this incredible unconscious mind, and you've got a conscious mind that is learning all these things about your unconscious mind, and if your conscious mind..... that means your conscious mind is learning more and more how to be on side with your unconscious. What we're doing now is the other way. We're making sure your unconscious mind is totally on board with you, is on your side, is understanding the ways in which it can change this, and as I explained to that guy, you know, it's easy to change this. It's much easier than you thought. Your conscious mind can carry on being sceptical about this, because that's served you well hasn't it?

On the one hand, I want to honour the useful purpose of Janet's scepticism. On the other, I do not want her to feel that we have to tiptoe around it as if we might upset something. Her situation is too serious to play maybe-maybe not games with. If she wants change she needs to firmly demand it of herself.

Janet: Yeah, I guess it has.

Richard: I mean, it's important. I mean, like that is a healthy thing. I'm a sceptic, you know that.

Janet: Yes, I know that.

Richard: So the only reason I believe these things is because I'm sceptical enough to test out everything. I didn't believe any of this stuff until I could find that it works on people I'm using with. I've found that it works on everyone that I've, you know, wanted to talk to their unconscious mind and that it makes a difference. And it's not because I know how to do it, it's because your unconscious mind was always able to do these things. I don't know if you feel the change in your comfort level yet, but you the unconscious mind can tell us; just confirm for us that you're making the adjustments so that..... that's right (finger moving) you are. Do you notice that consciously yet?

This is a clear test of the effectiveness of our session. Janet notices that her pain has reduced markedly in the last few minutes. Her scepticism is an important part of her career and I suggest jobs it could usefully do while her unconscious mind continues to protect her from pain.

Janet: Yeah, my conscious mind's noticing it yeah.

Richard: Yeah. This is pretty good isn't it?

Janet: Yeah, it is, it's excellent.

Ecological Exit

Richard: I mean I'm not kidding. You've waited for months for this and you've been sitting around with an absolute genius inside you, who knows how to regulate every cell in your body, and for good reason, it's been hard for you to believe that that would be that easy. And I want you to preserve that scepticism because there's a lot of flaky stuff in the world.

Janet: The lunatic fringe, yeah.

Richard: Yeah.

Janet: I just wonder though. I mean my unconscious mind is saying yes, yes, yes, yes, yes and I am, yes I'm still sceptical. And I'm just wondering what I need to do consciously.

Richard: Right, to allow this....

Janet: I mean when we finish this session to allow this to continue.

Richard: Yeah. So okay, now we're on track. Now what you're thinking is: "How can I use my conscious mind?" because your conscious mind has scepticism for a good reason, and I think it's actually healthy to check things out in that way and what this means is it's just a matter of working out how can your conscious mind serve you more effectively. It has things it knows how to do. Do you know the story: You've done some meditation – awareness meditation? What sort of meditation did you say?

Pacing her experience with Buddhism, I will now tell he a Buddhist story about allowing the sceptical conscious mind to find a useful function, so that the learnings get through at an unconscious level.

Janet: Ah mindfulness meditation, Buddhist meditation.

Richard: Yeah. Do you know the story of how the Buddhist texts got from India to China?

Janet: No.

Richard: Because there's a metaphorical story about that that they tell in China and the story concerns Monkey. Have you heard it when I mention that?

Janet: Mmm. Monkey yeah.

Richard: Yeah, Monkey – Sun Hou Tzu.

Janet: It's in Taoist....

Richard: Yeah exactly, and the idea in that is that the monkey <u>mind</u> is the conscious mind, is always leaping around and analysing things, and wants to be in charge of the universe. You know one of the stories is that the monkey says he wants to be in charge of the universe and the Buddha says "Well okay, if you're going to be in charge of the universe, you have to be able to get from one side of it to the other obviously." The Monkey goes "Yeah", so the Buddha says "Alright, so just leap to the other side of the universe and bring back something you know, so I know that you've been there." So the Monkey leaps right to the edge of the universe and it turns out there are huge mountains up there, and he makes a mark, makes his name, Sun Hou Tzu, on the mountains and leaps back to the Buddha very smug and says

"Now, I've left my mark on the edge of the universe", and the Buddha holds up his hand and there's the Monkey's name written on his fingertip. And that's all he was doing. And then, so then the problem is though that Monkey's still trying to think how to be in control, because that's his nature. You know he likes to be in charge and he's a trickster, he's playful you know, like he's got a quick mind. And so they think about this in a lot of different ways, how to deal with this: when I say they, The Buddha and Kuan Yin the bodhisattva.

Possible metaphorical meaning: "Your conscious mind thinks it is very smart, but your unconscious mind is vastly smarter."

Janet: The goddess of compassion.

Richard: Yeah, the goddess of compassion, so they think about how can we deal with the Monkey, and what they do is finally they say to him "Look we're trying to get these important teachings from India to China, and we've got a monk whose name is Tripitaka who's going to be travelling from India to China through many different places. It's a challenging journey, it's a long journey, it's a lifetime mission, and what we need is someone who's strong enough, brave enough, courageous enough to protect the teachings as they go, and they give him that job. That's a good job for the conscious mind.

Possible metaphorical meaning: "Give your conscious mind the task of being playful and sceptical in defence of the new learnings you have, rather than using its energy to harm you."

Janet: Yep.

Richard: So do you understand that, unconscious mind (finger moves). Yeah, I thought you would. That's what metaphors are for.

Janet: Mmm exactly.

Richard: Now I guess part of the usefulness of this is like, as you allow this unconscious change to happen so that you can feel comfortable, and I mean <u>really feel comfortable</u>, I mean you can allow this to change so you feel totally comfortable; you can be someone who surprises doctors, you know.

Janet: Mmm. I can already see the look on their faces you know.

Now Janet is futurepacing the successful results of our session. I also rehearse her through the possible scepticism of others.

Richard: Exactly. That's what I was wondering if you realised what this will do. They're not going to believe you at first of course. They're going to say "This thing", - if you told them what happened over the last few minutes, they're going to say "I think you imagined that Janet."

Janet: Mmm. Interesting. I'll check it out with my psychologist and see what she thinks.

Richard: Yeah. That's right.

Janet: She, I think J– will be alright with it but I don't think M– will.

Richard: Right, well it's nice to know who you can tell this stuff to and who you need to frame it carefully for.

Janet: And I think if they don't need to know.....

Richard: That's exactly right and that's about looking after yourself; it's about making sure that this change is, you know, we'd use the word 'ecological'.

This entire piece of conversation is predicated on the idea that her pain has gone.

Janet: Well I just don't know with doctors though, I mean whether I'd want them to think that they're the ones that have actually done it. I might just tell them anyway.

Richard: Yeah. So they know <u>you did it</u>. Yeah, well.

Janet: I'll think about that one – I may not need to do that at all.

Richard: Yeah. You deserve to get some credit for this.

Janet: Could just be my own little secret maybe.

Richard: So how ever you.....So.....

Janet: Can I have my hand back? 'Cause it's cold.

Richard: Yeah. Free movement returns to your hand and arm.

Janet: You should have some hot water, if you're going to do this very often Richard.

Richard: Yeah. That's another thing you know – how you can create those sensations of coolness and warmth in places, you know. That's.....

Janet: Oh that's right. My unconscious mind can do this can't it?

Richard: Yeah. I mean do you know the feeling of coolness that, have you ever; do you remember going to school when you were young and having that feeling of coldness on your hand and how it goes numb.....how the fingers go numb?

Janet: Yeah, and my toes, through the puddles.

Richard: Exactly, and they go quite numb. You know, so you don't feel it. Of course, that's another thing you can with nerve endings, you know in the meantime while they change, is you can cause them to go numb like that. You notice how quickly that

More suggestions to the unconscious mind to keep changing this.

happens with your hand if you just hold the muscles in a certain way; and your unconscious mind knows how to do that. But that's another whole – we could. There are 100 ways to solve this instantly.

Janet: We've solved it already haven't we.

Now that we are agreed that it's solved, my question "What are we going to play with next?" presupposes success and that we are having fun.

Richard: I'm afraid so.

Janet: Great. Excellent.

Richard: So. What are we going to play with next?

Janet: Ah, the world's my oyster now!

Follow Up

Richard: So Janet, it's been two weeks since we did that last session and during that time you've been doing some other NLP work because you've been doing an NLP training. So I had a couple of questions. I was interested in finding out for example what was the session like? As you think back to it now, what was it like going through that session? We did a couple of things. We did the things with the discomfort that you'd had.

Two weeks later, Janet is able to describe her response to arm catalepsy (which she expressed doubts about the reality of, during the session). She now says that was "weird" and also amusing.

Janet: Yeah, the session was a bit weird I guess with the arm thing and remembering the feeling of the arm and what that had meant.

Richard: Right. So that was a whole new kind of experience.

Janet: Yeah. It was a whole new experience. But it was sort of – I had a bit of a giggle at the same time so.

Richard: And over this week you've had time to find out to what extent anything has changed. Like, what's happened over this week with the couple of things that we were working with?

Janet: Well, immediately after the session that we had I felt just absolutely wonderful and I drove from here back to Hamilton and I didn't take any medication that whole day, that whole night.

This is a description of a medical miracle. The initial duration of pain free time is longer than we would expect with any placebo results. Her unconscious mind has demonstrated its

Richard: Right. Is that something that would happen every so often for you?

Janet: No, no. I've been taking 60 milligrams 3 times a day.

Richard: Right.

Janet: And I could walk into the house and my brother asked me

how it was going and I said. "Oh yeah, it's really, really good. I had a video session today and I got cured of my pain." And I just sort of walked away. He did a double take and thought, wow. Over the week that's just been and the rest of that week, at times the pain would sort of come back, but not at the same strength. And so I've managed to cut my medication down to just 30 milligrams twice a day.

ability to completely solve this problem.

Richard: Oh, that's pretty exciting.

Janet: So, yeah, that's changed. And throughout the various processes that we've done with Transformations; yeah some mornings I get up and I set a goal and I get up and there's no pain. And then sometimes it comes back. So it's definitely, yeah, I think the big thing is the medications – the medication's down and it's coming in and out.

Janet now has very clear "NLP compatible" frames for understanding the results she is getting. She is able to recognise that, to the extent that she keeps in charge of her mind-body, she can completely eliminate this pain.

Richard: Yeah, so the medication's reduced and it sounds like you almost have more sense of – it's not total control – but it's some kind of sense of control or that you're participating in making yourself more comfortable.

Janet: Yes; that feeling goes up and down as well. Generally I'm really, sometimes I'm really strong in the magic that I'm creating for myself, and other times I'm a bit doubtful, that you know, you can't change your personality quite that fast – I'm working on it.

Her doubt about changing her personality fast is, in my model of the world, another opening for NLP change techniques, but this is merely a followup interview, so we both use a little light humour about it. Janet also reported noticing success with the other issue that we dealt with in our hour long session, but that's another story….

Richard: Well, we wouldn't want to do that in one hour, but.....

Janet: No. No. Other people might; I need to do it over a bit longer.

Richard: Gently; yeah.

The Author

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